

Archives and Records Management



Retention Schedules

Specific Schedules: SRDS 0011205

Health Services Authority Records Retention/Disposal: F

General Health Services Records (i)

Hospital Services Records (ii)

Hospital Patients Case Records (iii)

Hospital Building Records (see Buildings Records)

Health Services Authority Personnel Records (see GRS-Personnel Records)

Health Services Authority Financial Records (see GRS-Finance)

These schedules are aimed at Permanent Secretary, Ministry of Health, Chief of Medical Staff, and Heads of Divisions/Units within the Health Services, senior staff, records officers and other stakeholders.

You are kindly requested to apply the Schedules diligently

Chief Records Management Officer

Deputy Governor's Officer.

1st December, 2005

Retention/Disposal Scheduling

Specific Records Disposal Schedules: SRDS: 0011205

***Health Services Authority Records Retention Disposal Schedules: (F)**

1. Nature and Scope of Records

1.1 National Health Service records created in the Health Services Authority are designated public records. Chief Executives and senior managers of all NHS Authority bodies are personally accountable for records management within their organisation and have a duty to make arrangements for the safekeeping of those records under the overall supervision of the Chief Executive of the National Archives. The Department of Health is the liaison point between them and National Archives whose responsibility is to ensure the permanent preservation of valuable records. Locally relevant records over 30 years old, and of permanent archival value are to be kept in places of deposit as laid out in the law. The retention periods indicate only the minimum document retention periods based on legal and other requirements: there may be circumstances where records could be kept for longer periods for specific purposes.

2. General Notes

In the light of the latest trends in medical and historical research, it may be appropriate to select some of these records for permanent preservation. Selection should be performed in consultation with health professionals and archivists. If records are to be sampled, specialist advice should be sought from the same health professionals and archivists. If a NHS Trust or Health Authority has taken on a leading role in the development of specialised treatments, then the patient records relating to these treatments may be especially worthy of permanent preservation.

If a whole run of patient records is considered worthy of permanent preservation but nevertheless contains some material of research value, then the option of presenting these records to local records offices and other institution should be considered. Advice on the presentation procedure may be obtained from the National Archives.

If a whole run of patient records is considered worthy of permanent preservation but there is a lack of space in the relevant place of deposit to store these records, it may be appropriate to make a microfilm copy and then to destroy the paper originals. Microfilms should be produced in accordance with the British and International Standard BS ISO 6199: copies of which can be purchased from the British Standards Institute.

3. Notes on the destruction of confidential patient records

Destruction of confidential records must ensure that their confidentiality is fully maintained. Normally destruction should be by incineration or shredding. Where a contractor provides this service it is the responsibility of the Health Authority to satisfy itself that the methods used throughout all stages including transport to the destruction site provide satisfactory safeguards against accidental loss or disclosure.

4. Where the period of retention is indicated with an asterisk (*) permanent preservation must be considered and the advice of the Archivist on an appropriate 'place of deposit' for public records obtained.

5. This section does not cover GP medical records

The retention periods that are listed in the GP medical records schedule reflect minimum requirements of clinical need. Personal health records may be required as evidence in legal actions; the minimum retention periods take account of this requirement. It is not necessary to keep every piece of paper received in connection with patients. HS Trusts and Health Authorities should determine in consultation with health professionals which elements should be considered as a permanent paper record and which should be transient and discarded as their value ceases.

Any reference to “conclusion of treatment” in the following recommended minimum retention period should be taken to include all follow-up checks and action in connection with the treatment

Before any destruction takes place, ensure that

- a) there is consultancy with the relevant health professional body or records committee and actions clearly minuted;
- b) any other local clinical need is considered; and
- c) the value of the records of long-term research purposes has been assessed in consultation with the Archivist

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General Health Service Records: F (i)

No.	Type of Record	Retention Period (KIOF)	Action to be taken and notes
1	Accident Register	3 years	Decision to be made with Health Professionals
2	Admission books	3 years	Decision to be made with Health Professional and Archivist
3	Agendas	2 years	To Records Centre
4	Audit Records- Original Documents	2 years	From completion of audit
5	Audit Reports (including Management Letters, reports and systems/final accounts memorandum)	2 years	After formal clearance by statutory auditor To Records Centre
6	Birth register (i.e. register of births kept by hospital)		Local decision should be made with regards to the permanent preservation of these records, in consultation with the relevant health professional and Archivist
7	Computerised records	6 years	The recommended minimum retention periods apply to paper and computerised records, though extra care needs to be taken to prevent corruption or deterioration of the data. Recording/migration of data will also need to be considered as equipment and software become obsolete.
8	Funding Data	6	To Records Centre
9	Health Records-personal/patients		See Hospital Patient Case Records
10	History of Authority or Predecessors, its organisation and procedures	6 years	To Records Centre
11	History of Hospitals	6 years	To Records Centre

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Hospital Services Records: F (ii)

No.	Type of Record/Description	Retention Period (KIOF)	Action to be taken
1	Hospital Services	10 years	*
2	Indexes	Lifetime	Registry lists may describe public records marked for permanent preservation, or contain the record of management of public records. They should, in these cases, be retained permanently. Files-list and documents lists, where public records and their management are not covered, should be retained until they have no further administrative use.
3	Industrial Relation (not routine staff matters)	*	*
4	Inspection Reports- (Boiler, lift etc.)	Lifetime	Normally retain for the lifetime of an installation. However, it is necessary to assess whether obligations incurred during the lifetime may not be invoked until afterwards, in which case a judgement should be made. If where is any measurable risk of a liability in respect of installations beyond their operational lives, records of this kind should be retained indefinitely.
5	Inventories (not in current use) of items having a life of less than 5 years	2	Keep for Board of Survey and then destroy
6	Job Advertisements	1	Destroy
7	Job Applications (following termination of employment)	3	Destroy
8	Job Descriptions (following termination of employment)	3	Destroy
9	Laboratory records		Local decisions should be made with regard to the permanent preservation of these records, in consultation with relevant health professionals and Archivist
10.	Manuals – operating	Lifetime	*

11	Manuals –policy and procedures	Lifetime	
12	Maps	*	
13	Maternity records		See Hospital patient case records
14	Medical records		See Hospital patient case records
15	Meeting papers- committees, sub-committees, predecessors (Master copies)	Permanent	To Archives
16	Midwifery records		See Hospital Patient case records
17	Minutes of the NHS Trust or Health Authority, major committees and sub-committees-signed	Permanent	To Archives
18	Minutes – reference copies	1	Complete set to be retained. Destroy Duplicates
19	Mortgage documents (acquisition, transfer and disposal)	Permanent	To Archives
20	Nominal Rolls	6	As a general rule, it may be appropriate for only the current nominal roll and the immediately preceding roll to be kept

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Hospital Patient Case Records: F (iii)

Hospital patient case records (Individual)

Date	Type of Record/Description	Retention Period (KIOF)	Action to be taken
1.	Abortion records	3 years	See Abortion Regulation, Statutory instruments-Note: some authorities recommend 8 years retention as patient notes.
2.	Children and young people	Until the patient's 25 th birthday or 26 th if young person was 17 at conclusion of treatment: or 8 years after patient's death has occurred before 18 th birthday	
3.	Donor records	11 years post transplantation Committee	See Regulations
4.	Maternity (all obstetric and midwifery records including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years	Maternity records retained should include booking data pregnancy records, antenatal records, intrapartum and postnatal records, including prescriptions, clinical test results and scans
5.	Mentally disordered persons (with in the meaning of the Mental Health Act	20 years after no further treatment considered necessary; or	8 years after the patient's death if the patient died while still receiving treatment
6.	Oncology	8 years after conclusion of treatment especially when surgery only involved	*
7.	Patients involved in clinical trails	15 years after conclusion of treatment especially when surgery only involved	*
8.	All other hospital patients case records	8 years after conclusion of treatment especially when surgery only involved	After conclusion of treatment
9.	Establishment records – minor (e.g. attendance books, annual leave record, duty rosters, clock cards, timesheets)	2 years	Destroy
10.	Forms-Surgical Appliances	2 From completion of the audit	Destroy
11.	Forms-Superannuation	10	Originals are sent to Human Resources
12.	Funding Data	6	To Records Centre
13.	FWH- Personal Record of Hours Actually Worked	0.5	Destroy
14.	Health Records-personal/patients		See Hospital Patient case records
15.	All other Hospital Patients case records	All other Hospital Patients case records	

16.	Day Files	1 year	Discuss with Health Professionals
17.	Death registers (i.e. Register of death kept by hospital)	Permanent	Local decisions should be made with regard to the permanent preservation of these records, in consultation with the relevant health professionals and places of deposit
18.	Debtor's records-cleared	2 years from completion of the audit	Destroy
19.	Debtor's records-unclear	6 years	After clearance -Destroy
20.	Deeds of Title	Permanent	T A
21.	Delivery Notes	1.5 years	Destroy
22.	Diaries –office – completion	1 year	To Records Centre
23.	Discharge books (i.e. register of those discharged by the hospital)	Permanent	Local decisions should be made with regard to the permanent preservation of these records, in consultation with the relevant health professionals and places of deposit
24.	Equipment		See Products-Liability
25.	Establishment records – major (e.g. Personal files, letters of appointment, contracts references and related correspondence)	Keep for 6 years after the subject of the files leaves service, or until the subject's 70 th birthday, whichever is later	Only the summary needs to be kept to age 70; remainder of file can be destroyed 6 years after subject leaves service

Abbreviations:

KIOF: Keep In Office For

R.C.: Records Centre

TA. To Archives