NHS SCOTLAND

eHealth
Better eHealth: Better Care

The Scottish Government

SCOTTISH GOVERNMENT RECORDS MANAGEMENT: NHS CODE OF PRACTICE (SCOTLAND) Version 2.1

January 2012

Records Management: NHS Code of Practice (Scotland)

The Scottish Government, Edinburgh 2012

This document is available from our website at **www.scotland.gov.uk**.

ISBN: 978-1-78045-547-1 (web only)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS12340 (01/12)

Published by the Scottish Government, January 2012

DOCUMENT CONTROL SHEET:

Title:	***Records Management: NHSScotland Guidance***
Date Published/Issued:	January 2012
Date Effective From:	January 2012
Version/Issue Number:	Version 2.1
Document Type:	Best Practice Guidance
Document status:	Final
Author:	Information Assurance Manager
Owner:	eHealth Directorate, Scottish Government
Contact:	Information Assurance Manager
Target Audience	Records Managers
Supersedes	▪ CEL 31 (2010) - Records Management: NHS Code of Practice (Scotland)

Distribution: This document has been distributed to

Name:	**Title/Organisation :**	**Date of Issue:**	**Version:**

Contents

SECTION 1 – FOREWORD

Background

1. The Records Management: NHS Code of Practice, version 2.0, was published by the Scottish Government in August 2010, as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in Scotland.

2. This document is a refreshed version for 2011. It is based on current legal requirements and professional best practice.

3. The original guidance was drafted in collaboration with a working group made up of representatives from the Scottish Government, Scottish NHS archivists, NHS Health Records Managers, patient groups and GP Practices. It has subsequently been reviewed and updated following the recommendations contained within the Strathmartine Report published in 2008, requests from the service to incorporate the guidance and retention schedules for both Health Records and Administrative Records in to a single document, and feedback received from the service since publication.

4. This 2011 update takes into account the Public Records (Scotland) Act 2011, which seeks to improve records management across Scottish public authorities, including NHS Boards. This revised code offers guidance that is well aligned with the aims of this legislation.

Strategic Context

5. The Healthcare Quality Strategy for NHSScotland puts people at the heart of everything the health service does. Through the implementation of the strategy, people will be encouraged to be partners in their own care and can expect a culture of continuous improvement within the NHS. Going forward, the effectiveness and safety of care and the efficient management of healthcare services depends on the right information being available to the right people at the right time. This Code provides a key component of the information governance arrangements that are necessary to support this significant culture change.

Aims

6. The aims of this NHS Code of Practice are to:

- establish, as part of the Information Assurance Strategy, records management best practice in relation to the creation, use, storage, management and disposal of NHS records;
- provide information on the general legal obligations that apply to NHS records;
- set out recommendations for best practice to assist in fulfilling these obligations, for example adhering to National Information Governance Standards;
- explain the requirement to select records for permanent preservation;
- set out recommended minimum periods for retention of NHS personal health records and administrative records, regardless of the media on which they are held; and
- indicate where further information on records management may be found.

7. This is an evolving document because standards and practice covered by the Code will change over time. It will therefore be subject to regular review and updated as necessary, with the next review scheduled for 2012, once the implications of the Public Records (Scotland) Act 2011 are fully understood.

Types of Record covered by the Code of Practice

8. The following types of NHS records are covered by this Code of Practice (including records of NHS patients treated on behalf of the NHS in the private health sector) regardless of the media on which they are held, including paper, electronic, still and video images, and sound:

- personal health records (paper based or electronic including those concerning all specialties, and GP medical records);
- records of private patients seen on NHS premises;
- records of blood and tissue donors;
- accident & emergency, birth, and all other registers;
- theatre registers & minor operations (and other related);
- x-ray and imaging reports, output and images;
- administrative records (including, for example, general, financial, property, environmental, health and safety, human resource, procurement/stores, NHS Board and service planning records).

Annex B applies to personal health records and annex C to administrative records.

Please note:

- sections **1, 2, 3**, **annex B** and **C** are for implementation;
- annexes **A** is to aid understanding.

SECTION 2 – INTRODUCTION

9. The guidelines draw on advice and published guidance available from the Scottish Government Freedom of Information Unit and the National Records of Scotland, such as the section 61 Code of Practice on Records Management, and also from best practices followed by a wide range of organisations in both the public and private sectors. The guidelines provide a framework for consistent and effective records management that is standards based and fully integrated with other key information governance work areas.

10. This is an overarching Code of Practice on records management for Scottish NHS organisations. It incorporates references and links to previously published guidance and also takes cognisance of the recommendations accepted by the Cabinet Secretary for Health and Wellbeing in October 2008 following publication of the NHS QIS (now Healthcare Improvement Scotland) report in response to reports that person identifiable information had been found in disused buildings on the former Strathmartine Hospital in Tayside.

11. NHS managers should demonstrate active progress in enabling staff to conform to the standards, identifying resource requirements and any related areas where organisational or systems changes are required. Information Governance performance assessment and management arrangements need to facilitate and drive forward the required changes. Those responsible for monitoring NHS performance, (e.g. Healthcare Improvement Scotland) will play a key role in ensuring that effective systems are in place.

12. The NHS is provided with support to deliver change through:

- Information Governance materials available via the IG Knowledge Network; and
- Policy advisers in the Scottish Government eHealth Team.

General Context

13. All NHS organisations are public authorities under Schedule 1 of the Freedom of Information (Scotland) Act 2002, and the records they create are subject to the Public Records (Scotland) Act 2011. Scottish Ministers and all NHS organisations are obliged under Data Protection, Freedom of Information legislation, and the Environmental Information (Scotland) Regulations 2004, to make arrangements for the safe keeping and eventual disposal of all types of their records. This is carried out under the overall guidance and supervision of the Keeper of the Records of Scotland, who is answerable to the Scottish Parliament. Whilst this Code of Practice is based on the Scottish Government's understanding of the relevant law in Scotland, as at the date of publication it is not, and should not be read as, a statement of the definitive legal position on any matter. NHS organisations should consult their own legal advisors for advice on any legal issues that arise regarding the matters covered in this Code of Practice.

14. NHS organisations should seek advice from their Board's own archivist on the management of records, particularly in relation to the permanent preservation of records. Where organisations do not have access to their own archivist, advice may be sought from the NHSScotland archivists, or the National Records of Scotland.

15. Part one of the Freedom of Information (Scotland) Act 2002 Code of Practice on Records Management states:

"Records management should be recognised as a specific corporate function within the authority and should receive the necessary levels of organisational support to ensure effectiveness. It should bring together responsibilities for **all** records held by the authority, throughout their lifecycle, from planning and creation through to ultimate disposition. It should have clearly defined responsibilities and objectives, and the resources to achieve them. It is desirable that the person, or persons, responsible for the records management function should also have either direct responsibility for, or a formal working relationship with, the person(s) responsible for freedom of information, data protection and other information management issues."

16. The Chief Executive has overall accountability for ensuring that records management operates legally within the Board. The Caldicott Guardian works in liaison with the organisation's Health Records Manager(s), Corporate Records Manager(s), Information and Communications Technology (eHealth) Manager(s), Information Governance Manager(s) and others with similar responsibilities, to ensure there are agreed systems for records management including managing the confidentiality and security of information and records within their organisation. NHS organisations are also required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and/or obsolete services.

17. NHS organisations need robust records management procedures to meet the requirements set out under the Data Protection Act 1998, the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. In addition they will be required to produce and implement a records management plan under the terms of the Public Records (Scotland) Act 2011.

18. Records are a valuable resource because of the information they contain. High quality information underpins the delivery of high quality evidence based health care, accountability, clinical and corporate governance and many other key service deliverables. Information has most value when it is accurate, up to date and accessible when it is needed. An effective records management service ensures that information is properly managed and is available whenever and wherever there is a justified need for information, and in whatever media it is held or required to:

- support patient care and continuity of care;
- support day to day business which underpins the delivery of care;
- support evidence based clinical practice;
- support sound administrative and managerial decision making, as part of the knowledge base for NHS services;
- meet legal requirements, including requests from patients or other individuals made through provisions of the Data Protection Act 1998 or Freedom of Information (Scotland) Act 2002 legislations;
- assist clinical and other audits;

- support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research; and
- support patient choice and control over treatment and services designed around patients.

19. Effective records management also supports operational efficiency by reducing the time taken to identify and locate information, minimising duplication of records and confusion over version control, and offering significant savings in physical and electronic space.

20. This Code of Practice, together with the supporting Annexes identifies the specific actions, managerial responsibilities, and recommended retention periods (in line with the 5th principle of the Data Protection Act 1998) for the effective management of all NHS records, from creation, as well as day-to-day use of the record, storage, maintenance and ultimate disposal.

21. All individuals who work for an NHS organisation are responsible for any records that they create or use in the performance of their duties. Furthermore, any record that an individual creates is subject to the Public Records (Scotland) Act 2011, and the information contained in such records is subject to the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. There is a specific requirement under Regulation 4 of the Regulations on a public authority to take reasonable steps to organise and keep up to date the environmental information relevant to its functions which it holds and at least the types of information detailed in Reg 4 (2). Further information on legal and professional obligations is available on the Information Governance section of The Knowledge Network at http://www.knowledge.scot.nhs.uk/recordsmgt/guidance

Legal and Professional Obligations

22. A key statutory requirement for compliance with records management principles is the Data Protection Act 1998. It provides a broad framework of general standards that have to be met and considered in conjunction with other legal obligations. The Act regulates the processing of personal data, held manually and on computer. It applies to personal information generally, not just to health records. Therefore the same principles apply to personal data relating to staff, contractors, volunteers, students and other individuals who work in or have dealings with NHSScotland.

23. Personal data is defined as data relating to a living individual that enables him/her to be identified either from that data alone or from that data in conjunction with other information in the data controller's possession. It therefore includes such items of information as name, address, age, race, religion, gender and physical, mental or sexual health.

24. Processing includes everything done with that information, i.e. holding, obtaining, recording, using, disclosure, sharing, disposal, transfer or destruction.

25. A summary of legislation relating to personal and corporate information and the records management function generally can be found at http://www.knowledge.scot.nhs.uk/recordsmgt/guidance Additionally, clinicians are under a duty to meet record keeping standards set by their regulatory and professional bodies.

NHSScotland eHealth Strategy

26. The eHealth programme aims to ensure a complete health record is available at the point of need in NHSScotland. The success of this will depend on many factors, and good records management will be essential to ensure paper and electronic records are managed consistently. The eHealth Strategy 2011-17 is the key document governing this area of work.

Social Care Records

27. Social Care Records Management is outside the scope of this Code of Practice. However, with greater integration and joint working between health and social care, this Code of Practice is generally applicable to all organisations, and colleagues from social care organisations are encouraged to adopt similar standards of practice.

SECTION 3 – NHS RECORDS MANAGEMENT AND INFORMATION LIFECYCLE

28. Records and information are considered to have a "lifecycle" from creation or receipt in the organisation, throughout the period of its 'active' use, then into the period of 'inactive' retention, (such as closed files which may still be required occasionally for reference purposes) and then finally to either confidential disposal or (for a very small proportion) permanent preservation in an archival facility.

29. A similar "information lifecycle" approach applies to managing the flow of an information system's data and associated metadata, from creation and initial storage to the time when it becomes obsolete and is deleted.

Roles and Responsibilities for Records Management and Organisational Responsibility

30. Effective records managements allows NHS organisations to provide and maintain a high level of service to patients and clinicians, in terms of accuracy, security, confidentiality, privacy, and integrity. Adherence to this code of practice will support organisations to act in accordance with legal requirements, standards, evidence based practice and professional work practice.

31. The records management function should be recognised as a specific corporate responsibility within every NHS organisation. It should provide a managerial focus for records of all types in all formats, including electronic records, throughout their lifecycle, from planning and creation through to ultimate disposal. It should have clearly defined responsibilities and objectives, and necessary resources to achieve them.

32. Designated members of staff of appropriate seniority (i.e. Board level or reporting directly to a Board member) should have lead responsibility for corporate and health records management within the organisation. The model within each Health Board may differ dependent on local accountability. This lead role should be formally acknowledged and made widely known throughout the organisation.

33. The manager, or managers, responsible for the records management function should be directly accountable to, or work in close association with, the manager or managers responsible for Freedom of Information, Data Protection and other information governance issues as well as the Medical Director who is operationally accountable for the quality of clinical information contained within personal health records in the organisation.

Roles

The NHS Board: is responsible for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

The Chief Executive: has overall responsibility for records management in the NHS Board. As accountable officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records Management is key to this as it will ensure appropriate, accurate information is available whenever required.

The Caldicott Guardian: has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

The Health Records Manager: is responsible for the overall development and maintenance of health records management practices throughout the organisation. They have particular responsibility for drafting guidance to support good records management practice in relation to clinical records and for promoting compliance with this Records Management Code of Practice, in such a way as to ensure the efficient, safe, appropriate and timely retrieval of patient information.

The Corporate Records Manager: is responsible for the overall development and maintenance of corporate and administrative records management practices throughout the organisation. They have particular responsibility for drafting guidance to support good records management practice (other than for clinical records) and for promoting compliance with this Records Management Code of Practice.

Local Records Management Co-ordinators:
The responsibility for records management at directorate or departmental level is devolved to the relevant directors, directorate and departmental managers. Senior managers of units and business functions within the NHS Board have overall responsibility for the management of records generated by their activities in compliance with the NHS Board's records management policy. Local Records Management Co-ordinators may be designated to support the Health and Corporate Records Manager(s) to oversee local implementation and compliance.

All Staff:
All NHS staff , whether clinical or administrative, who create, receive and use documents and records have records management responsibilities. All staff should ensure that they keep appropriate records of their work and manage those records in keeping with the Records Management Code of Practice and the relevant policies and guidance within their Board.

Training

34. All staff, whether clinical or administrative, should be appropriately trained so that they are fully aware of their personal responsibilities as individuals with respect to record keeping and management, and that they are competent to carry out their designated duties. This should include training for staff in the use of electronic records systems, where appropriate. It should be done through both generic and specific training programmes, complemented by organisational policies and procedures and guidance documentation. For example, Health Records Managers who have lead responsibility for personal health records and the operational processes associated with the provision of a comprehensive health record service should have up-to-date knowledge of, or access to expert advice on, the laws, guidelines, standards and best practice relating to records management and informatics.

35. NHSScotland, working closely with a number of NHS boards, has developed training based on the Institute of Health Records & Information Management's (IHRIM) Certificates of Technical Competence (CTC) framework. Training materials, candidate work books, trainer manuals and presentations have been developed to support candidates undertaking the course. These are available via on the Knowledge Network and at the NHS Education Scotland Admin Centre portal.

Policy and Strategy

36. Each NHS organisation should have in place an overall policy statement, endorsed by the Board and made readily available to staff at all levels of the organisation on induction and through regular update training, on how it manages all of its records, including electronic records.

37. The policy statement should provide a mandate for the performance of all records and information management functions. In particular, it should set out an organisation's commitment to create, keep and manage records and document its principal activities in this respect.

38. The policy should also:

- outline the purpose of records management within the organisation, and its relationship to the organisation's overall strategy;
- define roles and responsibilities within the organisation including the responsibility of individual NHS staff to document their actions and decisions in the organisation's records, and to dispose of records appropriately when they are no longer required;
- define roles, responsibilities and procedures for safe transfer, storage or confidential disposal of records when staff leave an organisation, or when NHS Board premises are being decommissioned;
- define the process of managing records throughout their lifecycle, from their creation, usage, maintenance and storage to their ultimate destruction or permanent preservation;
- provide a framework for supporting standards, procedures and guidelines; and
- indicate the way in which compliance with the policy and its supporting standards, procedures and guidelines will be monitored and maintained.

39. The policy statement should be reviewed at regular intervals (a minimum of once every 3 years or sooner if new legislation, codes of practice or national standards are introduced) and, if appropriate, it should be amended to maintain its currency and relevance.

Record Creation

40. Each operational unit (for example Finance, Estates and Facilities, eHealth, Human Resources, Direct Patient Care) of an NHS organisation should have in place procedures for documenting its activities. This process should take into account the legislative and regulatory environment in which the unit operates.

41. Records of operational activities should be complete and accurate in order to allow employees and their successors to undertake appropriate actions in the context of their responsibilities, to facilitate an audit or examination of the organisation by anyone so authorised, to protect the legal and other rights of the organisation, its patients, staff and any other people affected by its actions, and provide authenticity of the records so that the evidence derived from them is shown to be credible and authoritative. Appropriate version control arrangements that support the management of multiple revisions to the same document should be in place.

42. Records created by the organisation should be arranged in a record-keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information while having regard to security.

43. Not all documents created or received by NHS employees in the course of their work need to be retained for any period of time. For example, some emails are of only passing value and can be deleted as soon as they have been read or actioned. However, emails containing significant information or instructions should be retained, as appropriate, within the record-keeping system. Many circulars and routine correspondence can be destroyed once read. It should be recognised that the decision to dispose of these records immediately is still made within the context of the overall record-keeping system.

Record Keeping

44. Implementing and maintaining an effective records management service depends on knowledge of what records are held, where they are stored, who manages them, in what form(s) they are made accessible, and their relationship to organisational functions (e.g. Finance, Estates, IT, Direct Patient Care). An information survey or record audit is essential to meeting this requirement. The survey will provide a description of the record collection along with its location and details of the responsible manager. This helps to promote control over the records, and provides valuable data for developing records appraisal and disposal policies and procedures.

45. Paper and electronic record keeping systems should contain descriptive and technical documentation to enable the system to be operated efficiently, and the records held in the system to be understood. The documentation should provide an administrative context for effective management of the records.

46. The record keeping system, whether paper or electronic, should include a documented set of rules for referencing, titling, indexing, and the protective marking of records. These should be easily understood to enable the efficient retrieval of information when it is needed and to maintain security and confidentiality.

47. Records should be structured within an organisation-wide corporate "file plan" which reflects the functions and activities of the organisations and facilitates the appropriate sharing and effective retrieval of information.

48. Where records are kept in electronic form, wherever possible they should be held within an Electronic Document and Records Management System (EDRMS) which conforms to the standards of the European Union "Model Requirements" (MoReq). Find more details here

49. Where an EDRMS is not yet available, electronic records should be stored on shared, network servers in a clear and meaningful folder structure. The folder structure should reflect the organisation's fileplan in the same way as paper files, which represent the functions and activities of the organisation. The server should be subject to frequent back-up procedures in line with the NHS Information Security Policy. Users should apply the functionality of the relevant software to protect electronic documents against inappropriate amendment (for example, by password protecting documents.) Please note: it is almost impossible to fully protect documents in a non-EDRMS environment, or provide full audit and authenticity evidence.

Record Maintenance – Storage Archiving and Scanning

50. The NHS organisation should put in place robust procedures to manage control of access, retrieval and use of records to ensure continued integrity, reliability and authenticity of the records as well as their accessibility for the duration of their retention until the time of their ultimate disposal.

51. NHS organisations may consider the option of scanning records which currently exist in paper format into electronic format, for reasons such as business efficiency.

Records Inventory

52. Each NHS organisation should be clear as to which departments can register records and media containing business or personal identifiable information they are maintaining. The inventory should provide a description of the record collection along with its location and details of the responsible manager. The register should be reviewed annually. Further information can be found in Records Management Guidance Note 004 here.

Records Management Systems Audit

53. The NHS organisation will regularly audit its records management practices as part of its existing audit activity. This can include checking for compliance with this Records Management Code of Practice. Results of audits will be reported to the NHS Board through the appropriate committee.

Disclosure and Transfer of Records

54. There are a range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties, and similarly, a range of provisions that require or permit disclosure.

55. The mechanisms for transferring records from one organisation to another should also be tailored to the sensitivity of the material contained within them and the media on which they are held. Information Security staff should be able to advise on appropriate safeguards. The NHSScotland Information Security policy and eHealth Mobile Data Protection standard set out the requirements for the safe handling and transmission of corporate and health records, across a range of media.

56. In addition, guidance for administrative staff is available on The Knowledge Network.

Retention and Disposal Arrangements

57. The phrase "retention and disposal" relates to the actual processes of retention and disposal of records throughout their lifecycle (i.e. primary storage, secondary storage – which may includes microform, scanning or summarising, archiving and confidential destruction).

58. Detailed guidance for retention and disposal of personal health records can be found in Annex B.

59. Detailed guidance for retention and disposal of administrative records can be found in Annex C.

60. It is particularly important under Freedom of Information legislation that the disposal of records - which is defined as the point in their lifecycle when they are either transferred to an archive or destroyed - is undertaken in accordance with clearly established policies which have been formally adopted by the organisation and which are enforced by properly trained and authorised staff. In addition, the disposal of records should be clearly documented.

61. The design of databases and other structured information management systems must include the functionality to dispose of time-expired records. Databases should be subject to regular removal of non-current records in line with the organisation's retention schedule.

62. Each NHS organisation should have a dated documented policy which has been written/reviewed within the last three years, for the retention, archiving or destruction of the organisation's records in accordance with this Records Management Code of Practice. The policy should be ratified by the Board or by an appropriately delegated committee of the Board for example the Health Records, Information Governance or Clinical Governance Committee. The schedules should cover all series of records held, in any media, and should state the agreed retention period and disposal action, including, where appropriate, an indication of those records which should be considered for archival preservation.

63. The records policy document should contain detailed guidance of the process to be followed to ensure complete clearance and removal of business documents, health records or documents containing person identifiable information whenever NHS premises are being decommissioned. Further information can be found in Records Management Guidance Note Number 008.

Appraisal of Records

64. Appraisal refers to the process of determining whether records are worthy of permanent archival preservation. This should be undertaken in consultation with the organisations own Archivist, or with a local authority, university or other archive where there is an existing relationship

65. It is important when reviewing records that their long term historical and research value is taken in to account. Records which document the history and development of the organisation and important policy decisions, such as board or committee minutes, annual reports, policy and strategy documents and major departmental reports and investigations, should be considered. In addition, samples of patient files and older registers and ward journals are valuable for historical medical and social research. Note that no surviving personal health or administrative record dated 1948 or earlier should be destroyed.

66. National Records of Scotland can provide advice about records requiring permanent preservation.

67. Procedures should be put in place in all NHS organisations to ensure that appropriately trained personnel appraise records at the appropriate time.

Record Closure

68. Records should be closed (i.e. made inactive and transferred to secondary storage) as soon as they have ceased to be in active use other than for reference purposes. An indication that a file of paper records or folder of electronic records has been closed together with the date of closure, should be shown on the record itself as well as noted in the index or database of the files/folders. Where possible, information on the intended disposal of electronic records should be included in the metadata when the record is created.

69. The storage of closed records should follow accepted standards relating to environment, security and physical organisation of the files.

Record Disposal

70. Each organisation should have a retention/disposal policy that is based on the retention schedules referred to in paragraphs 58 and 59 of this Code of Practice. The policy should be supported by, or linked to, the retention schedules, which should cover all records created, including electronic records. Schedules should be arranged based on series or collection of records and should indicate the appropriate disposal action for all records. Schedules should clearly specify the agreed retention periods, which must be based on the retention schedules referred to in paragraphs 58 and 59 of this Code of Practice, for the organisation.

71. Records selected for archival preservation and no longer in regular use by the organisation should be transferred as soon as possible to an archive. No surviving personal health or administrative record dated 1948 or earlier should be destroyed.

72. Good practice suggests that non-active records should be transferred no later than 30 years from creation of the record, with electronic records being transferred within a shorter period.

73. Records (including copies) not selected for archival preservation and which have reached the end of their administrative life should be destroyed in as secure a manner as is appropriate for the level of confidentiality or protective markings they bear. This can be undertaken on site or via an approved contractor. Confidential records should be destroyed in accordance with BS EN 15713:2009 – Secure Destruction of Confidential Material - Code of Practice. It is the responsibility of the NHS organisation to ensure that the methods used throughout the destruction process provide appropriate safeguards against the accidental loss or disclosure of the contents of the records at every stage. Accordingly, contractors should be required to sign confidentiality undertakings and to produce written certification as proof of destruction. There is a common law duty of confidence to patients and employees as well as a duty to maintain professional ethical standards of confidentiality. This duty of confidence continues after an employee or contractor has left the NHS. Ethical obligations around confidentiality remain even after the death of a patient.

74. Many NHS records, including corporate ones, contain sensitive or confidential information. It is therefore vital that confidentiality is safeguarded at every stage of the lifecycle of the record, including destruction. The methods used to destroy records must be fully effective and secure their complete illegibility. Destruction by shredding or pulping is preferable. If the hospital or NHS organisation has no immediate access to an industrial shredder there are numerous firms that can provide this service. Recycling is an alternative option but this should only be considered for non-person identifiable or non sensitive business documents, otherwise the records should be shredded before being sent for recycling. This can be done on site or via an approved contractor.

75. It is important to have destruction as well as preservation policies for electronic records. It is often helpful that an expert can retrieve deleted files in an emergency, but this ability to retrieve deleted electronic data has inherent dangers for confidential information when hardware and software is discarded. It may also jeopardise the viability of a records management programme if records that are supposedly ‘destroyed’ can be retrieved from the system. If

hardware or software is to be discarded, advice must be sought from the relevant IT Security Officer.

76. It is essential that the destruction process is documented. The following information should be recorded and preserved by the Records Manager, so that the organisation is aware of those records that have been destroyed and are therefore no longer available:

- Description of record;
- Reference number if applicable;
- Number of records destroyed;
- Date of destruction;
- Who authorised destruction;
- Who carried out the process; and
- Reason for destruction (this should refer to the retention/disposal policy).

Disposal schedules would constitute the basis of such a record.

77. Whenever patient/client records are being destroyed the relevant Master Patient Index should be updated with the date of destruction so that this is immediately known should the patient/client represent to the service or make an enquiry for access to their health records.

78. Records should not be destroyed before the end of the period stated in the Records Management Code of Practice Annex B and C. These periods reflect the statutory time limits for legal action to be taken. Any NHS Board which ignores these minimum periods would be in breach of guidelines laid down by Scottish Government, and would run the risk of being unable to defend itself against claims for alleged medical negligence.

79. If a record due for destruction is known to be the subject of a request for information, or potential legal action, destruction should be delayed until disclosure has taken place or, if the authority has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information (Scotland) Act have been exhausted or the legal process completed. It is important to note that section 65 of FOISA and Regulation 19 of the Environmental Information (Scotland) Regulations 2004 provide that it is a criminal offence to destroy, etc. records with the intent to prevent disclosure.

SECTION 4 – USEFUL GUIDANCE

80. The following section provides a short summary of useful guidance that is available:

- Scottish Clinical Information in Practice (SCIMP) have produced the **'Good Practice Guidelines for General Practice Electronic Patient Records'** for Scottish guidance on the transfer of electronic health records.

- SCIMP have produced a simple guide to **Scanning and Document Management in General Practice**, which covers the implementation the single scanning and document management system that has now been procured for Scottish General Practices.

- The National Archives of the United Kingdom published a **'Code of Practice for Archivists and Records Managers under Section 51(4) of the Data Protection Act 1998'** (Oct 2007). Chapter 3 summarises the particular responsibilities of records managers in relation to personal data.

- **The Knowledge Network** provides a range of guidance on Information Governance matters at http://www.knowledge.scot.nhs.uk/ig

ANNEX A - GLOSSARY OF RECORDS MANAGEMENT TERMS

Note: The National Archives of the United Kingdom publishes standards, guidance and toolkits on the management of public records in all formats. These standards reflect the legislative and administrative arrangements, which apply to UK public records. However, in so far as they are applicable to Scotland, they contain helpful practical advice, which is commended to Scottish public authorities.

A

Access

The availability of, or permission to consult, records. (The National Archives, Records Management Standard RMS1.1)

Appraisal

The process of evaluating an organisation's activities to determine which records should be kept, and for how long, to meet the needs of the organisation, the requirements of Government accountability and the expectations of researchers and other users of the records. (The National Archives, Records Management Standard RMS 1.1)

Archives

Those records that are appraised as having permanent value for evidence of ongoing rights or obligations, for historical or statistical research or as part of the corporate memory of the organisation. Those records that are appraised as having permanent value. (The National Archives, Records Management Standard RMS 3.1)

Authenticity

An authentic record is one that can be proven:

- To be what it purports to be;
- To have been created or sent by the person purported to have created or sent it; and
- To have been created or sent at the time purported.

To ensure the authenticity of records, organisations should implement and document policies and procedures which control the creation, receipt, transmission, maintenance and disposition of records to ensure that records creators are authorised and identified and that records are protected against unauthorised addition, deletion, alteration, use and concealment. (BS ISO 15489-1:2001(E))

B - C

CHI Number

The CHI ('Community Health Index') number is a unique numeric identifier, allocated to each patient on first registration with the system. It is a 10-character code consisting of the 6-digit date of birth (DDMMYY), two digits, a 9th digit, which is always even for females and odd for males, and an arithmetical check digit. It is a key component in the implementation of an Electronic Patient Record in Scotland.

Classification

The systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in a classification system. (BS ISO 15489-1:2001(E))

Conversion (See Also Migration)

The process of changing records from one medium to another, or from one format to another. (BS ISO 15489-1:2001(E))

Corporate Records

Records (other than health records) that are of, or relating to, an organisation's business activities covering all the functions, processes, activities and transactions of the organisation and of its employees.

Current Records

Current records are those records necessary for conducting the current and on-going business of an organisation.

D

Destruction

The process of eliminating or deleting records beyond any possible reconstruction. (BS ISO 15489-1.2001(E))

Disposal

Disposal is the implementation of appraisal and review decisions. These comprise the destruction of records and the transfer of custody of records (including the transfer of selected records to an archive institution). They may also include the movement of records from one system to another (for example, paper to electronic). (The National Archives, Records Management Standard RMS1.1)

Disposition

A range of processes associated with implementing records retention, destruction or transfer decisions which are documented in disposition authorities or other instruments. (BS ISO 15489- 1:2001(E))

E

Electronic Record Management System

A system that manages electronic records throughout their lifecycle, from creation and capture through to their disposal or permanent retention, and retains their integrity and authenticity while ensuring that they remain accessible.

F - G

File

An organised unit of documents grouped together either for current use by the creator or in the process of archival arrangement, because they relate to the same subject, activity or transaction. A file is usually the basic unit within a records series.

An accumulation of records maintained in a predetermined physical arrangement. Used primarily in reference to current records. (The National Archives, Records Management Standard RMS 1.1)

Filing System

A plan for organising records so that they can be found when needed. (The National Archives, Records Management Standard RMS 1.1)

H

Health Record

Health records are the most important tool to support patient care and continuity of that care. The health record is a single record with a unique identifier, which is a composite of all data on a given patient held by an organisation. It contains information relating to the physical or mental health of an individual who can be identified from that information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that individual. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the on-going care of the patient to which it refers.

I

Indexing

The process of establishing access points to facilitate retrieval of records and/or information. (BS ISO 15489-1:2001(E))

Information Audit

An information audit looks at the means by which an information survey will be carried out and what the survey is intended to capture.

Information Survey/Records Audit

An information survey or records audit is the comprehensive gathering of information about records created or processed by an organisation. It helps an organisation to promote control over its records, and provides valuable data for developing records appraisal and disposal procedures. It will also help an organisation to:

- Identify where and when records are generated and stored within the organisation and how they are ultimately disposed of;

- Accurately chart the current situation in respect of records storage and retention organisation-wide, to make recommendations on the way forward and the resource implications to meet existing and future demands of the records management function.

Integrity of Records

The integrity of a record refers to its being complete and unaltered. It is necessary that a record be protected against unauthorised alteration. Records management policies and procedures should specify what additions or annotations may be made to a record after it is created, under what circumstances additions or annotations may be authorised and who is authorised to take them. Any unauthorised annotation, addition or deletion to a record should be explicitly indicated and traceable.

J

Jointly Held Records

Where a record is jointly held by health and social care professionals, e.g. in an Integrated Health and Social Care Community Mental Health Team (CMHT), it should be retained for the longest period for that type of record. That is, if social care has a longer retention period than health, the record should be held for the longer period.

K - M

Metadata

Contextual information about a record. Data describing context, content and structure of records and their management through time. Metadata is structured information that enables us to describe, locate, control and manage other information. Metadata can be broadly defined as "data about data". Metadata is defined in ISO 15489 as: data describing context, content and structure of records and their management through time. It refers to the searchable definitional data that provides information about or documentation of other data managed within an application or environment. For example, a library catalogue, which contains data about the nature and location of a book, is data about the data in the book.

Therefore, metadata should include (amongst other details) elements such as the title, subject and description of a record, the creator and any contributors, the date and format. For further information, see The National Archives: Metadata Standard here

The e-Government Metadata Standard (e-GMS) lays down the elements refinements and encoding schemes to be used by government officers when creating metadata for their information systems. The e-GMS forms part of the e-Government Information Framework (e-GIF). The e-GMS is required to ensure maximum consistency of metadata across public sector organisations. Find out more here

Microform

Records in the form of microfilm or microfiche, including aperture cards.

Migration (See Also Conversion)

The act of moving records from one system to another, while maintaining the records' authenticity, integrity, reliability and usability. (BS ISO 15489-1:2001(E))

Minutes (Master Copies)

Master copies are the copies held by the secretariat of the meeting, i.e. the person or department who actually takes the minutes, writes them and issues them.

Minutes (Reference Copies)

Copies of minutes held by individual attendees at a given meeting.

N

NHS Records

All NHS organisations are public authorities under Schedule 1 of the Freedom of Information (Scotland) Act 2002. The records created and used by all NHS employees are subject to the terms of the Public Records (Scotland) Act 2011. The information contained in those records is subject to Data Protection and Freedom of Information legislation.

O- P

Paper Records

Records in the form of files, volumes, folders, bundles, maps, plans, charts, etc.

Permanent Retention

Corporate and health records will not normally be retained for longer than the specified retention period. However a selection of records of long-term legal, administrative, epidemiological and/or historical value should be identified for permanent preservation. Such records should be transferred to an archive, either the organisation's own NHS archive or a local authority, university, or other archive with which the organisation has an existing relationship.

Section 33 of the Data Protection Act permits personal data identified as being of historical or statistical research value to be kept indefinitely as archives.

Preservation

Processes and operations involved in ensuring the technical and intellectual survival of authentic records through time. (BS ISO 15489-1:2001(E))

Protective Marking

The Protective Marking System (often referred to as the Government Protective Marking System/Scheme or GPMS) is the Government's administrative system to ensure that access to information and other assets is correctly managed and safeguarded to an agreed and proportionate level throughout their lifecycle, including creation, storage, transmission and destruction.

Publication Scheme

A publication scheme is required of all NHS organisations under the Freedom of Information (Scotland) Act. It details information, which is available to the public now or will be in the future where it can be obtained from and the format it is available in. Schemes must be approved by the Scottish Information Commissioner and should be reviewed periodically to make sure they are accurate and up to date.

Public Records (Scotland) Act 2011

The Act's purpose is to improve records management in named Scottish public authorities, including NHS Boards. It aims to do this by making it compulsory to produce and maintain Records Management Plans, updating the definition of 'public records', setting up the Keeper's role in compliance monitoring and guidance provisions, and updating the law on records of the Scottish courts.

R

Records

Information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations, or in the transaction of business. (BS ISO 15489.1) An NHS record is anything, which contains information (in any medium) which has been created or gathered as a result of any aspect of the work of NHS employees - including consultants, agency or casual staff.

Records Management

Field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records. (BS ISO 15489-1:2001(E))

Records Management Plan (defined in the Public Records (Scotland) Act 2011

Part 1 of the Public Records (Scotland) Act 2011 imposes duties on certain public authorities such as NHS Boards to produce, implement and review records management plans.

- The Plan must set out the arrangements for the management of records created or held by the NHS Board and records created or held by contractors who carry out any functions on behalf of the Board.

- Each Plan must identify a coherent governance structure, and list the processes and procedures the Board will undertake to ensure effective management, storage and disposal of records
- Each Plan must be submitted to the Keeper of the Records of Scotland for agreement and, once implemented, be kept under internal review
- Boards must have due regard to the model plan and the guidance issued by the Keeper when preparing their own plans.

Record Series

Documents arranged in accordance with a filing system or maintained as a unit because they result from the same accumulation or filing process, or the same activity; have a particular form; or because of some other relationship arising out of their creation, receipt or use. (International Council on Archives' (ICA) General International Standard Archival Description or ISAD(G). Find out more here

Record System/Record-Keeping System

An information system which captures, manages and provides access to records through time. (The National Archives, Records Management: Standards and Guidance - Introduction Standards for the Management of Government Records). Records created by the organisation should be arranged in a record-keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information. Paper and electronic record-keeping systems should contain descriptive and technical documentation to enable the system and the records to be understood and to be operated efficiently, and to provide an administrative context for effective management of the records. The record-keeping system, whether paper or electronic, should include a documented set of rules for referencing, titling, indexing and, if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information and to maintain security and confidentiality.

Redaction

The process of removing, withholding or hiding parts of a record, for example in a Subject Access Request where parts of the health record refers to third-party information. The National Archives provides guidance on redaction, available here

Registration

Registration is the act of giving a record a unique identifier on its entry into a record-keeping system.

Retention

The continued storage and maintenance of records for as long as they are required by the creating or holding organisation until their disposal, according to their administrative, legal, financial and historical evaluation.

Review

The examination of records to determine whether they should be destroyed, retained for a further period, or transferred to an archive.

S

Scottish Information Commissioner (See Also UK Information Commissioner)

The Scottish Information Commissioner enforces and promotes the right to access information held by public authorities, created by the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004, both of which came into force on 1 January 2005. The Act and the Regulations give *anyone*, *anywhere in the world*, important rights to access the information held by more than 10,000 public authorities in Scotland.

Scottish NHS Archivists

Three NHS Boards in Scotland employ archivists: Grampian (which also provides an archive service to NHS Highland), Lothian, and Glasgow. The funding and managerial arrangements for each of these archives differs, but each collects, lists and preserves corporate and health records of and relating to the NHS organisations and predecessor bodies and institutions in their local area. NHS organisations which do not employ their own Archivist are welcome to contact one of the NHS Archivists for advice and information on records management and archiving. These organisations may wish to make their own arrangements with local authority, university or other archives for the transfer of records selected for permanent preservation; such arrangements require the agreement of the Keeper of the Records of Scotland.

The Health Archives and Records Group (HARG) is a representative body for archivists and records managers working in the health sector, including but not limited to the NHS. Its membership is drawn from across the UK and the Republic of Ireland. It has been an affiliated group of the Society of Archivists' Specialist Repositories Group since 2001. HARG aims to raise the profile of health archives and to improve the level of awareness in the NHS and elsewhere about record-keeping issues.

T

Tracking

Creating, capturing and maintaining information about the movement and use of records. (BS ISO 15489-1:2001(E))

Transfer Of Records

Transfer (custody) – Change of custody, ownership and/or responsibility for records. (BS ISO 15489-1:2001(E))

Transfer (movement) – Moving records from one location to another. (BS ISO 15489-1:2001(E))

U - Z

UK Information Commissioner (See Also Scottish Information Commissioner)

The UK Information Commissioner enforces and oversees the Data Protection Act 1998 in the UK and liaises with the Scottish Information Commissioner with regards to the interaction between the Data Protection Act 1998 and the Freedom of Information (Scotland) Act 2002.

Weeding

The process of removing inactive/non-current records from the active/current or primary records storage area to a designated secondary storage area after a locally agreed timescale after the date of last entry in the record.

In an archiving sense, weeding can also mean the removal of records during appraisal which are not suitable for permanent retention and should be destroyed.

ANNEX B – 'THE MANAGEMENT, RETENTION AND DISPOSAL OF PERSONAL HEALTH RECORDS

Introduction

Scope of Schedule

This Annex sets out the minimum periods for which the various personal health records created within the NHS or by predecessor bodies should be retained (in line with Principle 5 of The Data Protection Act 1998), either due to their ongoing administrative value or as a result of statutory requirement. It also provides guidance on dealing with records which have ongoing research or historical value and should be selected for permanent preservation as archives and transferred to an appropriate archive.

The Annex provides information and advice about all personal health records commonly found within NHS organisations. The retention schedules apply to all the records concerned, irrespective of the format (e.g. paper, databases, emails, X-rays, photographs, CD-ROMs) in which they are created or held.

This Annex does not provide specific guidelines on determining which documents are retained as part of a personal health record. However, principles to be used in determining policy regarding the retention and storage of essential maternity records are set out. In addition, NHS organisations are reminded that good practice suggests that a policy determining which documents should remain in the record after discharge (or weeding) should be in place. The development of such a policy should include addressing any clinical requirements for completeness of information, as well as the legal requirements of the Data Protection Act 1998, which states that only personal information which is relevant and not excessive should be retained.

Whenever the schedule is used, the guidelines listed below should be followed:

i) The minimum retention periods in this schedule must be adopted. However, local business requirements or risk analysis may require some categories of record to be kept for longer.

ii) Recommended minimum retention periods should be calculated from the end of the calendar year following the last entry on the document.

iii) The provisions of the Data Protection Act 1998 and the Freedom of Information (Scotland) Act 2002 must be observed. Decisions should also be considered in the light of the need to preserve records that may be in the substantial public interest or in relation to research purposes (Section 33(3) contains some exemptions from the 5th principle of the Data Protection Act 1998.) This applies to records whose use cannot be anticipated fully at the present time, but which may be of value to future generations.

iv) Some classes of document must be permanently preserved and the advice of the local NHS archivist or National Records of Scotland regarding an appropriate place of deposit should be obtained.

v) The selection of records for permanent archival preservation is partly informed by precedent (the establishment of a continuity of selection) and partly by the historical context of the subject (the informed identification of a selection). It is also possible to retain a sample of certain record series. General rules should be drawn up locally, using the profile of material that has already been selected, and the history of the institution or organisation (including pioneering treatments and examples of excellence) within the context of its service to the local and wider communities.

vi) Records which, having been retained for the minimum retention period, are selected for destruction, should be destroyed appropriately, with particular regard being to whether the information contained in them is of a confidential or sensitive nature.

Guidance on corporate (i.e. administrative, non-health) records commonly found within NHS organisations is given in Annex C. These rules apply equally to the schedules contained there.

Responsibilities and Decision Making

For an NHS organisation to manage its records effectively, wider records management responsibilities need to be considered, placed with the appropriate individuals and/or committees, and resourced. For example, organisations may require local records managers and/or a corporate records manager; a health or medical records manager and/or committee; and an archivist.

In addition, NHS Boards are required to comply with the Information Governance standards set out in the Clinical Governance and Risk Assessment standards specified by Healthcare Improvement Scotland. These include standards applicable to administrative and patient records.

Retention Periods

Each organisation should produce its own retention schedule, specifying the locally agreed retention periods, in the light of its own internal requirements. Organisations will need to bear in mind the need to retain records where there is any risk that they may be needed to consider/defend any legal actions. Organisations must not apply to any records a shorter retention period than the minimum set out in this schedule, but there may be circumstances in which they need to apply a longer retention period. Organisations should ensure that they are able to justify, particularly in terms of the Data Protection Act when applicable, the retention of records for longer than the minimum period set out in this schedule. NHS Boards and GPs as producers of products and equipment, are affected by the provisions of the Consumer Protection Act 1987 covering the liability of producers for defective products. They may also be liable in certain circumstances as suppliers and users of products. An obligation for liability lasts for 10 years and within this period the Prescription and Limitation (Scotland) Act 1973, as amended by the Consumer Protection Act 1987, provides that the pursuer must commence any action within 3 years' from the date on which the pursuer was aware of the defect and aware that the damage was caused by the defect. It will be for Boards and GPs to make their own judgement in such cases on whether any health records should be retained for this minimum period in order to defend any action brought under the Consumer Protection Act 1987. Organisations should ensure that they have mechanisms in place to identify records for which the appropriate

minimum retention period has expired, in line with the 5th principle of the Data Protection Act 1998. It is acknowledged that organizations will have different mechanisms available to them in order to do this, and that these may vary depending on the medium on which the record is held. In relation to paper records in particular, it is acknowledged that organisations may 'batch' records together e.g. on an annual basis, in order to make disposal decisions. In such instances, one approach to the calculation of minimum retention periods would be to base it on the beginning of the year after the last date on the record. For example, a file in which the first entry is in February 2001 and the last in September 2004, and for which the retention period is six years would be kept in its entirety at least until the beginning of 2011.

Disposal and Destruction of Personal Health Records

Decision Making

Staff in the operational area that ordinarily uses the records will usually be able to decide on their disposal and/or destruction. Operational managers are responsible for making sure that all records are periodically and routinely reviewed to determine what can be disposed of or destroyed in the light of local and national guidance.

In respect of personal health records, the NHSScotland Information Governance Standards require that NHS Boards establish a Patient Records Committee, which makes decisions on policy matters and which includes representation from clinical and non-clinical staff, and which is linked appropriately to other Information Governance Groups. Input from local healthcare professionals should be a key element of any records management strategy.

Once the appropriate minimum period has expired, the need to retain records further for local use should be reviewed periodically. Because of the sensitive and confidential nature of such records and the need to ensure that decisions on retention balance the interests of professional staff, including any research in which they are or may be engaged, and the resources available for storage, it is recommended that the views of the profession's local representatives should be obtained.

Disposal and Destruction

At the end of the relevant minimum retention period, one or more of the following listed actions will apply:

Review: records may need to be kept for longer than the minimum retention period due to ongoing administrative and/or clinical need. As part of the review, the organisation should have regard to the fifth principle of the Data Protection Act 1998, which requires that personal data is not kept longer than is necessary. If it is decided that the records should be retained for a period longer than the minimum the internal retention schedules will need to be amended accordingly and a further review date set. Otherwise, one of the following will apply:

Transfer to or consult an NHS archivist or The National Records of Scotland (see 'Archives' section below): if the records have no ongoing administrative value but have, or may have, long-term historical or research value. Organisations that do not have their own archivist should consult an NHS Archivist or the National Records of Scotland for advice.

Destroy: where the records are no longer required to be kept due to statutory requirement or administrative or clinical need, and they have no long-term historical or research value. In the case of personal health records, this should be done in consultation with clinicians in the organisation and archivists, with the necessary arrangements made to protect patient confidentiality where appropriate. It is important that records of destruction of health records contained in this retention schedule are retained permanently. No surviving health record dated 1948 or earlier should be destroyed. Organisations should also remember that records containing personal information are subject to the Data Protection Act 1998.

Interpretation of the Schedule

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, still and video images, and sound, and including all records of NHS patients treated on behalf of the NHS in the private health sector):

- personal health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident and Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (i.e. microfiche/microfilm);
- audio and video recordings;
- emails;
- records held on computer; and
- scanned documents.

The layout and some of the content of the schedules is based on that published by the Department of Health on 30 March 2006 in its publication: 'Records Management: NHS Code of Practice' (270422/2/Records Management: NHS Code of Practice Part 2). Find out more here

The Schedules are organised into a table with 3 headings:

RECORD TYPE: lists alphabetically records created as part of a particular function.

MINIMUM RETENTION PERIOD: specifies the shortest period of time for which the particular type of record is required to be kept. This period of time is usually set either because of statutory requirement or because the record may be needed for administrative purposes during this time. If an organisation decides that it needs to keep records longer than the recommended minimum period, it can vary the period accordingly and record the decision on its own retention schedule. In this regard, however, organisations must consider the fifth principle of the Data Protection Act 1998, i.e. that personal data should not be retained longer than is necessary.

NOTE: provides further information, such as whether the record type is likely to have long-term research or historical value.

The following 'standard' retention periods apply to the following record types:

Health Record Type	*Minimum NHS Retention Period*
Adult	6 years after date of last entry or 3 years after death if earlier
All types of records relating to Children and young people (including children's and young person's Mental Health Records)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 3 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain for a longer period.
Mentally disordered person (within the meaning of any Mental Health Act)	20 years after date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 3 years after the death of the patient/client/service user if sooner and the patient died while in the care of the organisation. N.B. NHS organisations may wish to keep mental health records for up to 30 years before review. Records must be kept as complete records for the first 20 years in accordance with this retention schedule but records may then be summarised and kept in summary format for the additional 10-year period. Social services records are retained for a longer period. Where there is a joint mental health and

Health Record Type	*Minimum NHS Retention Period*
	social care record, the higher of the two retention periods should be adopted. When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review.

Throughout this Schedule, where the 'standard' retention period specified above applies, the relevant record type has the entry 'Retain according to the standard minimum retention period appropriate to the patient/specialty (see above)' in the 'Minimum Retention Period' column. Where it does not apply, the required minimum retention period is listed in the 'Minimum Retention Period' column.

Health Records Retention Schedule

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
A&E records (where these are stored separately from the main patient record)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
A&E registers (where they exist in paper format)	8 years after the year to which they relate.	Likely to have archival value – see footnote
Abortion – Certificates set out in Schedule 1 to the Abortion (Scotland) Regulations 1991	3 years beginning with the date of the termination	
Admission books (where they exist in paper format)	8 years after the last entry	Likely to have archival value – see footnote
Ambulance records – patient identifiable Component (including paramedic records made on behalf of the Ambulance Service)	7 years	
Asylum seekers and refugees (NHS personal health record – patient held record)	Special NHS record – patient held, no requirement on the NHS to retain.	
Audiology records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Birth registers (ie register of births kept by the hospital)	2 years	Likely to have archival value – see footnote
Body release forms	2 years	
Breast screening X-rays	8 years	
Cervical screening slides	10 years	
Chaplaincy records	2 years	Likely to have archival value – see footnote
Child and family guidance	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Child Protection Register (records relating to)	Retain until the patient's 26th birthday	
Clinical audit records	5 years	
Clinical psychology	30 years	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Clinical trials of investigational medicinal products – health records of participants that are the source data for the trial	For trials to be included in regulatory submissions: At least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the Sponsor. It is the responsibility of the Sponsor/someone on behalf of the Sponsor to inform the investigator/institution as to when these documents no longer need to be retained. **For trials which are not to be used in regulatory submissions:** At least 5 years after completion of the trial. These documents should be retained for a longer period if required by the applicable regulatory requirement(s), the Sponsor or the funder of the trial, In either case, if the period appropriate to the specialty is greater, this is the minimum retention period.	Likely to have research value see footnote
Counselling records	30 years	Likely to have research/ historical value see footnote
Death – Cause of, Certificate counterfoils	2 years	
Death registers – i.e. register of deaths kept by the hospital, where they exist in paper format	2 years	Likely to have archival value – see footnote

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Dental epidemiological surveys	30 years	
Dental and auditory screening records	Adults: 11 years Children: 11 years, or up to 25th birthday, whichever is the longer	
Diaries – health visitors and district nurses	2 years after end of year to which diary relates. Patient relevant information should be transferred to the patient record.	It is not good practice to record patient identifiable information in diaries.
Dietetic and nutrition	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Discharge books (where they exist in paper format)	8 years after the last entry	Likely to have archival value – see footnote
Disposal of Foetal Tissue (under 24 weeks) Records	30 years	
District nursing records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Donor records (blood and tissue)	30 years post transplantation	Likely to have research/ historical value see footnote
Family planning records	10 years after the closure of the case For children retain until their 25th Birthday	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Procurator Fiscal's report, and human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	Records should be retained for 30 years. The exception is for post mortem records which form part of the Procurator Fiscal's report, where approval should be sought from the PF for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed. In cases where criminal proceedings are anticipated documentation is not normally entered in to the patient records.	Likely to have research/ historical value see footnote
Genetic records	30 years from date of last attendance.	Likely to have research/ historical value see footnote
Genito Urinary Medicine (GUM)	Store according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
GP records, including medical records relating to HM Armed Forces	Retain for the lifetime of the patient and for 3 years after their death. Records relating to those serving in HM Armed Forces - The Ministry of Defence (MoD) retains a copy of the records relating to service medical history. The patient may request a copy of these under the Data Protection Act (DPA), and may, if they choose, give them to their GP. GPs should also receive summary records when ex-Service personnel register with them. What GPs do with them is a matter for their professional judgement, taking into account clinical need and Data Protection Act requirements- they should not, for example, retain information that is not relevant to their clinical care of the patient. GP records of serving military personnel in existence prior to them enlisting must not be destroyed. Following the death of the patient the records should be retained for 3 years. *Electronic Patient Records (EPRs)- GP only- must not be destroyed, or deleted, for the foreseeable future	*The rationale for this is explained in 'SCIMP Good Practice Guidelines for General Practice Electronic Patient Records – section 6.1' (currently under review)

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
Health visitor records	10 years Records relating to children should be retained until their 25th birthday	
Homicide/ 'serious untoward incident' records	30 years	Likely to have research/ historical value see footnote
Hospital acquired infection records	6 years	
Human fertilisation records, including embryology records	Treatment Centres 1. If a live child is not born, records should be kept for at least 8 years after conclusion of treatment 2. If a live child is born, records shall be kept for at least 25 years after the child's birth 3. If there is no evidence whether a child was born or not, records must be kept for at least 50 years after the information was first recorded **Storage Centres** Where gametes etc have been used in research, records must be kept for at least 50 years after the information was first recorded. **Research Centres** Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA)	Likely to have research value see footnote

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Human tissue (within the meaning of the Human Tissue (Scotland) Act 2006) (see Forensic medicine above)	For post mortem records which form part of the Procurator Fiscal's report, approval should be sought from the Procurator Fiscal for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed.	Likely to have research value see footnote
Intensive Care Unit charts	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prosthesis was used. Only need to retain minimum of notes with specific information about the prosthesis.	Likely to have research value see footnote
Learning difficulties – (records of patients with)	Retain for 3 years after the death of the individual.	
Macmillan (cancer care) patient records – community and acute	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
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 after the birth of the last child	
Medical illustrations (see Photographs below)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Mentally disordered persons (within the meaning of any Mental Health Act)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Microfilm/microfiche records relating to patient care	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	Likely to have archival value – see footnote
Midwifery records	25 years after the birth of the last child	
Mortuary registers (where they exist in paper format)	10 years	Likely to have research/ historical value see footnote
Music therapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Neonatal screening records	25 years	
Notifiable diseases book	6 years	
Occupational Health Records (staff)	6 years after termination of employment	
Ophthalmic records	Adults: 7 years Children: 7 years, or up to 25th birthday, whichever is the longer	
Health Records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Likely to have research/ historical value see footnote
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	Likely to have research/ historical value see footnote
Personnel health records under occupational surveillance	40 years from last entry on the record	Likely to have research/ historical value see footnote
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	Likely to have research/ historical value see footnote

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Occupational therapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Oncology (including radiotherapy)	30 years N.B. Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes.	Likely to have research value see footnote
Operating theatre registers	8 years after the year to which they relate	Likely to have historical value – see footnote
Orthoptic records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 46-47)	
Out of hours records (GP cover), including video, DVD and voice recordings (clinician to patient)	Where the primary purpose of the voice recording is for patient triage and the output is recorded within the patients paper or electronic record (which is then retained according to the standard minimum retention period for the patient/specialty at pages 46-47) the audio recording need only be retained for 7 years	
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Parent held records	There should be a copy kept at the NHS organisation responsible for delivering that care and compiling the record of the care. The records should then be retained until the patient's 25th birthday, or 26th birthday if the young person was 17 at the conclusion of treatment, or 3 years after death	

Pathology records: Documents, electronic and paper

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	**MINIMUM RETENTION PERIOD**	**NOTE**
Accreditation documents; records of Inspections	10 years or until superseded	
Batch records results	10 years	
Bound copies of reports/records, if made	30 years	
Correspondence on patients	This should be lodged in the patient's record, if feasible. However this is often beyond the control of the laboratory, particularly for case referred distantly, and ensuring entry into the patients notes is not primarily the responsibility of laboratory staff. Otherwise, keep for at least 30 years; this may be most conveniently done in association with stored paper or scanned copy of the relevant specimen request and/or report kept by the relevant laboratory.	
Day books and other records of specimens received by a laboratory	2 years from specimen receipt	

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Equipment/instruments maintenance logs, records of service inspections	Lifetime of instrument; minimum of 10 years	
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	Comprehensive records relevant to procurement, use, modification and supply: 10 years.	
External quality control Records	Subscribing laboratories or individuals, 5 years to ensure continuity of data available for laboratory accreditation purposes. Records will be kept for longer periods by organisations providing external quality assessment schemes.	
Internal quality control Records	10 years	
Lab file cards or other working records of test results for named patients	1 year from specimen receipt if all results transcribed into a separately issued and stored formal report. Otherwise, they should be kept as for worksheets over. The diversity of these types of working records is very wide; within specialties and departments, consideration should be given to the potential audit or medico-legal value of storing such working records for 30 years, as for other primary records.	

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Mortuary Registers	30 years	
Near-patient test data	Result in patient record, log retained for lifetime of instrument	
Pathological archive/museum catalogues	For as long as the specimens are held or until the catalogue is updated, subject to consent where required, (with maintained and accessible documentation of consent)	
Photographic records	Where images represent a primary source of information for the diagnostic process, whether conventional photographs or digital images, they should be kept for at least 30 years.	
Records of telephoned Reports	Note of the fact and date/time that a telephone or fax report has been issued should be added to the laboratory electronic records of the relevant report, or to hard copies and kept for a minimum of 5 years. Where management advice is discussed in telephone calls, a summarised transcript should be retained long term, as for the retention of other correspondence. Clinical information or management advice provide by fax, in addition of pure transmission of report, should also be kept as correspondence in the patient note and/or stored with a laboratory copy of the specimen request/report for 30 years.	

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Records relating to cell/tissue transplantation	Records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to cell/tissue transplantation, including donated organs from deceased individuals should be kept for at least 30 years or the lifetime of the recipient, whichever is the longer.	
Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record	
Reports and copies (physical or electronic)	6 months or as needed for operational procedures. Where copies represent a means of communication or aide memoire, for example at a multi-disciplinary meeting or case conference, they may be disposed of when that function is complete. Copies of reports sent by fax, with accompanying details of the date and times of transmission, and the intended recipient, should be retained in conjunction with the matching specimen reports and stored long-term by the laboratory. Any such copies generated to substitute for an original report (e.g. if an original is misplaced) should be retained as for the original.	

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Reports, copies Post mortem reports	The report should be lodged in patient's record; in the case of Procurator Fiscal reports this is dependant on the PF's approval. Electronic or hard copy should be kept at least 30 years with maintained accessibility. In addition to accessible indexing of paper copies, there must be continuation of access to e-copies when laboratory, computer systems are upgraded or replaced. This guidance applies equally to rapid, short reports that maybe prepared for the PF, summarising cause of death and to the final reports of post-mortem examinations.	
Request forms that are not a unique record	Request forms should be kept until the authorised report, or reports on investigation arising from it, have been received by the requestor. As this period of time may vary with local circumstances, no minimum retention time is recommended, request forms need not to be kept for more than one month after the final checked report has been despatched. For many uncomplicated requests, retention of 1 week will suffice.	
Request forms that contain clinical information not readily available in the health record	30 years Where the request form is used to record working notes or as a worksheet, it should be retained as part of the laboratory record.	

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Standard operating procedures (both current and outdated protocols)	30 years	
Surgical (histological) reports	Copy lodged in patients notes. Electronic or hard copy to be kept for at least 30 years by the laboratory with maintained accessibility of e- copies when laboratory, computer systems are upgraded or replaced.	

Pathology Records: Specimens and Preparations.

TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Body fluids/aspirates/swabs	Keep for 48 hours after the final report has been issued by the laboratory, unless sample deterioration precludes storage.	
Blocks for electron microscopy	30 years	
Electrophoretic strips and immunofixation plates	Keep for 5 years, unless digital images are taken, if digital images of adequate quality for diagnosis are taken, then the original preparations may be discarded after 2 years. The images should then be stored under “photographic records” bearing in mind the need to maintain the ability to read archived digital images when equipment is updated.	
Foetal serum	Because of its rarity and value for future research, wherever possible foetal serum should be kept for at least 30 years.	

Pathology Records Specimens and Preparations		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides should be kept for a minimum of 10 years.	
Frozen tissues or cells for histochemical or molecular genetic analysis	10 years and preferably longer if storage facilities permit.	
Grids for electron microscopy	Requirements in different specialties differ. Grids prepared for human tissue diagnosis (e.g. renal, muscle, nerve, or tumour) should be kept for 10 years; preferably longer if practicable. Grids prepared for virus identification may be discarded 48 hours after the final report has been issued, provided that all derived images are retained and remain accessible for at least 30 years.	
Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)	
Microbiological cultures	24-28 days after final report of a positive culture issued. 7 days for certain specified cultures – see RCPath document	
Museum specimens (teaching collections)	Permanently. Consent of the relative is required if it is tissue	
Newborn blood spot screening cards	A minimum of 5 years storage is indicated for quality assurance purposes, with longer term storage recommended in accordance with the Code of Practice of the UK Newborn Screening Programme Centre (2005). See here for more information.	

Pathology Records Specimens and Preparations		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Paraffin blocks	Storage for at least 30 years is recommended, if facilities permit. If not, review the need for archiving at 10 years (and at similar intervals thereafter) and select representative blocks, showing the relevant pathology for permanent retention. Blocks representing rare pathologies and those (including representative normal tissue) from patients of diseases known or thought likely to have an inherited genetic pre-disposition should be particularly considered for permanent retention. Wherever possible, storage of all histology blocks should be for the full minimum of 30 years.	
Plasma and serum	Keep for 48 hours after the final report has been issued by the laboratory.	
Records relating to donor or recipient sera	Serum samples obtained from recipient (s) for the purposes of matching in cell/tissue transplantation, and their accompanying records, must be kept for the lifetime of the recipient.	
Serum from first pregnancy booking visit	Should be kept by microbiology/virology and other relevant laboratories to provide a baseline for further serological or other tests for infections or other disease during pregnancy and the first 12 months after delivery. Because of rarity and value to future research, wherever possible, foetal serum (from cordocentesis) should be kept for at least 30 years.	

Pathology Records Specimens and Preparations		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Stained slides	Appropriate retention times depend on their nature and purpose. Relevant guidance on minimum retention periods can be found here. Note that where sections are likely to contain intact human cells, or are intended to be representative of whole cells, they constitute "relevant material" under the Human Tissue act 2004; further information can be found here.	
Wet tissue (representative aliquot or whole tissue or organ)	For surgical specimens from living patients, keep for 4 weeks after issue of final report. For cases in which a supplementary report is anticipated after additional tests, (such as various molecular investigations or referral for expert opinion), which may occasionally exceed this period, arrangements should exist to ensure that individual specimens are retained until the additional report has been finalised.	
Whole blood samples, for full blood count	24 hours	

Pathology Records: Transfusion Laboratories

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Annual reports (where required by EU directive)	15 years	
Autopsy reports, specimens, archive material and other where the deceased has been the subject of Procurator Fiscals autopsy	Procurators Fiscal have absolute dominion over autopsy reports. They are confidential to them and may not be released without their consent to any third party. It is good practice to lodge copies of the autopsy report in the deceased patient's health record but the consent of the procurator fiscal should be obtained.	
Blood bank register, blood component audit trail and fates	30 years to allow full traceability of all blood products used. The data may be held in electronic form if robust archiving arrangements are in place. For hospital laboratories the records should include: Blood component supplier identification; Issued blood component identification; Transfused recipient identification; For blood units not transfused, confirmation of subsequent disposition (discard/other use); Lot number (s) of derived component (s) if relevant; Date of transfusion or disposition (day, month and year).	
Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4° C	

Pathology Records: Transfusion Laboratories		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Forensic material – criminal cases	Permanently – not part of the health record. In cases where criminal proceedings can be anticipated, all recording made at the autopsy, be the hand written notes (by everyone, i.e. pathologist, technician, trainee, etc), tape recordings, drawings or photographs, are all documentary records and as such their existence must be declared (disclosed). They must be available to all involved throughout the lifetime of the case, including appeals and other re-investigations.	
Refrigeration and freezer charts	15 years	
Request forms for grouping, antibody screening and cross-matching	1 month	
Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used, in compliance with the Blood Safety and Quality Regulations 2005.	
Separated serum/plasma, stored for transfusion purposes	No minimum storage time is recommended for recipient patient samples. Storage of donated serum/plasma should optimally be at -30 degrees Centigrade or colder. These materials may be stored for up to 6 months, but guidelines for the timeline of sample collection prior to blood transfusion must be followed. Archived blood donor samples should be stored by blood services for at least 3 years, and preferable longer if it is practicable, in order to facilitate 'look back' exercises.	

Pathology Records: Transfusion Laboratories		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Storage of material following analyses of nucleic acids	Developing technologies mean that there are now a variety of hard copy and/or electronic outputs associated with the analysis and interpretation of diagnostic tests using nucleic acid. It is recommended that all such outputs should be stored for at least 30 years unless the information is transcribed into permanently accessible report formats authorised by senior clinical laboratory staff or pathologists. The later reports should be kept for at least 30 years, as for other pathology reports may be regarded as reporting documents. For such working documents storage for at least the instrument, with a minimum of 10 years is recommended.	
Worksheets	30 years to allow full traceability of all blood products used	
End of Pathology Records		

Patient Held Records

Patient held records	At the end of an episode of care the NHS organisation responsible for delivering that care and compiling the record of the care must make appropriate arrangements to retrieve patient-held records. The records should then be retained for the period appropriate to the patient/specialty (see Above).	

Pharmacy Records: Prescriptions

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Chemotherapy	2 years after last treatment	
Clinical drug trials (non-sponsored)	2 years after completion of trial	
GP10, TTOs, outpatient, private	2 years	N.B. Inpatient prescriptions held as part of health record.
Immunoglobulins/ blood products	30 years	To allow full traceability of all blood products used
Parenteral nutrition	2 years	Original valid prescription to be held with the health record.
Unlicensed medicines dispensing record	5 years	

Pharmacy Records: Clinical trials

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Destruction records	2 years after end of trail	
Dispensing records	2 years	
Production batch records	5 years after end of trial	
Protocols	2 years	

Pharmacy Records: Worksheets

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
Chemotherapy, aseptics worksheets,	5 years	
Extemporaneous dispensing records	5 years	
Parenteral nutrition, production batch records	5 years	
Production batch records	5 years	
Raw material request and control forms	5 years	
Resuscitation box worksheet	1 year after the expiry of the longest data item Applies only to re-packaged items.	
Paediatric worksheets	As per Children and Young People (see Above)	

Pharmacy Records: Quality Assurance

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
Analysis certificates	5 years or 1 year after expiry date of batch (whichever is longer)	
Environmental monitoring results	1 year after expiry date of products	As electronic record in perpetuity
Equipment validation	Lifetime of the equipment	
Operators validation	Duration of employment	
QC Documentation,	5 years or 1 year after expiry date of batch (whichever is longer)	
Refrigerator temperature	1 year	Refrigerator records to be retained for the life of any product stored therein particularly vaccines
Standard operating procedures	15 years after superseded by revised version	As electronic record in perpetuity

Pharmacy Records: Orders

Ad hoc forms (dispensing requests forms to store)	3 months	
Invoices	6 years	
Order and delivery notes, requisition sheets, old order books	Current financial year plus one	
Picking tickets/delivery notes	3 months	
Ward Pharmacy requests	1 year	

Pharmacy Records: Controlled Drugs, Others

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
Aspectic controlled drugs worksheets (paediatric)	26 years	
Controlled drugs, Clinical trails	5 Years	
Controlled drug destruction records (pharmacy based)/destruction of patients' own CD's	7 years	
Controlled drug prescriptions (TTOs/OP)	2 years	
Controlled drug order books, ward orders and requisitions	2 years from date of last entry	
Controlled drug registers (pharmacy and ward based)	2 years from date of last entry, but best practice to keep for 7 years	
Copy of signature for CD ward order or requisition	Duration of employment	Copy of signature of each authorised signatory should be available in the pharmacy department
Extemporaneous controlled drugs preparation worksheets	13 years	
External controlled drug orders and delivery notes	2 years	

Pharmacy records: others		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Destruction of patients' own drugs	6 months	
Dispensing errors	1 year plus current	
Doctors/nurses signatures	Duration of contract plus one year	
Medicines information enquiry	8 years (25 years for child obstetrics and gynaecology enquiries)	
Minor clinical interventions	2 years	
Recall documentation	5 years	
Stock check list	1 year plus current	
Superseded group directions	10 years	
Superseded intravenous drug administration monographs	5 years	
(end of Pharmacy)		

Other Health Records

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see Above)	
Physiotherapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see Above)	
Podiatry records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see Above)	
Post mortem records (see Pathology records		
Post mortem registers (where they exist in paper format)	30 years	Likely to have archival value – see footnote
Private patient records admitted under section 57 of the National Health Service (Scotland) Act 1978 or section 5 of the National Health Service (Scotland) Act 1947 (now repealed)	It would be appropriate for authorities to retain these according to the standard minimum retention period appropriate to the patient/specialty (see above)	
Psychology Records	30 years	Likely to have research/ historical value see footnote

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed.	Likely to have research/ historical value see footnote
Records of destruction of individual health records (case notes) and other health related records contained in this retention schedule (in manual or computer format)	Permanently	Likely to have research/ historical value see footnote
Research records 1. Other than clinical trials of investigational medicinal products, health records of participants that are the source data for the research	30 years	See Footnote Review patient identifiable records every 5 years to see if they need to be retained or if their identifiably could be reduced.

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
2. Research records and research databases (not patient specific)	For clinical trials of investigational medicinal products, at least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the sponsor. It is the responsibility of the sponsor/someone on behalf of the sponsor to inform the investigator/institution as to when these documents no longer need retained. For research records other than for clinical trials of investigational medicinal products, as above.	Likely to have research value see footnote
Scanned records relating to patient care	Retain in main records and retain for the period of time according to the standard minimum retention period appropriate to the patient/specialty (see above)	
School health records (see Children and young people)	Retain in Child Health Records	
Speech and language therapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above)	

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Telemedicine records (clinician to patient)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above)	
Transplantation records	Records not otherwise kept or issued to patient, records that relate to investigations or storage of specimens relevant to organ transplantation should be kept for 3 years	Likely to have research value see footnote
Ultrasound records (e.g. vascular, obstetric)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see Above)	

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Video records/voice recordings (clinician to patient) (see also Telemedicine records and Out of hours records)	6 years subject to the following exceptions: **Children and Young People –** records must be kept until the patient's 25th birthday, if the patient was 17 at the conclusion of treatment until their 26th birthday, or until 3 years after the patient's death if sooner. **Maternity –** 25 years **Mentally disordered persons –** records should be kept for 20 years after the date of last contact between patient/client/service user and any healthcare professional or 3 years after the patient's death if sooner. **Cancer patients –** records should be kept until 6 years after the conclusion of treatment, especially if surgery was involved. The Royal College of Radiologists has recommended that such records be kept permanently where chemotherapy and/or radiotherapy was given.	The teaching and historical value of such recordings should be considered, especially where innovative procedures or unusual conditions are involved. Video/video-conferencing records should be either permanently archived or permanently destroyed by shredding or incineration (having due regard to the need to maintain patient confidentiality)

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Ward registers, including daily bed returns (where they exist in paper format)	2 years after the year to which they relate	Likely to have archival value – see footnote
X-Ray films (excluding PACS images)	The minimum retention period for these can continue to be determined locally by the NHS organisation responsible. In setting the minimum retention period, appropriate recognition should be given to current professional guidance, clinical need, special interest groups, cost of storage and the availability of storage space.	
X-Ray – PACS images	Policy reviewed and agreed with radiology clinical lead and National Clinical Advisory Group. Also reviewed by Clinical Change Leadership Group. **Local site:** Originating site remains at 18 months storage. **Primary archive site:** All data compressed to Royal College of Radiologists profile at 36 months from date of ingest. At 7 years data is aggressively compressed to 50:1 **Backup site:** Partial DR site 12 months of rolling lossless, full data base storage plus all data are copied to tape immediately.	As eHealth strategic developments progress, this guidance, along with that for other record types affected, will be reviewed.

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
X-Ray registers (where they exist in paper format)	30 years	Likely to have archival value – see footnote
X-Ray reports (including reports for all imaging modalities)	To be considered as part of the patient record. Retain according to the standard minimum retention period appropriate to the patient/specialty (see above)	

Footnote – record is likely to have permanent research and historical value, consult NHS archivist or National Records of Scotland.

Principles to be used in Determining Policy Regarding the Retention and Storage of Essential Maternity Records

Reproduced below is the joint position on the retention of maternity records as agreed by the British Paediatric Association, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the then United Kingdom Central Council for Nursery, Midwifery and Health Visiting. This is specified in the Department of Health publication: 'Records Management: NHS Code of Practice' (270422/2/Records Management: NHS Code of Practice Part 2).

Joint Position on the Retention of Maternity Records

All essential maternity records should be retained. 'Essential' maternity records mean those records relating to the care of a mother and baby during pregnancy, labour and the puerperium.

Records that should be retained are those that will, or may, be necessary for further professional use. 'Professional use' means necessary to the care to be given to the woman during her reproductive life, and/or her baby, or necessary for any investigation that may ensue under the Congenital Disabilities (Civil Liabilities) Act 1976, or any other litigation related to the care of the woman and/or her baby.

Local level decision making with administrators on behalf of the health authority must include proper professional representation when agreeing policy about essential maternity records. 'Proper professional' in this context should mean a senior medical practitioner(s) concerned in the direct clinical provision of maternity and neonatal services and a senior practising midwife.

Local policy should clearly specify particular records to be retained AND include detail regarding transfer of records, and needs for the final collation of the records for storage. For example, the necessity for inclusion of community midwifery records.

The policy should also determine details of the mechanisms for the return, collation and storage of those records, which are held by mothers themselves, during pregnancy and the puerperium.

List of Maternity Records to be retained

Maternity Records retained should include the following:

- documents recording booking data and pre-pregnancy records where appropriate;
- documentation recording subsequent antenatal visits and examinations;
- antenatal inpatient records;
- clinical test results including ultrasonic scans, alphafeto protein and chorionic villus sampling;
- blood test reports;
- all intrapartum records to include initial assessment, partograph and associated records including cardiotocographs;
- drug prescription and administration records;
- postnatal records including documents relating to the care of mother and baby, in both the hospital and community settings.

ANNEX C - ADMINISTRATIVE RECORDS RETENTION SCHEDULE

This schedule sets out minimum periods for which the various administrative records created within the NHS or predecessor bodies should be retained (in line with the Principle 5 of The Data Protection Act 1998), either due to their ongoing administrative value or as a result of statutory requirement. Records are listed alphabetically within each record category, e.g. financial, human resources. The retention schedules apply to all the records concerned, irrespective of the format (e.g. paper, databases, emails, photographs, CD ROMs) in which they are created or held.

Administrative Records - General

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES*
Conferences: lectures given by staff at other conferences	permanent	Significant conference papers should be selected for permanent retention
Conferences: organised by Boards – conference proceedings	permanent	
Conferences: organised by Boards - routine paperwork	destroy after conference	
Conferences: other conferences attended by staff	2 years	
Copies of out-letters	1 year	
Databases- records handling system	permanent	Retain to demonstrate implementation of established practice and provide audit trail, see also Indexes
Diaries - office	1 year after completion	
Enquiries (such Subject Access Request and FOISA)	Minimum of 40 working days following the response; requests for review for a minimum of six months	The authority may wish to keep the correspondence longer for its own business purposes
Indexes- file and document lists marked for permanent preservation	permanent	

Administrative Records: General		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Indexes- file and document lists not marked for permanent preservation	Destroy when no longer useful	Retention may be required if they are part of audit trails
Quality Assurance Records	12 years	
Receipts for registered and recorded delivery mail	2 years	
Records of custody and transfer of keys	2 years	
Research and development findings by Board staff (scientific, technological and medical)	Consider findings and reports for permanent preservation	Supporting records should be retained in line with the appropriate clinical, pharmaceutical, laboratory or other research standards, as set out by funding and professional bodies.
Software licenses	Operational lifetime of product	

Administrative Records - Financial

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES SEE FOOTNOTE*
Accounts – final annual master copies	permanent	
Accounts - cost	3 years	
Accounts - working papers	3 years	
Accounts - minor records: (including pass books, paying-in slips, cheque counterfoils, cancelled/discharged cheques, petty cash expenditure, travelling and subsistence accounts, minor vouchers, duplicate receipt books, income records, laundry lists)	3 years after completion of audit	See 'Receipts for cheques bearing printed receipts' below
Accounts - statutory final	permanent	
Advice Notes	3 years after formal clearance by statutory auditor	A longer period may be required for investigative purposes
Audit records - original documents	3 years after formal clearance by statutory auditor	A longer period may be required for investigative purposes
Audit reports (including Management letters, VFM reports and system/final accounts memorandum)	3 years after formal clearance by statutory auditor	A longer period may be required for investigative purposes

Administrative Records: Financial		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Bank statements	3 years after completion of audit	
Benefactions – endowments, legacies gifts etc.	permanent	
Bills and receipts	6 years	
Budget monitoring reports	3 years	
Budgets	2 years after completion of audit	
Capital paid invoices	3 years	See ‘Invoices’ below
Cash books and sheets	6 years	
Cost accounts		See ‘Accounts’ above
Creditor payments	3 years	
Debtors' records - cleared	6 years	
Debtors' records - uncleared	6 years	
Demand Notes	6 years	
Expenses claims		See ‘Accounts – minor’ above
Financial plans, estimates recovery plans	6 years	
Funding data	6 years	
General ledgers	6 years	
Income and expenditure sheets and journals	6 years	
Indemnity Forms	6 years after the indemnity has lapsed	

Administrative Records: Financial		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Inquiries involving fraud/other irregularities	10 years	Where action is in prospect or has been commenced, consult with legal representatives and NHS Counter Fraud Services and keep in accordance with advice provided
Invoices payable (creditors)	6 years	
Invoices receivable (debtors)	6 years	
Ledgers	6 years	See also 'General ledgers' above
Mortgage documents - acquisition, transfer and disposal	permanent	
Non-exchequer funds records		See 'Income and expenditure journals' above
PAYE records	6 years	
Receipts	6 years	Includes cheques bearing printed receipts
SFR returns	6 years	
Superannuation - accounts and registers	10 years	
Superannuation - forms	10 years	
Tax forms	6 years	
VAT records	6 years	In some instances a shorter period may be allowed, but agreement must be obtained from HM Revenue and Customs

Administrative Records: Financial		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Wages/salary records	10 years	For superannuation purposes authorities, may wish to retain such records until the subject reaches pensionable age

The Scottish Government policy on retention of financial records is set out in the Scottish Public Finance Manual, which can be accessed at: http://www.scotland.gov.uk/library5/finance/spfm/spf-00.asp

.

Administrative Records - Property, Environment and Health & Safety

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES*
Agreements	See 'Contracts' below	
Buildings - papers relating to occupation	Permanent or until property demolished or disposed	Does not include Health & Safety information
Capital charges data	3 years after completion of previous 5 year valuation term	
Contaminated Land	permanent	
Contracts - non sealed (property) on termination	6 years	
Environmental Information	permanent	
Equipment		See 'Products – liability' under 'Procurement Records'
Estimates: including supporting calculations and statistics	3 years	
Green code	permanent	
Health and safety: Asbestos Register	permanent	
Health and safety: Audit forms, COSHH (Control of Substances Hazardous to Health Regulations) documentation, safety risk data sheets, risk assessments and control measures etc.	10 years	
Health and Safety: Accident and Incident Forms	10 years	See 'Litigation dossiers' under 'NHS Board Records'

Property, Environment and Health and Safety Records		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Health and Safety: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) including Accident Register	10 years	
Inspection Reports – e.g. boilers, lifts etc.	2 years after operational lifetime of installation/plant	Should be retained indefinitely if there is any measurable risk of a liability
Inventories (non-current) of items having an operational lifetime of less than 5 years	2 years	
Land purchase and sale - deeds, leases, maps, surveys, registers etc	permanent	
Land purchase and sale - negotiations not completed	6 years	
Laundry lists		See 'Accounts – minor' under 'Financial Records'
Manuals - operating		See 'Inspection reports' above
Manuals- policy and procedure	permanent	
Maintenance contracts		See 'Property- Cleaning and Maintenance' below

Property, Environment and Health and Safety Records		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Maintenance request book	2 years after financial year referred to	
Maps	consider for permanent preservation	
Project files (£250,000 and over)	permanent	Including abandoned or deferred projects
Project files (under £250,000)	6 years after completion/abandonment of project	
Project team files (£250,000 and over)	3 years	
Project team files (under £250,000)	3 years	
Property- acquisition dossiers	permanent	
Property - cleaning and maintenance (contracts less than £100,000)	6 years	
Property - disposal dossiers	permanent	
Property/Estates- Land, Building and Engineering Construction Procurement: Key records (including: final accounts, surveys, site plans, bills of quantities, PFI/PPP records) Town and country planning matters and all formal contract documents (including: executed agreements, conditions of contract, specifications, "as built" record drawings and documents on the appointment and conditions of engagement of private buildings and engineering consultants)	permanent	Inclusive of major projects abandoned or deferred

Property, Environment and Health and Safety Records		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Property - leases	permanent	
Property management system	permanent	
Property - minor contracts	6 years	
Property performance	permanent	
Property - purchases	permanent	
Property strategy	permanent	
Property - title deeds	permanent	
Property- terriers (NHS premises site information)	permanent	
Safety Action Bulletins	Permanent	
SEPA Registrations, Licenses and Consents	permanent	
Specifications for work tendered	6 years	
Tenders (successful)		See 'Contracts' above
Tenders (unsuccessful)	6 years	
Waste Consignment Notes- Controlled wastes such as clinical/healthcare and household/domestic	2 years	
Waste Consignment Notes- Special/Hazardous/Radioactive Wastes	3 years	
Waste- Duty of Care Inspection Reports	permanent, or for life of external contract	

Administrative Records - Human Resource

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES*
Disciplinary: First written warning	6 months	
Disciplinary: Final written warning	12 months	
Disciplinary: First and final written warning	12 months	
Disciplinary: Letter of Dismissal	10 years	Where action is in prospect or has been commenced, consult with legal representatives and keep in accordance with advice provided.
Disciplinary: Records of action taken, including: Details of rules breached, Employee's defence or mitigation, Action taken and reasons for it, Details of appeal and any subsequent developments	6 years after leaving service	See above for retention periods for warnings.
Establishment records - major (including: Personnel files, letters of application and appointment, confirmation of qualifications, contracts, joining forms, references & related correspondence, termination forms)	6 years after leaving service	

Human Resources Records		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Establishment records – minor (including: attendance books, annual leave records, duty rosters, clock cards, timesheets)	2 years	
Industrial relations (not routine)	permanent	
Personal Development: Nurses – training records	30 years after completion of training	Applies only to Nurse Training carried out in hospital based nurse training schools
Personal Development: Study leave applications	2 years	
Recruitment: Applications for employment – unsuccessful applicants	1 year after completion of recruitment procedure	
Recruitment: CVs for non-executive directors (successful)	5 years following end of term of office	
Recruitment: CVs for non-executive directors (unsuccessful applicants)	2 years	
Recruitment: Disclosure Scotland information	90 days	90 days after the date on which recruitment or other relevant decisions have been taken; or 90 days after the date on which recruitment or other relevant decisions have been taken.
Recruitment: Job advertisements	1 year	

Administrative Records - Procurement and Stores

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES*
Approval files - contracts	permanent	
Approved suppliers lists	11 years	
Delivery notes	2 years	
Indents	2 years after financial year referred to	
Medical equipment specifications – major items purchased	permanent	
Medical Equipment – operating manuals	operational lifetime of equipment	
Procurement documentation	7 years	One copy of each supplier response from short listed to tender and the contract itself.
Products – liability	11 years	
Purchase orders	3 years after financial year referred to	
Requisitions	2 years after financial year referred to	
Stock control reports	2 years	
Stores – major (ledgers etc.)	6 years	
Stores – minor (requisitions, issue notes, transfer vouchers, goods received books etc.)	2 years	

Procurement and Stores		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Supplier correspondence	6 years after termination of agreement	
Supplies records – minor (e.g. invitations to tender and inadmissible tenders, routine papers relating to catering and demands for furniture, equipment, stationery and other supplies)	2 years	

Administrative Records - NHS Board

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES*
Area health plans	permanent	
Contracts – non sealed on termination	6 years	
Contracts – GP Practices and others to deliver core NHS services	permanent	
Contracts – sealed	permanent	Including associated records
Corporate policies	permanent	
Deeds of title	permanent	
Health promotion – core papers and visual materials relating to major initiatives	consider permanent preservation	
History of Boards or their predecessor organisations	permanent	
History of hospitals	permanent	
Hospital services files	consider permanent preservation	
Legal actions (adult)	7 years after case settled or dropped	
Legal actions (child)	until child is 18 or 7 years after case settled or dropped, whichever is later	
Litigation dossiers – complaints including accident reports	10 years	Where a legal action has commenced see Legal actions

NHS Board Records		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Meeting papers – master set	permanent	Main committees and sub-committees of NHS Boards and special Health Boards and other meetings of significance for legal, administrative or historical reasons
Minutes – master set	permanent	Main committees and sub-committees of NHS Boards and special Health Boards
NHS circulars – master set	permanent	
Nursing homes pre 1 April 2002: registration documents and building plans	permanent	The regulation of care services was taken over by the Care Commission on 1 April 2002.
Nursing homes pre 1 April 2002: inspection reports and general correspondence	5 years	The regulation of care services was taken over by the Care Commission on 1 April 2002.
Option appraisals	6 years after end of agreement	
Patient complaints without litigation – adults	7 years	
Patient complaints without litigation – children and young adults	until child is 16 or 7 years, whichever is later	

NHS Board Records		
TYPE/SUBTYPE OF RECORDS	***MINIMUM RETENTION PERIODS***	***NOTES***
Photographs	consider for permanent preservation	Corporate and publicity photographs, those not used for patient care purposes.
Press cuttings	consider for permanent preservation	
Register of seals	permanent	
Reports – major	permanent	
Serious incident files	permanent	
Service development reports	6 years	
Service level agreements	6 years	
Strategic plans	permanent	
Subject files	permanent	Files relating directly to the formulation of policy and major controversies must be permanently preserved. Other files should be disposed of when no longer needed.
Trust arrangements legally administered by NHS organisations – documents describing terms of foundation/establishment and winding-up	permanent	
Trusts arrangements legally administered by NHS organisations – other documents	6 years	

Administrative Records - Service Planning

TYPE/SUBTYPE OF RECORDS	*MINIMUM RETENTION PERIODS*	*NOTES*
Activity monitoring reports	6 years after end of agreement	
Admission, transfer and treatment of patients – policy files	permanent	
Databases – demographic and epidemiological based on data supplied by NHS National Service Scotland, Information Services		In accordance with general policies of NHS National Service Scotland, Information Services, and any specific terms and conditions imposed by them in relation to particular data sets
Databases – demographic and epidemiological based on survey data		May be retained indefinitely if data quality and potential for future re-use justifies cost of migration/regeneration to new formats and platforms
Patient activity data	3 years	
Summary bed statistics	permanent	
Waiting list monitoring reports	6 years	
Seasonal business plans	6 years	

ISBN: 978-1-78045-547-1 (web only)

APS Group Scotland
DPPAS12340 (01/12)

w w w . s c o t l a n d . g o v . u k