Records Management Policy

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2. Introduction

The Board acknowledges its responsibilities under statutory legislation and guidance and is committed to fulfilling its obligations and commitments for the management of all its records. This policy supports the implementation of the Public Records (Scotland) Act 2011.

Good record keeping ensures:

- Improved information sharing and the provision of quick and easy access to the right information at the right time
- The support and facilitation of more efficient service delivery
- Improved business efficiency through reduced time spent searching for information
- Demonstration of transparency and accountability for all actions
- The maintenance of the corporate memory
- The creation of better working environments and identification of opportunities for office rationalisation and increased mobile working
- Risk management in terms of ensuring and demonstrating compliance with all legal, regulatory and statutory obligations
- The meeting of stakeholder expectations through the provision of good quality services

This is vitally important in cases such as:

- Providing patient care
- Clinical Liability
- Complaints
- Legal action

This policy has been updated to comply with the requirements of the Public Records (Scotland) Act 2011 and the NHS Scotland Records Management: Code of Practice 2012. All NHS records are Public Records under the Public Records (Scotland) Act 2011 and must be kept in accordance with the following Acts and NHS Scotland guidelines:

- Public Services Reform (Scotland) Act 2010
- Data Protection Act 1998
- Freedom of Information Act (Scotland) 2002

Clinical team members must also follow their respective professional bodies guidance for record keeping

The Public Records (Scotland) Act places an obligation on public authorities to prepare and implement a Records Management Plan (RMP) which sets out proper arrangements for the management of their records. NHS Orkney's RMP has been agreed with the Keeper of the Records of Scotland and will be reviewed on an annual basis. Where authorities fail to meet their obligations under the Act the Keeper has powers to undertake records management reviews and issue action notices for improvement.

Other relevant documents:

- NHS Scotland Information Assurance Strategy
- NHS Scotland Information Governance Standards
- Scottish Government Records Management – Code of Practice

3. Associated Policies and Procedures

This policy should be read in association with the following Board policies, procedures and guidance:-

- Information Governance Policy, covers Data Protection requirements
- Information Security Policy
- Incident Management Policy

It is underpinned by the following records management procedures:

- Procedure regarding access to records
- Procedure for the Creation, Structure and Format of Records
- Procedure for the Disposal of Confidential Waste
- Procedure for the 24 hour access to Clinical Records
- Procedure for the Storage, Transfer and Tracking of Records
- Procedure for the Culling of Records
- Procedure for Digital Medical Records
- Procedure for DMR (Digital Medical Record) Quality Assurance Process
- Confidentiality Agreement for third Parties Accessing Records Protocol
- Procedure for Retention, Storage and Disposal of Records

4. Aims and Objectives

NHS Orkney aims to have a systematic and planned approach to records management from the moment they are created to their ultimate disposal. This will ensure that the Board can control both the quality and the quantity of the information that it generates.

This aim will be achieved by the delivery of the following objectives:

- To be compliant with the Data Protection Act 1998, including the management of requests from patients or any other person
- To be compliant with the Freedom of Information Act 2002 and the associated Code of Practice on the Management of Records
- To assure a robust framework for records management regarding the creation, use storage, management and disposal of records as set out in the Quality Improvement Scotland Information Governance Toolkit
- To set up an information asset register regarding all information the Board holds
- To select and archive those records that should be permanently preserved
- To preserve records for the **minimum** periods laid down for the retention of all types of NHS records, both paper and electronic
- To ensure that there is robust information to support the delivery of evidence based patient care
- To ensure there is robust information to support the day to day administrative and managerial decision making which underpins the delivery of care
- To ensure there is a robust information base to assist clinical and other audits

5. Scope of Policy

This policy relates to all records, clinical and non-clinical unless otherwise stated, that are created, maintained, stored or destroyed by staff working for, or on behalf of, NHS Orkney.

It must be followed by all staff who work for NHS Orkney (the Board), including those on temporary or honorary contracts, locums and bank staff, volunteers and students. Breaches of this policy may lead to disciplinary action being taken against the individual concerned.

Independent Contractors are responsible for the management of their own records and for ensuring compliance with relevant legislation and best practice guidelines. The Board is happy to provide such advice and support as required.

6. The Definition of a Record

In the context of this policy, a record is defined as anything that contains information, in any media, e.g. paper, audio or video recording, computer database notes, e.g. e-mail etc which forms part of the record which has been created or gathered as a result of any aspect of the work of NHS employees, including:-

- Patient health records (electronic or paper based)
- Staff records
- Photographs and other images
- Microform (in other words fiche/film)
- Audio and videotapes, cassettes, CD-Rom etc
- Computer databases, output and disks etc and all other electronic records
- Material intended for short term or transitory use, including notes and 'spare copies' of documents
- Administrative records (including NHS Board and service planning records, estates, financial and accounting records; procurement, litigation, records associated with complaint handling)
- Scanned records
- Text messages both outgoing from the NHS and incoming responses from the patient
- CCTV images
- Telephone messages
- emails

Note: *This list is not exhaustive*

7. Accountability and Responsibilities

a) The Board as a Corporate Body

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

a) The Chief Executive

The Chief Executive had overall responsibility for records management in NHS Orkney. 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.

b) The Caldicott Guardian

The Director of Public Health is the Board's Caldicott Guardian. Caldicott Guardians are responsible for ensuring that national and local guidelines and protocols on the handling and management of confidential personal information are in place and will also act as an advisor on such issues.

Security of a record held by a patient during an episode of care is the responsibility of that patient. This responsibility reverts back to the Board after the care is completed and the record returned.

Should a record not be returned to the Board or is lost, a Datix should be completed and forwarded to the manager responsible for Information Security[1] for investigation and advice.

c) Health Records Manager

The Health Records Manager[2] 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 the Records Management Policy, in such a way as to ensure the efficient, safe, appropriate and timely retrieval of patient information.

d) Corporate Records Manager

The Corporate Records Manager[3] 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 NHS Orkney's Records Management Policy.

e) Directors and Service Managers

The responsibility for records management at directorate or departmental level is devolved to the relevant directors, directorate and departmental managers. Senior managers 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.

f) All NHS Orkney staff

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 NHS Orkney Records Management policies and guidance and their own respective professional bodies record keeping guidance

[1] Currently Head of eHealth and IT
[2] Currently Clinical Administration and Out Patient Manager
[3] Currently Board Secretary

8. Committee Structure to oversee compliance with National Information Governance Standards

The Information Governance group will be the lead operational committee. The Information Governance group reports to the Board via Department Managers and Service Leads.

Department Managers and Service Leads will operationalise the information governance strategy and records management policy. They will report to the Information Governance group and will maintain standards by:

- Identifying areas where improvements could be made
- Reporting performance standards to provide assurance to the assigned Board Committee Monitoring compliance with the standards, legislation, policies and procedures relating to the management of records
- Approving locally devised methods of recording information
- Ensuring records collection are rationalised by encouraging users to share records and the information they contain (subject to Data Protection and agreed confidentiality guidelines)
- Publicising and promoting the local guidelines by supporting the implementation of a formal training programme to launch and support the guidelines and the inclusion of records management in induction training and staff handbooks.

9. Confidentiality of a Record

All staff and those carrying out functions on behalf of the Board have a duty of confidentiality to patients and a duty to support professional ethical standards of confidentiality. The duty of confidentiality continues even after death of the patient or after an employee or contractor has left the NHS. Unauthorised disclosure of information may lead to a complaint against the Board or disciplinary action against a member of staff for a breach of confidentiality.

Patient records must not be removed from NHS Orkney site and must be logged through TrakCare, or departmental recording log, as to the exact location and who borrowed them.

Refer to the Information Security Policy for further information and advice.

10. Creation of a Record

Due care must be taken in the creation of all records, whether paper or electronic, to ensure they are consistent and appropriate in structure and format, and that only necessary and sufficient information is recorded.

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 need and to maintain security and confidentiality.

Wher records are kept in electronic form, wherever possible they should be held within an Electronic Document and Records Management Sytsem (EDRMS) which conforms to the standards of the European Union “Model Requirements” (MoReg).

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 file plan 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.

11. Ownership of a Record

g) Health Records

- The Secretary of State for Health owns all records, including GP records
- The Personal Child Health Record (also known as “The Red Book”) belongs to the principle carer, for example the parent of the child

h) Single Assessment Documentation

Whilst contract and overview assessment documentation belongs to the patient, ownership of specialist documentation lies with the service delivering that episode of care.

i) Staff Records

Staff and personnel records belong to the employing organisation and are the responsibility of the individual’s line manager.

In line with Central Legal Office guidance, and over-riding the information in section 18 below, all information for staff (Human Resources, Payroll etc) must be retained from January 2000 until such time as the Equal Pay Litigation is fully and finally concluded and NHS Boards have been informed that the records are no longer so required.

12. Storage and Tracking of Clinical Records

Each clinical team must follow the Board’s filing procedure contained within the Procedure for the Storage, Transfer and Tracking of Clinical Records and all documentation must be stored in the appropriate filing system when not in use. The filing of documents is the responsibility of the person who last made an entry in the record.

Multiple documents belonging to an individual service and which constitutes a record should be filed together. Paper documents should be securely attached to each other.

Other than requests for copies of notes (which influence the criteria for retention and destruction), any complaints or litigation correspondence should be filed separately from the clinical case notes. This is the responsibility of the Patient Experience Officer.

13. Access to Records

a) Access to Clinical or Personal Records

Every patient or individual has the right to access their records. Any such request to access a health record under the Data Protection Act should be forwarded to the Clinical Administration Manager for hospital and community records or the Practice Manager at the relevant GP Practice for a Primary Care record, who will follow the procedure for the management of a subject access request.

Any member of staff has the right to access their personnel file. Any such request should be sent to the Data Protection Officer in the first instance, in line with the Policy for access to Staff Records.

b) Access to Corporate Records

Should any person request corporate Board information, this request should be forwarded to the Freedom of Information Officer who will deal with it in accordance with the Freedom of Information (Scotland) Act 2002 regulation.

c) 24 Hour Access by Care Professionals

It is important that those professions who care for patients or clients outside the normal working day should have access to clinical records. This is to minimise clinical incidents whose root cause is a lack of information. The procedure for 24 Hour access to health records should be followed in these circumstances.

14. Audits of Records Management

Audits measure compliance with this policy and its underpinning procedures. There are two types of records audit that must be carried out on an annual basis:-

a) Quality Assurance Audit Control

All services will be responsible for carrying out a yearly record keeping audit including clinical and non-clinical records regarding

- Quality of documentation
- Adherence to this policy and its underpinning procedures and guidance

This audit will focus on the following:

- Legibility
- Attributability
- Timelines of entries
- Content of information on which decisions have been made regarding the care of patients
- Whether the record is being store in accordance with the retention and destruction schedule

The results from the audit will be fed back to line managers. It is the responsibility of line managers to ensure that audits take place on an annual basis and that all action points are clearly documented and implemented in order to improve and maintain performance.

b) **Audit Record Types in use by Board staff**

Risk management standards require that the Board use just one record type per professional function. An annual audit must be undertaken by each Directorate in order to identify whether there are duplicate record formats in existence and undertake any remedial actions identified to ensure compliance with this standard.

15. Breaches in Security and Lost Records

Any incident or near miss relating to a breach in the security regarding the use, storage, transportation or handling of records must be reported using the Board's incident reporting system.

A serious breach of security, for example major theft or fire, must be managed in accordance with the Board's Management of Incidents including Significant Adverse Events Policy.

A lost record is defined as any record that cannot be located within 5 working days of first attempt to access the record or any record that has been stolen from a known place, for example the boot of a car. Any suspected thefts must be reported to the Police.

The Board's Caldicott Guardian must be informed immediately of any loss or misplacement of any document that is used to record patient information, including diaries, or Board business. When all efforts to locate the record have been exhausted, a Datix must be completed giving clear details of all actions including:-

- When and where record was last seen, with date if known
- If stolen, from where and Police Incident Number
- Actions taken to locate file

It is the responsibility of the line manager, liaising with and taking advice as necessary from the Clinical Administration Manager / Practice Manager, to investigate such incidents and identify any learning points that must be implemented in order to prevent a recurrence.

16. The Archiving and Destruction of Closed Records

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.

Each department must ensure that all closed records are securely archived until such time as they can be destroyed in accordance with the retention and destruction schedule contained within the NHS Records Management Code of Practice (refer to Appendix 1 of this policy).

All records that are archived should first be appraised to determine whether they are worthy of permanent archival preservation. This should be undertaken in consultation with the Board Information Governance Lead who will take advice as appropriate.

The destruction is an irreversible act. A record must be kept of everything that has been destroyed, and include

- Description of record;
- Reference number/CHI 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).

Paper waste containing patient and staff identifiable information must be treated as confidential waste and shredded or incinerated.

17. Research Governance

Any research, as opposed to audit, undertaken using patient records must first be approved by a Regional Research Ethics Committee and be given management approval approval by the Caldicott Guardian.

18. Retention of Non-Medical Records

The management, retention and disposal of administrative records

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, CDROMs) in which they are created or held.

General Records:

Record Type	Minimum Retention Period	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	

Record Type	Minimum Retention Period	Notes
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 as Subject Access Request and FOISA)	Minimum of 40 working days following the response; requests for review for a minimum of six months	May wish to keep the correspondence longer for own business purposes
Indexes- file and document lists marked for permanent preservation	permanent	
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 (scientific, technological and medical)	Consider for permanent preservation	
Software licenses	Operational lifetime of product	

Financial Records:

The Scottish Government Health Directorate 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

Financial records are required to be maintained for 3 years after the end of the financial year in question. Records relating to VAT however require to be kept for 6 years and in practice it may be difficult to differentiate VAT records from other financial records.

Record Type	Minimum Retention Period	Notes
Accounts – final annual master copies	permanent	
Accounts – cost	3 years	
Accounts – working papers	3 years	

Record Type	Minimum Retention Period	Notes
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 e required for investigative purposes
Audit Records – original documents	3 years after formal clearance by statutory auditor	
Audit Reports (including Management letters, VFM reports and system / final accounts memorandum)	3 years after formal clearance by statutory auditor	
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 'invoices' below
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	

Record Type	Minimum Retention Period	Notes
Income and expenditure sheets and journals	6 years	
Indemnity forms	6 years after the indemnity has lapsed	
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 Customs & Excise
Wages / salary records	10 years	For superannuation purposes authorities may wish to retain such records until the subject reaches pensionable age

Property, Environment and Health and Safety Records:

Record Type	Minimum Retention Period	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	

Record Type	Minimum Retention Period	Notes
	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	
Greencode	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’
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

Record Type	Minimum Retention Period	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 - acquisitions 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 - leases	permanent	
Property management system	permanent	
Property - minor contracts	6 years	
Property performance	permanent	
Property - purchases	permanent	
Property strategy	permanent	
Property - title deeds	permanent	

Record Type	Minimum Retention Period	Notes
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	

Human Resources Records:

Record Type	Minimum Retention Period	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.

Record Type	Minimum Retention Period	Notes
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	
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: Disclosure Scotland information	6 months	Six months after the date on which recruitment or other relevant decisions have been taken; or six months after the date on which recruitment or other relevant decisions have been taken.
Recruitment: Job advertisements	1 year	

Procurement and Stores Records:

Record Type	Minimum Retention Period	Notes
Approval files - contracts	permanent	
Approved suppliers lists	11 years	
Delivery notes	2 years	
Indents	2 years after financial year referred to	

Record Type	Minimum Retention Period	Notes
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	
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	

NHS Board Records:

Record Type	Minimum Retention Period	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	

Record Type	Minimum Retention Period	Notes
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
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 1st 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 1st 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	
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	

Record Type	Minimum Retention Period	Notes
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	

Service Planning:

Record Type	Minimum Retention Period	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	
Winter business plans	6 years	

19. Retention of Personal Health Records

Types of record covered by this retention schedule:

- Patient health records (electronic or paper based; including those concerning all specialities, and GP medical records);
- Records of private patients seen on NHS premises;
- Accident and Emergency, Birth, and all other Registers;
- Theatre Registers and Minor Operations (and other related) Registers;
- X-Ray and Imaging reports, output and images (but see also HSG(95)3, "*Health Service Use of Ionising Radiations*", which gives specific advice on record keeping for procedures and treatments, such as X-Rays, which use ionising radiations);
- Photographs, slides, and other images;
- Microform (that is fiche / film);
- Audio and video tapes, cassettes, CD-ROM and others;
- E mails;
- Digital records;
- Computerised records.

Detailed guidance on retention and destruction of health records is given in the policy Health Records Services: Retention and Destruction of Personal Health Records Policy, published in 2011. See http://www.scotland.gov.uk/Publications/2011/11/25111114/1 .

Note: No surviving health record dated 1948 or earlier should be destroyed.

Record Type	**Minimum Retention Period (SG Records Management COP Version 2.0)**
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 and neo-natal records)	Retain until the patient's 25 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
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

Record Type	Minimum Retention Period (SG Records Management COP Version 2.0)
Mentally Disordered Persons (within the meaning of the Mental Health (Scotland) Act 2003)	20 years after date of last contact between the client/service user and any health care professional employed by the mental health provider, or 3 years after death of the patient/client/service user if sooner and the patient died while in the care of the organisation. Social services records are retained for a longer period. Where there is a joint mental health and 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 in to account any genetic implications of the patient's illness. If it is decided they to retain the records, they should be subject to regular review
Oncology (including radiotherapy)	30 years. Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes
Clinical Psychology	30 years
Dental, ophthalmic & auditory screening records	Adults - 11 years Children - 11 years, or up to 25th birthday, whichever is the longer
Genetic Records	30 years from date of last attendance

Health Records Retention Schedule

Record Type	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)	
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
Audiology records	Retain according to the standard minimum retention period appropriate to the patient / specialty (see above table)	

Record Type	Minimum Retention Period	Note
Birth registers	2 years	Likely to have archival value – see footnote
Body release forms	2 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)	
Clinical Audit records	5 years	
Clinical psychology	30 years	
Counselling records	30 years	Likely to have research / historical value – see footnote
Death – Cause of, Certificate counterfoils	2 years	
Death Registers – ie register of deaths kep by the hospital where they exist in paper format	2 years	Likely to have research / historical value – see footnote
Dental epidemiological surveys	30 years	
Dental and auditory screening records	Adults – 11 years Children – 11 years, orup to 25th birthday, whichever is 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 table above)	

Record Type	Minimum Retention Period	Note
Discharge books (where they exist in paper format)	8 years after the last entry	Likely to have research / historical 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 table above)	
Family planning records	10 years after the closure of the case. For children retain until their 25th birthday	
Genetic records	30 years from date of last attendance	Likely to have research / historical value – see footnote
Genito Urinary Medicine	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
GP Records	Retain for the lifetime of the patient and for 3 years after death	
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
Healthcare associated infection records	6 years	
Intensive care unit charts	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Learning difficulties (records of patients with)	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	

Record Type	Minimum Retention Period	Note
Cancer care patient records –community and acute	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
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 table above)	
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 table above)	
Microfilm / microfiche records relating to patient care	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	Likely to have research / historical 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
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	50 years from the date of the last entry or age 75,	Likely to have research / historical value – see footnote

Record Type	Minimum Retention Period	Note
surveillance	whichever is the long	
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
Occupational Therapy records	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Oncology (including radiotherapy)	30 years NB records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes	Likely to have research / historical value – see footnote
Operating theatre registers	8 years after the year to which they relate	Likely to have research / historical value – see footnote
Orthoptic records	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Out of hours records (GP cover)	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate	
Parent held records	There should be a copy kept at the NHS organisation responsible for delivering that care and compiling the record of care.	

Record Type	Minimum Retention Period	Note
	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		
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 inpatient'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	
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	

Record Type	Minimum Retention Period	Note
External quality control records	5 year 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 ifall results transcribed into a separately issued and stored formal report. Otherwise, they should be kept as for worksheets. 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.	
Standard operating procedures (both current and outdated protocols)	30 years	
Surgical (histological) reports	Copy lodged in patient 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	
Refrigeration and freezer charts	15 years	
Request forms for grouping, antibody screening and cross-matching	1 month	

Record Type	Minimum Retention Period	Note
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	
Worksheets	30 years to allow full traceability of all blood products used.	
Patient Held Records		
Patient held records	At the end of an episode of care the NHS organisation responsible for delivery that care and compiling the record of 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		
Chemotherapy	2 years after last treatment	
Clinical drug trials (non – sponsored)	2 years after completion of trial	
GP10, TTOs, outpatient, private	2 years	NB 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	
Clinical Trials		
Destruction records	2 years after end of trial	

Record Type	Minimum Retention Period	Note
Dispensing records	2 years	
Production batch records	5 years after end of trial	
Protocols	2 years	
Worksheets		
Chemotherapy, aseptic, worksheets	5years	
Extempraneious 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 itme – applies only to re-packaged items	
Paediatric worksheets	As per Children and Young People (see above)	
Quality Assurance		
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

Record Type	Minimum Retention Period	Note
Standard operating procedures	15 years after superseded by revised version	As electronic record in perpetuity
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	
Controlled Drugs, Others		
Aspectic controlled drugs worksheets (paediatric)	26 years	
Controlled drugs, clinical trials	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 signature should be available in the pharmacy department
Extemporaneious controlled drugs preparation worksheets	13 years	

Record Type	Minimum Retention Period	Note
External controlled drug orders and delivery notes	2 years	
Destruction of patients' own drugs	6 months	
Dispensing errors	1 year plus current	
Doctors / nurses signatures	During 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	
Other Health Records		
Photographs (where the photograph refers to a particular patients it should be treated as part of the health record)	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Physiotherapy records	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Podiatry records	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Psychology Records	30 years	Likely to have research / historical value – see footnote
Records / documents related to any litigation	As advised by the organisation's legal advisor.	Likely to have research / historical value – see footnote

Record Type	Minimum Retention Period	Note
	All records to be reviewed.	
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 2. Research records and research databases (not patient specific)	30 years 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 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.	See footnote – review patient identifiable records every 5 years to see if they need to be retained or if their identifiability could be reduced Likely to have research / historical 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	

Record Type	Minimum Retention Period	Note
	patient / specialty (see table above)	
Telemedicine records (clinician to patient)	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
Ultrasound records (eg vascular, obstetric)	Retain according to the standard minimum retention period appropriate to the patient / specialty (see table above)	
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	
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 table above)	

Footnote: records is likely to have permanent research and historical value, consult National Records of Scotland

20. Rapid Impact Assessment

NHS Orkney – Equality and Diversity Impact Assessment **Rapid Impact Checklist: Summary Sheet** **Document title:** Records Management Policy	
Positive Impacts (Note the groups affected) Applies equally to all staff, contractors Provides clear guidance on how to process all records (clinical and non-clinical) from creation to destruction	**Negative Impacts (Note the groups affected)** None identified
Additional Information and Evidence Required None required	
Recommendations Fully compliant following some minor layout amendments	
From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not? Full EQIA not required	

Names and Signature(s) of Level One

Impact Assessor(s) Jean Aim Jean Aim 11 October 2017

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