Annex D1: Health Records Retention Schedule

This retention schedule details a **Minimum Retention Period** for each type of health record. Records (whatever the media) may be retained for longer than the minimum period. However, records should not ordinarily be retained for more than 30 years. Where a period longer than 30 years is required (eg to be preserved for historical purposes), or for any pre-1948 records, The National Archives (see note 1 below) should be consulted. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

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

- patient health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident & 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 (ie microfiche/microfilm);
- audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents.

If viewed in electronic format, the search facility in Word or PDF can be used to search for particular record types.

Notes

1. Where an organisation has an existing relationship with an approved Place of Deposit, it should consult the Place of Deposit in the first instance. Where there is no pre-existing relationship with a Place of Deposit, organisations should consult The National Archives.

2. The coding below denotes the status of the type of record and its retention period:

   C = a previously existing record type (ie referenced in a previous retention schedule) but a **C**hange to the retention period

   N = a **N**ew record type (either not referenced in a previous retention schedule or a more explicit description of a record type than previously published)

   S = a previously existing record type, with the **S**ame retention period.

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
A&E records (where these are stored separately from the main patient record)	Retain for the period of time appropriate to the patient/specialty, eg children's A&E records should be retained as per the retention period for the records of children and young people shown below		Destroy under confidential conditions	N
A&E registers (where they exist in paper format)	8 years after the year to which they relate		Likely to have archival value. See note 1	C
Abortion – Certificate A (Form HSA1) and Certificate B (Emergency Abortion)	3 years		Destroy under confidential conditions	S
Admission books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. See note 1	C
Adoption records – see non-health records				
Ambulance records – patient identifiable component (including paramedic records made on behalf of the Ambulance Service)	10 years	Limitation Act	Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Asylum seekers and refugees (NHS personal health record – patient-held record)	Special NHS record – patient held – no requirement on NHS to retain			N
Audiology records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Autopsy records – see Post mortem records and registers				
Birth registers (ie register of births kept by the hospital)	Lists sent to General Register Office on a monthly basis. Retain for 2 years		Likely to have archival value. See note 1	C
Blood transfusion records (see pathology records)				
Body release forms	2 years		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Breast screening X-rays	8 years		Destroy under confidential conditions	N
Care records – compiled by employees of a Care Trust (including information on an individual's educational status, care needs, etc)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Cervical screening slides	10 years		Destroy under confidential conditions	N
Chaplaincy records	2 years		Likely to have archival value. See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Child and family guidance	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Child Protection Register (records relating to)	Retain until the patient's 26th birthday		Destroy under confidential conditions	N
Children and young people (all types of records relating to children and young people)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 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 the records for a longer period		Destroy under confidential conditions	S
Clinical audit records	5 years		Destroy under confidential conditions	N
Clinical psychology	30 years		See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
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 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	European Commission Directive 2005/28/EC of 8 April 2005 laying down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorisation of the manufacturing or importation of such products: http:/pharmacos.eudra.org/F2/pharmacos/dir200120ec.htm	See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use Directive 2001/20/EC: The Medicines for Human Use (Clinical Trials) Regulations 2004		

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		ENTR/F/2 D(2002) – detailed guidelines on the trial master file and archiving ICH Harmonised Tripartite Guideline, guidance for good clinical practice, CPMP/ICH/135/95: http://www.emea.eu.int.pdfs/human/ich/013595en.pdf		
Controlled drug order books – see Pharmacy records				
Controlled drug prescriptions – see Pharmacy records				
Controlled drug registers (ward and pharmacy based) – see Pharmacy records				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Controlled drug ward orders of requisitions – see Pharmacy records				
Counselling records	30 years		See note 1	N
Creutzfeldt-Jakob Disease (hospital and GP)	30 years from date of diagnosis, including deceased patients	CJD Incidents Panel	See note 1	N
Death – Cause of, Certificate counterfoils	2 years		Destroy under confidential conditions	N
Death registers – ie register of deaths kept by the hospital, where they exist in paper format	Lists sent to GRO on a monthly basis. Retain for 2 years Death registers prior to lists sent to GRO – offer to Place of Deposit		Likely to have archival value. See note 1	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Dental epidemiological surveys	30 years		Destroy under confidential conditions	N
Dental, ophthalmic and auditory screening records	11 years for adults For children 11 years or up to their 25th birthday, whichever is the longer		Destroy under confidential conditions	N
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		Destroy under confidential conditions	N
Dietetic and nutrition	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Discharge books (where they exist in paper format)	8 years after the last entry		Likely to have archival value. See note 1	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
District nursing records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Donor records (blood and tissue)	30 years post transplantation	Committee on Microbiological Safety of Blood and Tissues for Transplantation (MSBT); guidance issued in 1996	See note 1	N
Drug trials, records (see Clinical trials)				
Family planning records	10 years after closure of the case For children retain until their 25th birthday		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Coroner's report, and human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	For post-mortem records which form part of the Coroner's report, approval should be sought from the coroner 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 All other records retain for 30 years	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) guidance from the Royal College of Pathologists and the Institute of Biomedical Science: http://www.rcpath.org.uk/resources/pdf/retention-SEPT05.pdf Human Tissue Act 2004	See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Genetic records	30 years from date of last attendance	The Royal College of Pathologists endorses the Code of Practice and Guidance of the Advisory Committee on Genetic Testing (1997) and its recommendations on storage, archiving and disposal of specimens and records related to human testing services (genetics) offered and supplied direct to the public. Those who intend to offer such services should follow its guidance	See note 1	N
Genito Urinary Medicine (GUM)	8 years from date of last attendance For children retain until their 25th birthday		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
GP records, including medical records relating to HM Armed Forces or those serving a period of imprisonment	Maternity records – 25 years after last live birth	Limitation Act 1980, Congenital Disabilities (Civil Liability) Act 1976, Consumer Protection Act 1987	Destroy under confidential conditions	S
	Records relating to children and young people (including paediatric, vaccination and community child health service records) – until the patient's 25th birthday or 26th if an entry was made when the young person was 17; or 10 years after death of a patient if sooner		Destroy under confidential conditions	S
	Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983 – 20 years after the date of the last contact; or 10 years after patient's death if sooner		Destroy under confidential conditions	S
	NB GPs may wish to keep mental health records for up to 30 years before review. They must be kept as complete records for the first 20 years but records may then be summarised and kept in summary format for the additional 10-year period	Royal College of Psychiatrists		

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	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 then is a matter for their professional judgement, taking into account clinical need and DPA requirements – they should not, for example, retain information that is not relevant to their clinical care of the patient Records relating to those serving a prison sentence		Not to be destroyed. This refers to GP records of serving military personnel that were in existence prior to them enlisting. Following the death of the patient, the records should be retained for 10 years after their death Not to be destroyed. This refers to GP records of serving prisoners that were in existence prior to their imprisonment. After their death, the records should be retained for 10 years	S

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
	All other patients – 10 years after their death or after the patient has permanently left the country unless the patient remains in the European Union		Destroy under confidential conditions	S
	Electronic patient records (EPRs) must not be destroyed, or deleted, for the foreseeable future	Good Practice Guidelines for General Practice Electronic Patient Records (version 3.1)		N
Health records (excluding records not specified elsewhere in this schedule)	8 years after conclusion of treatment or death		Destroy under confidential conditions	C
Health visitor records	10 years. Records relating to children should be retained until their 25th birthday		Destroy under confidential conditions	N
Homicide/'serious untoward incident' records	30 years		See note 1	N
Hospital acquired infection records	6 years		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
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	Directions given under the Human Fertilisation and Embryology Act 1990, 24 January 1992 (this Act is subject to review by the Government: http://www.dca.gov.uk/StatutoryBarsReport2005.pdf)	See note 1	N
	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	This applies to centres in respect of information which they are directed to record and maintain under a treatment licence		N
	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)	This applies to centres in respect of information which they are directed to record and maintain under a storage licence		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Human tissue (within the meaning of the Human Tissue Act 2004) (see Forensic medicine above)	For post mortem records which form part of the Coroner's report, approval should be sought from the Coroner 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 All other records retain for 30 years		See note 1	N
Immunisation and vaccination records	For children and young people – retain until the patient's 25th birthday or 26th if the young person was 17 at conclusion of treatment All others retain for 10 years after conclusion of treatment		Destroy under confidential conditions	N
Intensive Care Unit charts	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prothesis was used. Only need to retain minimum of notes with specific information about the prosthesis	http://www.njrcentre.org.uk	See note 1	N
Learning difficulties – (records of patients with)	Retain for 10 years after the death of the individual		Destroy under confidential conditions	N
Macmillan (cancer care) patient records – community and acute	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
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	See Addendum 1 (*Joint Position on the Retention of Maternity Records*) devised by: British Paediatric Association, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting	Destroy under confidential conditions	N
Medical illustrations (see Photographs below)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Mentally disordered persons (within the meaning of any Mental Health Act)	20 years after the date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner NB Mental health organisations may wish to keep mental heath 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 social care trust, the higher of the two retention periods should be adopted	Mental Health Act 1983 and its successors Royal College of Psychiatrists	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	C
Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		May have archival value. See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Midwifery records	25 years after the birth of the last child	*Midwives rules and standards* 05.04 (rule 9)	Destroy under confidential conditions	N
Mortuary registers (where they exist in paper format)	10 years		See note 1	N
Music therapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Neonatal screening records	25 years		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Notifiable diseases book	6 years		Destroy under confidential conditions	N
Occupational health records (staff)	3 years after termination of employment unless litigation ensues (see Litigation)		Destroy under confidential conditions	N
Health records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Control of Substances Hazardous to Health Regulations 2002 (reg. 24(3))	See note 1	N
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	See above (reg. 10(5))	See note 1	N
Personnel health records under occupational surveillance	40 years from last entry on the record	Ionising Radiation Regulations 1999 (reg. 11(3))	See note 1	N
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	See above (reg. 19(3)(a))	See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Occupational therapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
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	BFCO(96)3 issued by the Royal College of Radiologists with the support of the Joint Council for Clinical Oncology	See note 1	N
Operating theatre registers	8 years after the year to which they relate		Likely to have archival value. See note 1	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Orthoptic records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Out of hours records (GP cover), including video, DVD and tape voice recordings	If the only record, retain for 3 years. If placed on other records, retain for period appropriate to the specialty. If required in litigation, see Litigation		Destroy under confidential conditions	N
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate		Destroy under confidential conditions	N
Paediatric records (see Children and young people above)				

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Parent-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 parent-held records. 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 8 years after death		Destroy under confidential conditions	N
Pathology records *Documents, electronic and paper records*		http://www.rcpath.org/resources/pdf/retention-SEPT05.pdf	Destroy under confidential conditions	
Accreditation documents; records of inspections	10 years or until superseded			N
Batch records results	10 years	Consumer Protection Act 1987		N
Bound copies of reports/records, if made	30 years			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Day books and other records of specimens received by a laboratory	2 calendar years			N
Equipment/ instruments maintenance logs, records of service inspections	Lifetime of equipment			N
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	11 years			
External quality control records	2 years			N
Internal quality control records	10 years	Consumer Protection Act 1987		N
Lab file cards or other working records of test results for named patients	2 calendar years			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Near-patient test data	Result in patient record, log retained for lifetime of instrument			N
Pathological archive/museum catalogues	30 years, subject to consent			N
Photographic records	30 years where images present the primary source of information for the diagnostic process			N
Records of telephoned reports	2 calendar years			N
Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record			N
Reports, copies Post mortem reports	6 months Held in the patient's health record for 8 years after the patient's death			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Request forms that are not a unique record	1 week after report received by requestor			N
Request forms that contain clinical information not readily available in the health record	30 years			N
Standard operating procedures (current and old)	30 years			N
Specimens and preparations				
Blocks for electron microscopy	30 years			N
Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record			N
Foetal serum	30 years			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides – 10 years Residual tissue – kept as fixed specimen once frozen section complete			N
Frozen tissue or cells for histochemical or molecular genetic analysis	10 years			N
Grids for electron microscopy	10 years			N
Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)			N
Microbiological cultures	24–28 days after final report of a positive culture issued. 7 days for certain specified cultures – see RCPath document			N
Museum specimens (teaching collections) Stained slides	Permanently. Consent of the relative is required if it is tissue obtained through post mortem Depends on the purpose of the slide – see RCPath document for further details	http://www.rcpath.org/resources/pdf/Retention-SEPT05.pdf		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Newborn blood spot screening cards Body fluids/ aspirates/swabs	5 years – parents should be alerted to the possibility of contact from researchers after this period and a record kept of their consent to contact response 48 hours after the final report issued by lab	Code of Practice of the UK Newborn Screening Programme Centre and http://www.screening.nhs.uk/cpd/ICFactsheet4.pdf		N
Paraffin blocks	30 years and then appraise for achival value			N
Records relating to donor or recipient sera	11 years post transplant			N
Serum following needlestick injury or hazardous exposure	2 years			N
Serum from first pregnancy booking visit	1 year			N
Wet tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens	Human Tissue Act		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Whole blood samples, for full blood count	24 hours			N
Transfusion laboratories Annual reports (where required by EU directive)	15 years			N
Autopsy reports, specimens, archive material and other where the deceased has been the subject of a Coroner's autopsy	These are Coroner's records – copies may only be lodged on the health record with the Coroner's permission			N
Blood bank register, blood component audit trial and fates	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4°C			N
Forensic material – criminal cases	Permanently, not part of the health record			N
Refrigeration and freezer charts	11 years			N
Request forms for grouping, antibody screening and cross-matching	1 month	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		N
Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Separated serum/plasma, stored for transfusion purposes	Up to 6 months			N
Storage of material following analyses of nucleic acids	30 years See RCPath document for further guidance	http://www.cepath.org/resources/pdf/Retention-SEPT05.pdf		N
Worksheets	30 years to allow full traceability of all blood products used	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)		N
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 specialty		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Pharmacy records	Individual retention periods from Hospital Pharmacists Group 2003	http://www.pjonline.com/pdf/hp/200305/hp_200305_pharmacyrecords.pdf	Destroy under confidential conditions	N
Prescriptions				
Chemotherapy	2 years after last treatment			N
Clinical drug trials (non-sponsored)	2 years after completion of trial			N
FP10, TTOs, outpatient, private	2 years		NB Inpatient prescriptions held as part of health record	N
Parenteral nutrition	2 years		Original valid prescription to be held with the health record	N
Unlicensed medicines dispensing record	5 years			N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Worksheets Raw material request and control forms	5 years			N
Resuscitation box	1 year after the expiry of the longest dated item	Applies only to repackaged items		N
Chemotherapy, aseptics worksheets, parenteral nutrition, production batch records	5 years	Product liability extends up to 11 years after expiry		N
Paediatric	As per children and young people	Product liability extends up to 28 years		N
Quality Assurance Environmental monitoring results	1 year after expiry date of products			N
Equipment validation	Lifetime of the equipment			N
QC documentation, certificates of analysis	5 years or 1 year after expiry of batch (whichever is longer)	Article 51(3) Directive 2001/83		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Refrigerator temperature	1 year		Refrigerator records to be retained for the life of any product stored therein	N
Standard operating procedures	15 years after superseded by revised version			N
Orders Invoices	6 years			N
Order and delivery notes, requisition sheets, old order books	Current financial year plus one			N
Picking tickets/ delivery notes	3 months			N
Ward pharmacy requests	1 year	Limitation Act 1980		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Controlled Drugs				
Controlled drug destruction records (pharmacy and ward based)	2 years	Misuse of Drugs Regulations 2001		N
Controlled drug prescriptions (TTOs/OP)	2 years	Misuse of Drugs Regulations 2001		N
Controlled drug order books, ward orders and requisitions	2 years	Misuse of Drugs Regulations 2001		N
Controlled drug registers (pharmacy and ward based)	2 years	Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001		N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Physiotherapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Podiatry records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Post mortem records (see Pathology records)				
Post mortem registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	N
Prison healthcare records (see GP records)				
Private patient records admitted under section 58 of the National Health Service Act 1977 or section 5 of the National Health Service Act 1946	Although technically exempt from the Public Records Acts, it would be appropriate for authorities to treat such records as if they were not so exempt and retain for period appropriate to the specialty		Destroy under confidential conditions	N
Psychology records	30 years		See note 1	N
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed. Normal review 10 years after the file is closed		See note 1	C

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
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	BS ISO 15489 (section 9.10)	See note 1	N
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	Data Protection Act (section 33 and schedule 8 part IV) and Data Protection (Processing of Sensitive Personal Data) Order 2000 (section 9). Research Governance Framework for Health and Social Care 2005	See note 1. Review patient identifiable records every 5 years to see if they need to be retained or if their identifiability could be reduced	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
2. Research records and research databases (not patient specific)	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 to be retained Research records other than for clinical trials of investigational medicinal products – as above	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) Addendum 1. Commission Directive 2005/28/EC of 8 April 2005 laying down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorisation of the manufacturing or importation of such products: http:/pharmacos.eudra.org/F2/pharmacos/dir200120ec.htm	See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use		

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
		Directive 2001/20/EC: The Medicines for Human Use (Clinical Trials) Regulations 2004 ENTR/F/2 D(2002) – detailed guidelines on the trial master file and archiving ICH Harmonised Tripartite Guideline, guidance for good clinical practice, CPMP/ICH/135/95: http://www.emea.eu.int.pdfs/human/ich/013595en.pdf		

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Scanned records relating to patient care	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
School health records (see Children and young people)				
Speech and language therapy records	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
Suicide – notes of patients having committed suicide	10 years		See note 1	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Telemedicine records (see also Video records)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N
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	*The Retention and Storage of Pathological Records and Archives* (3rd edition 2005) Addendum 1	See note 1	C
Ultrasound records (eg vascular, obstetric)	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation		Destroy under confidential conditions	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
Vaccination records (see Immunisation and vaccination records)				
Video records/ voice recordings relating to patient care/video-conferencing records (see also Telemedicine records and Out of hours records)	8 years subject to the following exceptions: **Children and young people:** Records must be kept until the patient's 25th birthday, or if the patient was 17 at the conclusion of treatment, until their 26th birthday, or until 8 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 8 years after the patient's death if sooner **Cancer patients:** Records should be kept until 8 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	Guidance on use of video-conferencing in healthcare: http://www.wales.nhs.uk/sites/documents/351/1_multipart_xF8FF_3_Guidance%20on%20the%20Use%20of%20Videoconferencing%20in%20Healthcare%20_Ve_.pdf	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)	N

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	DERIVATION	FINAL ACTION	CODE (see note 2)
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 note 1	C
X-ray films (including other image formats for all imaging modalities/ diagnostics)	7 years	Guidance from the Royal College of Radiologists	Destroy under confidential conditions	N
X-ray registers (where they exist in paper format)	30 years		Likely to have archival value. See note 1	C
X-ray reports (including reports for all imaging modalities)	To be considered as a permanent part of the patient record and should be retained for the appropriate period of time			N

Addendum 1: Principles to be Used in Determining Policy Regarding the Retention and Storage of Essential Maternity Records

British Paediatric Association
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Joint Position on the Retention of Maternity Records

1. 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.

2. Records that should be retained are those which 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.

3. 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.

4. 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.

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

List of Maternity Records to be Retained

6. Maternity Records retained should include the following:

6.1 documents recording booking data and pre-pregnancy records where appropriate;

6.2 documentation recording subsequent antenatal visits and examinations;

6.3 antenatal in-patient records;

6.4 clinical test results including ultrasonic scans, alpha-feto protein and chorionic villus sampling;

6.5 blood test reports;

6.6 all intrapartum records to include, initial assessment, partograph and associated records including cardiotocographs;

6.7 drug prescription and administration records;

6.8 postnatal records including documents relating to the care of mother and baby, in both the hospital and community settings.