Annex 4 applies to personal health records and annex 5 to administrative records.

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

Health Record Type	*Minimum NHS Retention Period*
Adult	6 years after date of last entry or 3 years after death if earlier
All types of records relating to Children and young people (including children's and young person's Mental Health Records)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 3 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain for a longer period.

Mentally disordered person (within the meaning of any Mental Health Act)	20 years after date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 3 years after the death of the patient/client/service user if sooner and the patient died while in the care of the organisation. N.B. NHS organisations may wish to keep mental health records for up to 30 years before review. Records must be kept as complete records for the first 20 years in accordance with this retention schedule but records may then be summarised and kept in summary format for the additional 10-year period. Social services records are retained for a longer period. Where there is a joint mental health and social care record, the higher of the two retention periods should be adopted. When the records come to the end of their retention period, they must be reviewed and not automatically destroyed. Such a review should take into account any genetic implications of the patient's illness. If it is decided to retain the records, they should be subject to regular review.

Health Records Retention Schedule

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*
A&E records (where these are stored separately from the main patient record)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
A&E registers (where they exist in paper format)	8 years after the year to which they relate.	Likely to have archival value – see footnote
Abortion – Certificates set out in Schedule 1 to the Abortion (Scotland) Regulations 1991	3 years beginning with the date of the termination	
Admission books (where they exist in paper format)	8 years after the last entry	Likely to have archival value – see footnote
Ambulance records – patient identifiable Component (including paramedic records made on behalf of the Ambulance Service)	7 years	
Asylum seekers and refugees (NHS personal health record – patient held record)	Special NHS record – patient held, no requirement on the NHS to retain.	
Audiology records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	

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

Clinical trials of investigational medicinal products – health records of participants that are the source data for the trial	For trials to be included in regulatory submissions: At least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the Sponsor. It is the responsibility of the Sponsor/someone on behalf of the Sponsor to inform the investigator/institution as to when these documents no longer need to be retained. **For trials which are not to be used in regulatory submissions:** At least 5 years after completion of the trial. These	Likely to have research value see footnote

	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.	
Counselling records	30 years	Likely to have research/ historical value see footnote
Disposal of pregnancy loss up to and including 23 weeks and 6 days gestation records	50 years	
Death – Cause of, Certificate counterfoils	2 years	
Death registers – i.e. register of deaths kept by the hospital, where they exist in paper format	2 years	Likely to have archival value – see footnote
Dental epidemiological surveys	30 years	
Dental and auditory screening records	Adults: 11 years Children: 11 years, or up to 25th birthday, whichever is the longer	
Diaries – health visitors and district nurses	2 years after end of year to which diary relates. Patient relevant information should be transferred to the patient record.	It is not good practice to record patient identifiable information in diaries.
Dietetic and nutrition	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
Discharge books (where they exist in paper format)	8 years after the last entry	Likely to have archival value – see footnote

Disposal of Foetal Tissue (under 24 weeks) Records	30 years	
District nursing records	Retain according to the standard minimum retention period appropriate to the	

	patient/specialty (see above table at pages 8-10)	
Donor records (blood and tissue)	30 years post transplantation	Likely to have research/ historical value see footnote
Family planning records	10 years after the closure of the case For children retain until their 25th Birthday	
Forensic medicine records (including pathology, toxicology, haematology, dentistry, DNA testing, post mortems forming part of the Procurator Fiscal's report, and human tissue kept as part of the forensic record) See also Human tissue, Post mortem registers	Records should be retained for 30 years. The exception is for post mortem records which form part of the Procurator Fiscal's report, where approval should be sought from the PF for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed. In cases where criminal proceedings are anticipated documentation is not normally entered in to the patient records.	Likely to have research/ historical value see footnote
Genetic records	30 years from date of last attendance.	Likely to have research/ historical value see footnote
Genito Urinary Medicine (GUM)	Store according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	

GP records, including medical records relating to HM Armed Forces	Retain for the lifetime of the patient and for 3 years after their death. Records relating to those serving in HM Armed Forces - The Ministry of Defence (MoD) retains a copy of the records relating to service medical history. The patient may request a copy of these	

	under the Data Protection Act (DPA), and may, if they choose, give them to their GP. GPs should also receive summary records when ex-Service personnel register with them. What GPs do with them is a matter for their professional judgement, taking into account clinical need and Data Protection Act requirements- they should not, for example, retain information that is not relevant to their clinical care of the patient. GP records of serving military personnel in existence prior to them enlisting must not be destroyed. Following the death of the patient the records should be retained for 3 years. *Electronic Patient Records (EPRs)- GP only- must not be destroyed, or deleted, for the foreseeable future	*The rationale for this is explained in 'SCIMP Good Practice Guidelines for General Practice Electronic Patient Records – section 6.1' (currently under review)
Health visitor records	10 years Records relating to children should be retained until their 25th birthday	
Homicide/ 'serious untoward incident' records	30 years	Likely to have research/ historical value see footnote
Hospital acquired infection records	6 years	

Human fertilisation records, including embryology records	Treatment Centres 1. If a live child is not born, records should be kept for at least 8 years after conclusion of treatment 2. If a live child is born, records shall be kept for at least 25 years after the child's birth 3. If there is no evidence whether a child was born or not, records must be kept for at least 50 years after the information was first recorded **Storage Centres** Where gametes etc have been used in research, records must be kept for at least 50 years after the information was first recorded. **Research Centres**	Likely to have research value see footnote

	Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA)	

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Human tissue (within the meaning of the Human Tissue (Scotland) Act 2006) (see Forensic medicine above)	For post mortem records which form part of the Procurator Fiscal's report, approval should be sought from the Procurator Fiscal for a copy of the report to be incorporated in the patient's notes, which should then be kept in line with the specialty, and then reviewed.	Likely to have research value see footnote
Intensive Care Unit charts	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
Joint replacement records	For joint replacement surgery the revision of a primary replacement may be required after 10 years to identify which prosthesis was used. Only need to retain minimum of notes with specific information about the prosthesis.	Likely to have research value see footnote
Learning difficulties – (records of patients with)	Retain for 3 years after the death of the individual.	
Macmillan (cancer care) patient records – community and acute	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
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 from date of last contact	
Medical illustrations (see Photographs below)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	

Mentally disordered persons (within the meaning of any Mental Health Act)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
Microfilm/microfiche records relating to	Retain according to the standard minimum retention period appropriate to the	Likely to have archival

patient care	patient/specialty (see above table at pages 8-10)	value – see footnote
Midwifery records	25 years after the birth of the last child	
Mortuary registers (where they exist in paper format)	10 years	Likely to have research/ historical value see footnote
Music therapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
Neonatal screening records	25 years	
Notifiable diseases book	6 years	
Occupational Health Records (staff)	6 years after termination of employment	
Ophthalmic records	Adults: 7 years Children: 7 years, or up to 25th birthday, whichever is the longer	
Health Records for classified persons under medical surveillance	50 years from the date of the last entry or age 75, whichever is the longer	Likely to have research/ historical value see footnote
Personal exposure of an identifiable employee monitoring record	40 years from exposure date	Likely to have research/ historical value see footnote
Personnel health records under occupational surveillance	40 years from last entry on the record	Likely to have research/ historical value see footnote
Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	Likely to have research/ historical value see footnote

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Occupational therapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
Oncology (including radiotherapy)	30 years N.B. Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes.	Likely to have research value see footnote
Operating theatre registers	8 years after the year to which they relate	Likely to have historical value – see footnote
Orthoptic records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above table at pages 8-10)	
Out of hours records (GP cover), including video, DVD and voice recordings (clinician to patient)	Where the primary purpose of the voice recording is for patient triage and the output is recorded within the patients paper or electronic record (which is then retained according to the standard minimum retention period for the patient/specialty at pages 8-10) the audio recording need only be retained for 7 years	
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate	
Parent held records	There should be a copy kept at the NHS organisation responsible for delivering that care and compiling the record of the care. The records should then be retained until the patient's 25th birthday, or 26th birthday if the young person was 17 at the conclusion of treatment, or 3 years after death	

Pathology records: Documents, electronic and paper

Pathology records: Documents, Electronic and Paper Records		
TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Accreditation documents; records of Inspections	10 years or until superseded	
Batch records results	10 years	

Bound copies of reports/records, if made	30 years	
Correspondence on patients	This should be lodged in the patient's record, if feasible. However this is often beyond the	

	control of the laboratory, particularly for case referred distantly, and ensuring entry into the patients notes is not primarily the responsibility of laboratory staff. Otherwise, keep for at least 30 years; this may be most conveniently done in association with stored paper or scanned copy of the relevant specimen request and/or report kept by the relevant laboratory.	
Day books and other records of specimens received by a laboratory	2 years from specimen receipt	
Equipment/instruments maintenance logs, records of service inspections	Lifetime of instrument; minimum of 10 years	
Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	Comprehensive records relevant to procurement, use, modification and supply: 10 years.	
External quality control Records	Subscribing laboratories or individuals, 5 years to ensure continuity of data available for laboratory accreditation purposes. Records will be kept for longer periods by organisations providing external quality assessment schemes.	
Internal quality control Records	10 years	
Lab file cards or other working records of test results for named patients	1 year from specimen receipt if all results transcribed into a separately issued and stored formal report. Otherwise, they should be kept as for worksheets over. The diversity of these types of working records is very wide; within specialties and departments, consideration should be given to the potential audit or medico- legal value of storing such working records for 30 years, as for other primary records.	
Mortuary Registers	30 years	

Near-patient test data	Result in patient record, log retained for lifetime of instrument	
Pathological	For as long as the specimens are held or until	

archive/museum catalogues	the catalogue is updated, subject to consent where required, (with maintained and accessible documentation of consent)	
Photographic records	Where images represent a primary source of information for the diagnostic process, whether conventional photographs or digital images, they should be kept for at least 30 years.	
Records of telephoned Reports	Note of the fact and date/time that a telephone or fax report has been issued should be added to the laboratory electronic records of the relevant report, or to hard copies and kept for a minimum of 5 years. Where management advice is discussed in telephone calls, a summarised transcript should be retained long term, as for the retention of other correspondence. Clinical information or management advice provide by fax, in addition of pure transmission of report, should also be kept as correspondence in the patient note and/or stored with a laboratory copy of the specimen request/report for 30 years.	
Records relating to cell/tissue transplantation	Records not otherwise kept or issued to patient records that relate to investigations or storage of specimens relevant to cell/tissue transplantation, including donated organs from deceased individuals should be kept for at least 30 years or the lifetime of the recipient, whichever is the longer.	
Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record	

Reports and copies (physical or electronic)	6 months or as needed for operational procedures. Where copies represent a means of communication or aide memoire, for example at a multi-disciplinary meeting or case conference, they may be disposed of when that function is complete. Copies of reports sent by fax, with accompanying details of the date and times of transmission, and the intended recipient, should be retained in conjunction with the matching specimen reports and stored long-term by the laboratory.	

	Any such copies generated to substitute for an original report (e.g. if an original is misplaced) should be retained as for the original.	
Reports, copies Post mortem reports	The report should be lodged in patient's record; in the case of Procurator Fiscal reports this is dependant on the PF's approval. Electronic or hard copy should be kept at least 30 years with maintained accessibility. In addition to accessible indexing of paper copies, there must be continuation of access to e-copies when laboratory, computer systems are upgraded or replaced. This guidance applies equally to rapid, short reports that maybe prepared for the PF, summarising cause of death and to the final reports of post-mortem examinations.	
Request forms that are not a unique record	Request forms should be kept until the authorised report, or reports on investigation arising from it, have been received by the requestor. As this period of time may vary with local circumstances, no minimum retention time is recommended, request forms need not to be kept for more than one month after the final checked report has been despatched. For many uncomplicated requests, retention of 1 week will suffice.	
Request forms that contain clinical information not readily available in the health record	30 years Where the request form is used to record working notes or as a worksheet, it should be retained as part of the laboratory record.	
Standard operating procedures (both current and outdated protocols)	30 years	
Surgical (histological) reports	Copy lodged in patients notes. Electronic or hard copy to be kept for at least 30 years by the laboratory with maintained accessibility of e- copies when laboratory, computer systems are upgraded or replaced.	

Pathology Records: Specimens and Preparations.

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Body fluids/aspirates/swabs	Keep for 48 hours after the final report has been issued by the laboratory, unless sample deterioration precludes storage.	
Blocks for electron microscopy	30 years	
Electrophoretic strips and immunofixation plates	Keep for 5 years, unless digital images are taken, if digital images of adequate quality for diagnosis are taken, then the original preparations may be discarded after 2 years. The images should then be stored under "photographic records" bearing in mind the need to maintain the ability to read archived digital images when equipment is updated.	
Foetal serum	Because of its rarity and value for future research, wherever possible foetal serum should be kept for at least 30 years.	
Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides should be kept for a minimum of 10 years.	
Frozen tissues or cells for histochemical or molecular genetic analysis	10 years and preferably longer if storage facilities permit.	
Grids for electron microscopy	Requirements in different specialties differ. Grids prepared for human tissue diagnosis (e.g. renal, muscle, nerve, or tumour) should be kept for 10 years; preferably longer if practicable. Grids prepared for virus identification may be discarded 48 hours after the final report has been issued, provided that all derived images are retained and remain accessible for at least 30 years.	
Human DNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)	

Microbiological cultures	24-28 days after final report of a positive culture issued. 7 days for certain specified cultures – see RCPath document
Museum specimens (teaching collections)	Permanently. Consent of the relative is required if it is tissue

Newborn blood spot screening cards	A minimum of 5 years storage is indicated for quality assurance purposes, with longer term storage recommended in accordance with the Code of Practice of the UK Newborn Screening Programme Centre (2005). See **here** for more information.	
Paraffin blocks	Storage for at least 30 years is recommended, if facilities permit. If not, review the need for archiving at 10 years (and at similar intervals thereafter) and select representative blocks, showing the relevant pathology for permanent retention. Blocks representing rare pathologies and those (including representative normal tissue) from patients of diseases known or thought likely to have an inherited genetic pre-disposition should be particularly considered for permanent retention. Wherever possible, storage of all histology blocks should be for the full minimum of 30 years.	
Plasma and serum	Keep for 48 hours after the final report has been issued by the laboratory.	
Records relating to donor or recipient sera	Serum samples obtained from recipient (s) for the purposes of matching in cell/tissue transplantation, and their accompanying records, must be kept for the lifetime of the recipient.	
Serum from first pregnancy booking visit	Should be kept by microbiology/virology and other relevant laboratories to provide a baseline for further serological or other tests for infections or other disease during pregnancy and the first 12 months after delivery. Because of rarity and value to future research, wherever possible, foetal serum (from cordocentesis) should be kept for at least 30 years.	

Stained slides	Appropriate retention times depend on their nature and purpose. Relevant guidance on minimum retention periods can be found **here**. Note that where sections are likely to contain intact human cells, or are intended to be representative of whole cells, they constitute "relevant material" under the Human Tissue act 2004; further information can be found **here**.	
Wet tissue	For surgical specimens from living patients,	

(representative aliquot or whole tissue or organ)	keep for 4 weeks after issue of final report. For cases in which a supplementary report is anticipated after additional tests, (such as various molecular investigations or referral for expert opinion), which may occasionally exceed this period, arrangements should exist to ensure that individual specimens are retained until the additional report has been finalised.	
Whole blood samples, for full blood count	24 hours	

Pathology Records: Transfusion Laboratories

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

Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4° C	
Forensic material – criminal cases	Permanently – not part of the health record. In cases where criminal proceedings can be anticipated, all recording made at the autopsy,	

	be the hand written notes (by everyone, i.e. pathologist, technician, trainee, etc), tape recordings, drawings or photographs, are all documentary records and as such their existence must be declared (disclosed). They must be available to all involved throughout the lifetime of the case, including appeals and other re-investigations.	
Refrigeration and freezer charts	15 years	
Request forms for grouping, antibody screening and cross-matching	1 month	
Results of grouping, antibody screening and other blood transfusion-related tests	30 years to allow full traceability of all blood products used, in compliance with the Blood Safety and Quality Regulations 2005.	
Separated serum/plasma, stored for transfusion purposes	No minimum storage time is recommended for recipient patient samples. Storage of donated serum/plasma should optimally be at -30 degrees Centigrade or colder. These materials may be stored for up to 6 months, but guidelines for the timeline of sample collection prior to blood transfusion must be followed. Archived blood donor samples should be stored by blood services for at least 3 years, and preferable longer if it is practicable, in order to facilitate 'look back' exercises.	

Pathology Records: Transfusion Laboratories		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***

Storage of material following analyses of nucleic acids	Developing technologies mean that there are now a variety of hard copy and/or electronic outputs associated with the analysis and interpretation of diagnostic tests using nucleic acid. It is recommended that all such outputs should be stored for at least 30 years unless the information is transcribed into permanently accessible report formats authorised by senior clinical laboratory staff or pathologists. The later reports should be kept for at least 30 years, as for other pathology reports may be regarded as reporting documents. For such working documents storage for at least the instrument, with a minimum of 10 years is	

	recommended.	
Worksheets	30 years to allow full traceability of all blood products used	
End of Pathology Records		

Patient Held Records

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

Pharmacy Records: Prescriptions

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

Pharmacy Records: Clinical trials

TYPE OF HEALTH RECORD	*MINIMUM RETENTION PERIOD*	*NOTE*

Destruction records	2 years after end of trail
Dispensing records	2 years
Production batch	5 years after end of trial

records		
Protocols	2 years	

Pharmacy Records: Worksheets

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

Pharmacy Records: Quality Assurance

TYPE OF HEALTH RECORD	MINIMUM RETENTION PERIOD	NOTE
Analysis certificates	5 years or 1 year after expiry date of batch (whichever is longer)	
Environmental monitoring results	1 year after expiry date of products	As electronic record in perpetuity
Equipment validation	Lifetime of the equipment	
Operators validation	Duration of employment	
QC Documentation,	5 years or 1 year after expiry date of batch (whichever is longer)	

Refrigerator temperature	1 year	Refrigerator records to be retained for the life of any product

		stored therein particularly vaccines
Standard operating procedures	15 years after superseded by revised version	As electronic record in perpetuity

Pharmacy Records: Orders

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

Pharmacy Records: Controlled Drugs, Others

TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Aspectic controlled drugs worksheets (paediatric)	26 years	
Controlled drugs, Clinical trails	5 Years	
Controlled drug destruction records (pharmacy based)/destruction of patients' own CD's	7 years	
Controlled drug prescriptions (TTOs/OP)	2 years	
Controlled drug order books, ward orders and requisitions	2 years from date of last entry	
Controlled drug registers (pharmacy and ward based)	2 years from date of last entry, but best practice to keep for 7 years	

Copy of signature for CD ward order or requisition	Duration of employment	Copy of signature of each authorised signatory should be available in the pharmacy

		department
Extemporaneous controlled drugs preparation worksheets	13 years	
External controlled drug orders and delivery notes	2 years	
Pharmacy records: others		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Destruction of patients' own drugs	6 months	
Dispensing errors	1 year plus current	
Doctors/nurses signatures	Duration of contract plus one year	
Medicines information enquiry	8 years (25 years for child obstetrics and gynaecology enquiries)	
Minor clinical interventions	2 years	
Recall documentation	5 years	
Stock check list	1 year plus current	
Superseded group directions	10 years	
Superseded intravenous drug administration monographs	5 years	
(end of Pharmacy)		

Other Health Records

TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record)	Retain according to the standard minimum retention period appropriate to the patient/specialty (see Above)	
Physiotherapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see Above)	

Podiatry records	Retain according to the standard minimum retention period appropriate to the patient/specialty	

	(see Above)	
Post mortem records (see Pathology records		
Post mortem registers (where they exist in paper format)	30 years	Likely to have archival value – see footnote
Private patient records admitted under section 57 of the National Health Service (Scotland) Act 1978 or section 5 of the National Health Service (Scotland) Act 1947 (now repealed)	It would be appropriate for authorities to retain these according to the standard minimum retention period appropriate to the patient/specialty (see above)	
Psychology Records	30 years	Likely to have research/ historical value see footnote
Records/documents related to any litigation	As advised by the organisation's legal advisor. All records to be reviewed.	Likely to have research/ historical value see footnote
Records of destruction of individual health records (case notes) and other health related records contained in this retention schedule (in manual or computer format)	Permanently	Likely to have research/ historical value see footnote

Research records 1. Other than clinical trials of investigational medicinal products, health records of participants that are the source data for the research	30 years	See Footnote Review patient identifiable records every 5 years to see if they need to be retained or if heir identifiably could be reduced.
2. Research records and research databases (not patient specific)	For clinical trials of investigational medicinal products, at least 2 years after the last approval of a marketing	Likely to have research value see footnote

	application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the sponsor. It is the responsibility of the sponsor/someone on behalf of the sponsor to inform the investigator/institution as to when these documents no longer need retained. For research records other than for clinical trials of investigational medicinal products, as above.	
Scanned records relating to patient care	Retain in main records and retain for the period of time according to the standard minimum retention period appropriate to the patient/specialty (see above)	
School health records (see Children and young people)	Retain in Child Health Records	
Speech and language therapy records	Retain according to the standard minimum retention period appropriate to the patient/specialty (see above)	

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

Other Health Records		
TYPE OF HEALTH RECORD	***MINIMUM RETENTION PERIOD***	***NOTE***

Video records/voice recordings (clinician to patient) (see also Telemedicine records and Out of hours records)	6 years subject to the following exceptions: **Children and Young People –** records must be kept until the patient's 25th birthday, if the patient was 17 at the conclusion of treatment until their 26th birthday, or until 3 years after the patient's death if sooner. **Maternity –** 25 years **Mentally disordered persons –** records should be kept for 20 years after the date of last contact between patient/client/service user and any healthcare professional or 3 years after the patient's death if sooner. **Cancer patients –** records should be kept until 6 years after the conclusion of treatment, especially if	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

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

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

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

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

Joint Position on the Retention of Maternity Records

All essential maternity records should be retained. 'Essential' maternity records mean those records relating to the care of a mother and baby during pregnancy, labour and the puerperium.
Records that should be retained are those that will, or may, be necessary for further professional use. 'Professional use' means necessary to the care to be given to the woman during her reproductive life, and/or her baby, or necessary for any investigation that may ensue under the Congenital Disabilities (Civil Liabilities) Act 1976, or any other litigation related to the care of the woman and/or her baby.
Local level decision making with administrators on behalf of the health authority must include proper professional representation when agreeing policy about essential maternity records. 'Proper professional' in this context should mean a senior medical practitioner(s) concerned in the direct clinical provision of maternity and neonatal services and a senior practising midwife.
Local policy should clearly specify particular records to be retained AND include detail regarding transfer of records, and needs for the final collation of the records for storage. For example, the necessity for inclusion of community midwifery records. The policy should also determine details of the mechanisms for the return, collation and storage of those records, which are held by mothers themselves, during pregnancy and the puerperium.

List of Maternity Records to be retained

Maternity Records retained should include the following:

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

Unique ID: NHSL.
Author (s): Head of Information Governance
Category/Level/Type:
Version: 1.4 February 2018 TECHNICAL UPDATE
Status: Final
Authorised by: Information Governance Assurance Board
Date of Authorisation:
Review Date: February 2021
Date added to Intranet:
Key Words: Records Management – Retention and Destruction