

PCS Records Retention Schedule

1. Introduction

1.1 The PCS Records Retention Schedule identifies the main classifications of records and information held by the PCS Service and provides retention rules for each. The records and information are represented in terms of functions and activities.

1.2 This schedule is designed to be flexible enough to permit expansion and is independent of format or media of the records and information. It should be used by all departments within PCS to manage the information they create and receive and to inform all of who is responsible for the management of what records and information. It also details how long records and information should be retained for and how to manage their storage and disposal.

1.3 This schedule based on the Department of Health Records Management NHS Code of Practice (Part 2) and The National Archives (TNA) guidelines for Public Records and follows their Model Retention Schedules, as adopted by other NHS organisations. It is also partly based on the recommendations contained in Government guidelines, and incorporates Retention of Documents requirements set out in delivery contracts held by NHS England. The schedule was also aligned with PCS categories.

2. Retention and disposal schedules and the Freedom of Information Act

2.1 Retention and disposal schedules are a very important part of accounting for the legitimate absence of information under the Freedom of Information (FOI) Act. Demonstrating to requesters or the Information Commissioner that disposal decisions have been made and implemented following due process, will enable the PCS to defend legitimate records management activity from undue criticism under FOI.

2.2 Successful compliance with FOI legislation requires the highest standards of records management; records created in response to FOI enquiries serve as evidence of NHS England's compliance with its legal obligations. These records could be subject to an FOI enquiry, like any other information NHS England holds, and may come under external scrutiny. Such records may also form part of an evidential record in the event of a complaint to the Information Commissioner or an appeal to the First Tier Information Tribunal.

3. Definition

3.1 A retention, storage and disposal schedule is a timetable for the planned review of all records to determine their ultimate fate, which is either:

- ☐ Permanent retention for records having long term value for the organisation or nationally, or
- ☐ Secure destruction of records which the organisation is not obliged to keep for legislative or business reasons

3.2 This schedule lists record types with brief descriptions and their minimum required retention period. Note that retention periods apply to both paper and electronic records. At the end of their retention period, a sample of records from a series should be reviewed before destruction to confirm that they are no longer required.

4. Record Storage

4.1 At present time there are multiple data storage solutions for paper records for NHS England PCS Services. This includes on-site storage, NHS owned storage facilities and contracted services from a variety of external organisations.

4.2 For small amount of PCS data, saving in PDF format is recommended where it is practical.

5. Record Disposal

5.1 When records identified for disposal are destroyed, a register of these records needs to be kept. This can be noted on the relevant Archive Corporate Records Inventory, held locally within Directorates/Areas.

5.2 In the case of electronic records please note that a record is not deleted if it is merely sent to the 'recycle bin'. It must also be deleted from this folder to be considered fully deleted. This is important in terms of the Freedom of Information Act 2000, where the Information Commissioner has produced Retention and Destruction of Requested Information Guidance specifically stating when a record can be regarded as being fully deleted and, therefore, not eligible to be disclosed under the Act.

6. Record Destruction

6.1 The destruction of records is an irreversible act and must be clearly documented. All records identified for disposal will be destroyed under confidential conditions and in accordance with the PCS Records Retention Schedule.

7. Retaining records or information beyond the retention period

7.1 In the majority of cases records will be disposed of when they reach their retention period. However, when assessing whether records or information is required to be retained for a longer period than that identified within the PCS Records Retention Schedule, consideration should be given to the holding of information for longer than necessary which incurs extra storage costs and leaves the organisation vulnerable to risks of theft, misuse, disclosure, legal discovery, and non-compliance fines.

7.2 Examples of when information may be required to be held for longer periods are where:

- ☐ The information is subject to a request for information under access to information legislation, such as a Subject Access Request under the Data Protection Act.
- ☐ NHS England is subject to on-going legal action.
- ☐ The information is subject to an investigation e.g. criminal investigation
- ☐ There is greater public interest in an issue requiring permanent preservation e.g. records pertaining to the establishment of NHS England.
- ☐ Changes are made to the regulatory or legislative framework.

7.3 If records do need to be kept for a longer period of time, the record retention schedule will need to be amended accordingly and a further review date set.

8. Records for permanent preservation

8.1 Records for permanent preservation, e.g. investigatory decisions, inquiry reports, significant records concerning government issues should be appraised and possibly transfer

to The National Archives for continuing retention and storage or National Archives approved Places of Deposit.

9. Associated documentation

9.1 Further Records Management Guidance and information can be found in the Records Management Policy and associated guidance found on NHS England's intranet.

10. Legislation and statutory codes used by TNA in recommending retention periods

10.1 Legislation:

- ☐ Public Records Act 1958
 - ☐ Local Government Act 1972
 - ☐ Local Government Act 1974
 - ☐ Limitation Act 1980
 - ☐ Local Government (Access to Information) Act 1985
 - ☐ Access to Health Records Act 1990
 - ☐ Local Government (Wales) Act 1994
 - ☐ Data Protection Act 1998
 - ☐ Freedom of Information Act 2000 (specifically Section 46 Code of Practice on Records Management)
 - ☐ Health and Social Care Act 2001
- Records Management NHS Code of Practice Part 2 (specifically the retention schedules at Annex D1 and D2)

10.2 Statutory codes:

Link to the Lord Chancellor's Code of Practice on Records Management (made under Section 46 of the Freedom of Information Act 2000)

Abbreviations used in this schedule:

DH RM Code of Practice Part 2 = Department of Health Records Management NHS Code of Practice Part 2 Annex D2: Business and Corporate (Non-Health) Records Retention Schedule.

Contacts For further information or advice on Records Management, please contact the corporate IG team on england.ig-corporate@nhs.net

How to use the PCS Records Retention Schedule

1. Use the 'Category', 'Type, and 'Description' columns to **identify the records you wish to retain**, whether paper or electronic.
2. Use the 'Minimum Retention Period' column to **establish the minimum retention period**. Calculate using the current financial year + minimum retention period. E.g. records created in May 2011 with a retention period of 6 years should be reviewed on 31st March 2018.
3. **At the end of the appropriate minimum retention period, the record series should be reviewed by a PCS Officer**, with knowledge of the subject area, to establish whether the records are required for further retention (e.g. where they are subject of a legal challenge or an information request), need to be archived, or destroyed under confidential conditions.
4. **Records retained for a further retention period** should be reviewed again at the end of the further retention period by a senior manager with knowledge of the subject area to establish whether the records are required for further retention (e.g. where they are subject of a legal challenge or an information request), need to be archived, or destroyed under confidential conditions.
5. Records deemed for **archival preservation** should be transferred to an NHS England's place of deposit. The Records Management Team will assist in this process.
6. Records not selected for archival preservation and which have no further business or legal requirement or historical value should be **destroyed under confidential conditions**, as appropriate.

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PCS Records Retention Schedule

Type of Record	Minimum Retention Period	Derivation	Final Action
A) Health Records			
A1 Pre-adoption records	Records, where the NHS number has been changed following adoption, should be retained securely and confidentially for the same period of time as all records for children and young people. Genetic information should be transferred across to the post-adoption record. 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 for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period. PCS will need to issue guidance to the GP practices as part of the adoption administrative process, instructing them to transfer any genetic information. This process is straightforward when the adoption takes place within the same NHAIS system; however, if the transfer was from one system to another system or site, then this would be impossible to do as the originating / sending site will not know where the patient has moved to. Strict guidance on this needs to be given.	This is local decision, and would be made by the GP / clinician.	Destroy under confidential conditions
A2 Cervical records (Cytology Records – variety held – see list in next column)	<i>Cervical Screening Records</i> 10 years • Network Lists (AJ-CINCD) – 3 months	NHS Code of Practice, Pg 12	Destroy under confidential conditions

	• CD (CYT DECUDED PRINT) – 1 month and current • RP (DIST LT) – 3 months • RG (PN S LT) – 3 months • CL (CALL LT) - 1 month • CYIC (INTEGRITY CHECKER) – 6 months • CP (RSPR SM/LAB RLT) – 3 months • CIN (TRANSFERS IN ACCEPTED) 3 Months • DF Prints (O/AREA ACCEPTANCES) - 3 Months • DFPR (DEDUCTED PATIENT FOLLOW-UP) - 3 Months • PHCN (PH NETWORK EXCEPTIONS)-FAILED - 6 Months • CGPL (ELECTRONIC EXCEPTIONS) - 3 Months • Correspondence - 2 Years • Colposcopy Discharge Letters - 12 Months • Ceased (From Women/GP) - Indefinitely • Delay (From Women/GP) - 3 Months • Lab link reports - 3 Months • O/Area Copies - 3 Months • Change of DOB (DND Folder) - Indefinitely		
A3 GP records, including those serving a period of imprisonment, including Temporary Resident's Forms (GMS 3/99), including referral letters for patients who are treated by the	GP Records, wherever they are held, other than the records listed below retain for 10 years after death or after the patient has permanently left the country unless the patient remains in the European Union. In the case of a child if the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period.	PCS Business Case Decision Limitation Act 1980, Congenital Disabilities (Civil Liability) Act 1976, Consumer Protection Act 1987 Royal College of Psychiatrists	Destroy under confidential conditions

organisation to which they were referred, referral letters for clients referred to health or care services but not accepted, referral letters where the results are sent back to GPs and referral letters where the appointment was cancelled by the patient before the referral letter was included in the patient record i.e. before the clinic preparation process)	Note 1: If the relevant GP office advises to retain the information for longer, PCS will do so. Note 2: Maternity records should be held for 25 years after the live birth, but these records will be held by the hospital or relevant care provider at the birth. PCS have taken the decision to follow the retention period above (i.e. 10 years after death), following a risk assessment. Note 3: Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983 should be retained for 20 years after the date of the last contact; or 10 years after patient's death if sooner 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. PCS have taken the decision to follow the retention period above (i.e. 10 years after death), following a risk assessment. Note 4: Records that relate to patients whose whereabouts is unknown (e.g. they may have left the country and it cannot be ascertained if they are in EU or non EU countries, they may be missing persons, they may have been deregistered by a practice and haven't re-registered yet). These records should be retained for 10 years after last contact.		Destroy under confidential conditions Destroy under confidential conditions Destroy under confidential conditions. Destroy under confidential conditions.
A4 GP records – pre enlistment records for Armed Forces /	Retain until the patient returns and re-registers.	PCS Business Case Decision	Destroy under confidential conditions.

Diplomats working abroad / families of Diplomats working abroad			
A5 Patient Assignment Cases	2 years after the date of assignment.	NHS Code of Practice	Destroy under confidential conditions.
A6 Applications for Access to Clinical Records under the Data Protection Act 1998 or the Access to Health Records Act 1990 (Subject Access Requests)	6 years after the application for information is completed.	Access to Health Records Act 1990 Data Protection Act 1998	Destroy under confidential conditions.
A7 Requests for patient removals (via GPs or via patients themselves)	2 years after the request for removal has been completed.	PCS Business Case Decision	Destroy under confidential conditions.
B) Business and Corporate (Non-Health) Records			
B1 Contractor Applications (Doctors, Dentists, Opticians and Pharmacists)	6 years after end of contract for approvals 6 years for non-approvals.	PCS Business Case Decision	Destroy under confidential conditions
B2 Contractor Records (eg. Ophthalmic Opticians, Ophthalmic Medical Practitioners,	7 years	NHS(General Ophthalmic Services) Regs 1986: A contractor shall keep a proper record in respect of each patient to whom he	Destroy under confidential conditions

Pharmacists, Pharmacy Premises, General Optical Council amendments to the register, Previous Pharmacy rotas and supporting information, copies of previous Pharmacy and Ophthalmic local lists, correspondence relating to pharmacies supplying oxygen and visiting		provides general ophthalmic services, giving appropriate details of sight testing. Subject to paragraph 8(5) a contractor shall retain all such records for a period of seven years, and shall during that period produce them when required to do so by a Primary Care Trust or the Secretary of State. Follow link below for more detail http://www.dh.gov.uk/assetsRooT/04/10/12/42/04101242.pdf	
B3 Expense claims, including travel and subsistence claims and claims and authorisations	5 years after end of financial year to which they relate	PCS Business Case Decision	Destroy under confidential conditions
B4 Invoices	6 years after end of financial year to which they relate	Limitation Act 1980	Destroy under confidential conditions
B5 Payments	6 years after year end	PCS Business Case Decision	Destroy under confidential conditions
B6 Pension forms (all)	7 years	HMRC Technical Pension Notes for registered pension schemes under regulation 18	Destroy under confidential conditions

		of SI2006/567 – 'RPSM12300020 – Scheme Administrator Information Requirements and Administration for General Retention of Records'	
B7 Personnel/human resources records – major (eg personal files, letters of appointment, contracts, references and related correspondence, registration authority forms, training records, RA smartcard forms, equal opportunity monitoring forms (if retained)) NB Includes locum doctors	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th birthday. Summary to be retained until individual's 70th birthday or until 6 years after cessation of employment if aged over 70 years at the time. The summary should contain everything except attendance books, annual leave records, duty rosters, clock cards, timesheets, study leave applications, training plans	The 6 year retention period is to take into account any ET claims, or EL claims that may arise after the employee leaves NHS employment, requests for information from the NHS pensions agency etc. Claims of this nature can include periods of up to 6 years or more prior to the claim and where evidence could be needed from a number of sources, it is appropriate to retain as much as possible from the original file.	See Final Action Note 1
B8 Personnel/human resources records – minor (eg attendance books, annual leave records, duty rosters (i.e. duty rosters held on the individual's record not the organisation or departmental rosters), clock cards,	2 years after the year to which they relate	PCS Business Case Decision	Destroy under confidential conditions

timesheets (relating to individual staff members)) NB Includes locum doctors			
B9 Software licences	Lifetime of software	PCS Business Case Decision	Destroy under confidential conditions
B10 Statistics (including Korner returns, contract minimum data set, statistical returns to DH, patient activity)	3 years from date of submission	PCS Business Case Decision	Destroy