CAPE HILL MEDICAL CENTRE

Records Retention Policy

Implemented: 01.04.2018
Review date: 31.05.2021

Type of record	Retention length	Disposal action	Notes
Adult care records	8 years	Review & destroy	Review must take place to check relevance of maintaining document
Children care records	25th or 26th birthday	Review & destroy	Review must take place to check relevance of maintaining document including medical illustrations such as X-rays and scans. If 17 at the conclusion of treatment, then retain record until 26th birthday.
Electronic patient records	See notes	See notes	Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain, demonstrating that a record has been destroyed, then the code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.
GP Patient records	10 years after death - see notes for exceptions	Review & destroy if no longer needed.	If a patient transfers to another GP, transfer records to new healthcare providers. If not transferring: Should a patient not return to the practice and the records are not transferred, the records are to be retained for 100 years unless it is known they have emigrated. If the patient comes back within the 100 years, the retention reverts to 10 years after death - unless it is known they have emigrated; if so, follow steps below.
Patient known to have emigrated	10 years	Review & destroy	Review must take place to check relevance of maintaining document
Mental health records	20 years or 8 years after the patient has died	Review & destroy	Covers records made where the person has been cared for under the Mental Health Act 1983 as amended by the Mental Health Act 2007. This includes psychology records. Retention solely for any persons who have been sectioned under the Mental Health Act 1983 must be considerably longer than 20 years where the case may be ongoing. Very mild forms of adult mental health treated in a community setting where a full recovery is made - may consider treating as an adult record and keep for 8 years after discharge. All must be reviewed prior to destruction, taking into account any serious incident retentions.
Obstetric records, maternity records and antenatal and post-natal records	25 years	Review & destroy	For the purposes of record-keeping, these records are to be considered as much a record of the child as that of the mother.
Cancer/oncology - the oncology records of any patient	30 years or 8 years after the patient has died	Review and consider transfer to a place of deposit	For the purposes of clinical care, the diagnosis records of any cancer must be retained in case of future reoccurrence. Where the oncology records are in a main patient file, the entire file must be retained. Retention is applicable to primary acute patient record of the cancer diagnosis and treatment only. If this is part of a wider patient record then the entire record may be retained. Any oncology records must be reviewed prior to destruction, taking into account any potential long-term research value which may require consent or anonymisation of the record.
Contraception, sexual health, family planning and Genito-Urinary Medicine (GUM)	8 or 10 years	Review & destroy	Basic retention requirement is 8 years unless there is an implant or device inserted, in which case it is 10 years. All must be reviewed prior to destruction, taking into account any serious incident retentions. If this is a record of a child, treat as a child record as above.
HFEA records of treatment provided in licensed treatment centres	3, 10, 30 or 50 years	Review & destroy	Retention periods are set out in the HFEA guidance at: http://www.hfea.gov.uk/docs/General_directions_0012.pdf
Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)	30 Years or 8 Years after the patient has died	Review and consider transfer to a place of deposit	For the purposes of clinical care, the diagnosis records of CJD must be retained. Where the CJD records are in a main patient file, the entire file must be retained. All must be reviewed prior to destruction, taking into account any serious incident retentions.
Record of long-term illness or an illness that may reoccur	30 years or 8 years after the patient has died	Review & destroy	Necessary for continuity of clinical care.The primary record of the illness and course of treatment must be kept of a patient where the illness may reoccur or is a life-long illness.
GP temporary resident forms	2 years	Review & destroy	Assumes a copy has been sent to responsible GP for inclusion in the primary care record.
Screening, including cervical screening, information where no cancer/illness is detected	10 years	Review & destroy	Where cancer is detected see: 2 Cancer/oncology. For child-screening, treat as a child health record and retain until 25th birthday or 10 years after the child has been screened, whichever is the longer.
Smoking cessation	2 years	Review & destroy	
Transplantation records	30 years	Review and consider transfer to a place of deposit	See guidance at: https://www.hta.gov.uk/codes-practice
Birth notification to child health	25 years	Review & destroy	Treat as a part of the child's health record if not already stored within health record such as the health visiting record.
Birth registers	2 years	Review and consider transfer to a place of deposit	Where registers of all the births that have taken place in a particular hospital/birth centre exist, these will have archival value and should be retained for 25 years and offered to a place of deposit at the end of this retention period. Information is also held in the NHS Number for Babies (NN4B) electronic system and by the Office for National Statistics. Other information about a birth must be recorded in the care record.
Body release forms	2 years	Review and consider transfer to a place of deposit	
Death - cause of death certificate counterfoil	2 years	Review and consider transfer to a place of deposit	
Death register information sent to General Registry Office on monthly basis	2 years	Review and consider transfer to a place of deposit	A full dataset is available from the Office for National Statistics.
Local authority adoption record (normally held by the local authority children's services)	100 years from the date of the adoption order	Review and consider transfer to a place of deposit	The primary record of the adoption process is held by the local authority children's service responsible for the adoption service
Mortuary records of deceased	10 years	Review and consider transfer to a place of deposit	
Mortuary register	10 years	Review and consider transfer to a place of deposit	
NHS medicals for adoption records	8 years or 25th birthday	Review and consider transfer to a place of deposit	The health reports will feed into the primary record held by local authority children’s services. This means that the adoption records held in the NHS relate to reports that are already kept in another file which is kept for 100 years by the appropriate agency and local authority.
Post-mortem records	10 years	Review and consider transfer to a place of deposit	The primary post-mortem file will be maintained by the coroner. The coroner will retain the post-mortem file including the report. Local records of post-mortem will not need to be kept for the same extended time.