Department of
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Records Management

Good Management Good Records

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Section 1 Foreword

Foreword

Good Management Good Records (GMGR) has been published by the Department of Health Social Services and Public Safety (DHSSPS) as a guide to the required standards of practice in the management of records for the DHSSPS, those who work within or under contract to Health and Social Care (HSC) and Public Safety i.e.:

- DHSSPS
- HSC Board;
- Public Health Agency (PHA);
- Business Services Organisation (BSO);
- HSC Trusts;
- Patient and Client Council (PCC);
- Regulation and Quality Improvement Authority (RQIA);
- Guardian AD Litem Agency;
- Blood Transfusion Service;
- Northern Ireland Fire and Rescue Service;
- Northern Ireland Social Care Council (NISCC);
- Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC);
- Northern Ireland Medical and Dental Training Agency (NIMDTA);
- Independent Contractors (e.g. general practitioners (GPs), dentists, orthodontists, optometrists and community pharmacists); and
- Early Years Services; Establishments and Agencies where public funds are involved.

For the purposes of this document those mentioned above will be referred to as (Organisation/Organisations).

It is based on professional best practice and reflects the current legal requirements. It is not an authoritative statement of the law, neither does it explain nor replace the law and in cases of doubt Organisations should take legal advice. Where legal proceedings have commenced records should be retained and specific legal advice sought.

It was drafted by a working group made up of representatives from the DHSSPS, the Department of Finance and Personnel (DFP), the Public Record Office of Northern Ireland (PRONI) the HSC Regional Records Management Working Group and Public Safety.

GMGR provides a key component of information governance arrangements for the DHSSPS, HSC and Public Safety. As standards and practice will change over time, especially with the evolving growth of technology, GMGR will be reviewed and updated as necessary.

Types of Records covered by GMGR

The guidelines contained in GMGR apply to the DHSSPS, HSC and Public Safety records of all types (including records of HSC patients treated on behalf of the HSC in the private healthcare sector, or receiving social care services contracted for (procured by) HSC bodies).

These may consist of:

- patient health records (electronic or paper based, including those concerning all specialties, and GP medical records);
- client social care records (electronic or paper based);
- records of private patients seen on HSC premises;[1.]
- accident & emergency, birth, and all other registers;
- theatre registers and minor operations (and other related) registers;
- X-ray and imaging reports, output and images;
- administrative records (including, for example, agendas and minutes of meetings, personnel, estates, financial and accounting records, notes associated with complaint-handling);
- records specified in regulations
- audit and accountability records
- information, technology and communication records and
- governance and policy records.

[1.] Although technically exempt from the Public Records Act (Northern Ireland) 1923 it would be appropriate for HSC organisations to treat such records as if they were not so exempt.

Media of Records covered by GMGR

The guidelines contained in GMGR apply to all DHSSPS, HSC and Public Safety records regardless of the media on which they are held. Examples of such media are:-

- photographs, slides, and other images;
- microform (i.e. microfiche/microfilm);
- audio and video tapes, cassettes, CD-ROM etc;
- e-mails;
- computerised records;
- scanned records; and
- text messages (both outgoing and incoming responses).

Section 2 Introduction

Introduction

GMGR replaces:

- Good Management, Good Records (issued in December 2004) and
- Circular HSS (PCCD) 1/2000 – *Preservation, Retention and Destruction of GP Medical Records*
- Circular HSS(F) 14/03 - Preservation and Destruction of Financial and Associated Records

This guidance provides a framework for consistent and effective records management and is based on advice and publications from the Ministry of Justice[2] PRONI, and also from best practice followed by a wide range of organisations in both the public and private sectors.

The aims of GMGR are to:

- establish a framework for records management in relation to the creation, use, storage, management and disposal (destruction or archiving) of all types of DHSSPS, HSC and Public Safety records;
- clarify the legal obligations in relation to records management and information access;
- explain the actions required by Chief Executives and other managers to fulfil these obligations;
- explain the requirement to select records for permanent preservation as directed by PRONI;
- set out recommended minimum periods for retention of all types of DHSSPS, HSC and Public Safety records, regardless of the media on which they are held; and
- indicate where further information on records management may be found.

[2] The Ministry of Justice assumed responsibility for the Department for Constitutional Affairs (formerly the Lord Chancellor's Office) on 09/05/2007. Publications for the Department for Constitutional Affairs are available at http://www.direct.gov.uk/en/Dl1/Directories/DG_10012316

General Context

All DHSSPS, HSC and Public Safety records are public records under the terms of the Public Records Act (Northern Ireland) 1923 (PRA 1923). The PRA 1923 established PRONI as the place of deposit for public records, created the roles of Keeper and Deputy Keeper of the records as well as defining NI public records. The PRA 1923 sets out the broad responsibilities for everyone who works with such records. Organisations have a statutory duty to make arrangements for the safe keeping and eventual disposal of their records. PRONI can assist and provide advice on how to manage all types of records.

The PRA 1923 made PRONI responsible for the records of any Court, Government Department, Authority or Office in Northern Ireland over which the Parliament of Northern Ireland (NI) has the power to legislate. It is therefore a statutory requirement for the HSC and Public Safety to implement records management as set out in the PRA 1923 and in the Disposal of Documents (NI) Order (1925). PRONI has an overarching responsibility within the public sector in NI to ensure that records are managed in accordance with agreed policies and procedures. In particular:

- PRONI is concerned with identifying any deficiencies in the way records are organised and maintained and in records management procedures as a whole.
- PRONI must be involved in:
    - updating and quality assurance of all Disposal Schedules;
    - the sampling of Particular Instance Papers (case files);
    - ensuring the proper use of microfilm and other non-paper based storage media e.g. records held electronically;
- the assessment of records for historical/research purposes;
- the storage of records identified for permanent preservation and which are no longer required by Organisations for administrative/business purposes.

The Permanent Secretary, Departmental Information Manager, Chief Executives and senior managers are personally accountable for records management within their Organisation and have a duty to make arrangements for the safe keeping and eventual disposal of those records under the overall supervision of the Deputy Keeper of Public Records at PRONI. Organisations are also required to take positive ownership of, and responsibility for, the records legacy of predecessor Organisations and/or obsolete services.

Robust records management procedures are required to meet the requirements set out under the Data Protection Act 1998 (DPA 1998), the Freedom of Information Act 2000 (FOI Act 2000) and the Environmental Information Regulations 2004 (EIR 2004).

Records are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence-based health and social care, and many other key service deliverables. Information has most value when it is accurate, up to date and accessible when it is needed. An effective records management system ensures that

information is properly managed and is available whenever and wherever there is a justified need for that information to:

- support patient / client care and continuity of care;
- support service provision;
- support day-to-day business which underpins the delivery of care;
- support evidence-based clinical practice;
- support sound administrative and managerial decision making, as part of the knowledge base for DHSSPS, HSC and Public Safety services;
- meet legal requirements, including requests from the public under subject access provisions of the DPA 1998, FOI Act 2000 or EIR 2004;
- assist clinical/professional and other types of audits;
- support improvements in clinical/professional and service effectiveness through research and also to support archival functions by taking account of the historical importance of material and the needs of future research; or
- support choice and control of patients and clients over treatment and services.

The increasing shift towards electronic records will transform the way health and social care information is managed. In the mixed economy of paper and electronic records it is essential that they are managed consistently to ensure that a complete record is available at the point of need.

GMGR identifies the specific actions, managerial responsibilities and minimum retention periods for the effective management of all types of DHSSPS, HSC (i.e. both corporate and individual health and social care records) and Public Safety records, regardless of whether they are paper or electronic, from creation to disposal.

Monitoring Records Management Performance

A number of bodies have oversight of DHSSPS, HSC and Public Safety performance in respect of records management. The Regulation and Quality Improvement Authority monitors a core governance standard relating to broad records management as part of its annual assessment of performance. The Audit Commission regularly conducts studies into records management and related data quality issues. The DHSSPS collects performance details as part of the annual Controls Assurance Standards.

Other bodies likely to comment on records management performance include the Northern Ireland Ombudsman when investigating a complaint, and the Information Commissioner when investigating alleged breaches of the DPA 1998 or the FOI Act 2000 or in promoting the Lord Chancellor's Code of Practice on Records Management under section 46 of the FOI Act 2000 and PRONI.

Legal and Professional Obligations

All individuals who work for an Organisation are responsible for any records which they create or use in the performance of their duties. Such records are public records and may be subject to both legal and professional requirements. A description of these obligations can be found in Annex C.

A key statutory requirement for compliance with records management in relation to records containing personal data lie within the principles of the DPA 1998. The DPA 1998 regulates the processing of all personal data, held both manually and on computer.

Personal data is defined as data relating to a living individual that enables him/her to be identified either from that data alone or from that data in conjunction with other information in the data controller's possession. It therefore includes such items of information as an individual's name, address, age, race, religion, gender and physical, mental or sexual health.

A Data Controller is defined as "a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or to be processed". Any organisation which acts as a data controller has responsibility in law for compliance with the DPA.

Data Controllers should be aware of the statutory requirements imposed upon them when engaging a data processor to process data on their behalf. At all times the responsibility for personal data remains with the data controller and any contract between a data controller and data processor should reflect this. 'In particular, it will be the responsibility of the data controller to ensure any data retention periods are clearly communicated to the data processor. Data Access Agreements should be drawn up between the Data Controller and the Data Processor, which will assist the data controller in setting out the guidelines for retention and disposal of the information. This will help the Data Controller to ensure retention and disposal actions are taken by the data processor'.

Processing includes everything done with that information, i.e., obtaining, recording, holding using, disclosing and sharing it. Using includes disposal, i.e. closure of the record, transfer to an archive or destruction of the record. More information on the application of the DPA is contained in Annex C.

Section 7 of the Data Protection Act 1998 gives individuals the right to request a copy of their personal data via a Subject Access Request. The Data Protection Act 1998 states that data subjects have the right to have access to any personal data that is held on them. As the data subjects in this instance will include vulnerable individuals and people with mental health disabilities, greater consideration needs to be given to ensuring that subject access provisions are effective and accessible. This can be achieved by ensuring that data subjects have access to all of the information and assistance that they may require in order to exercise their rights of access, and that all information provided is clear and understandable to its intended audience. A system of flagging records which may contain information that could be exempted from release under a subject access request should be considered.

Other legislation relating to personal and corporate information and the records management function generally can be found in Annex C. Additionally, health and social care professionals have a duty to comply with the Common Law Duty of Confidentiality and meet records management standards relating to patient and client care records set by their regulatory bodies.

Consent

The complexity of the delivery of health and social care and the increasing emphasis on team working and multidisciplinary management requires easy and appropriate access to patient/client information. The confidentiality of information about patients/clients is protected by law and professional values and practice. The Data Protection Act allows for the lawful sharing of patient/client identifiable information. The law and related professional guidelines make clear that informed consent is of paramount importance. The implementation of the law has to take account of the complexities of modern health care and research and the conflicts that arise over access to information about patients/clients.

Organisations must ensure that DPA 'fair processing' obligations are met in relation to any request for consent. This means that each organisation must provide patients/clients with sufficient information to make them aware of:

- the uses and disclosures of their information associated with their care;
- the identity of who will be holding their information (the data controller and any representatives);
- the choices they have (except where collection and disclosure is mandatory);
- the implications of choosing to limit how their information may be used or shared.

Should a patient choose to refuse or limit the use of his / her information, the implications of such limitation or refusal must be clearly explained and the discussion clearly recorded in his / her record.

If information sharing is to operate by consent then there will also be issues surrounding an individual's capacity for providing that consent, particularly if the individual is an older person or has any form of degenerative mental illness or disability.

Security

With regard to the security of personal and sensitive personal data, the seventh data protection principle requires that:

(a) 'Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data'.

The Act further states that "Having regard to the state of technological development and the cost of implementing any measures, the measures must ensure a level of security appropriate to the harm that might result from such unauthorised or unlawful processing or accidental loss, destruction or damage as are mentioned in the seventh principle, and

(b) the nature of the data to be protected."

Organisations should be aware of the potential risk to personal data that they hold and ensure that:

- Measures taken are appropriate in proportion to the detriment that could be caused to the data subjects and the nature of the information involved if their personal data were to be compromised;
- All staff and particularly those who have responsibility for the management and retention of information are trained on all relevant aspects of Data Protection to ensure that their information management is well targeted and effective.

This will help with the early identification and classification of personal data for retention or destruction.

Section 3 Records Management

What is a record?

A record is information that has been received, created or maintained by an individual or an Organisation as evidence of a business activity, patient/client care, treatment given, treatment planned and can be in any format – paper, electronic, digital and/or voice.

In the context of GMGR a record is anything which contains information (in any media) which has been created or gathered as a result of *any* aspect of the work of employees or those providing a service– including consultants, General Practitioners, Dentists , Opticians, Pharmacists, agency, or casual staff and all contracted services.

DHSSPS, HSC and Public Safety records are public records as defined in the PRA 1923.

Why do you need to keep records

Records enable Organisations to:

- conduct business in an orderly, efficient and accountable manner;
- deliver care and services in a consistent and equitable manner;
- support and document policy formation and managerial decision-making;
- provide consistency, continuity and productivity in management and administration;
- facilitate the effective performance of activities throughout the DHSSPS, HSC and Public Safety;
- provide continuity in the provision of services, care, or treatment;
- provide continuity in the event of a disaster;
- meet legislative and regulatory requirements including archival, audit and oversight activities;
- provide protection and support in litigation including the management of risks associated with the existence of or lack of evidence of DHSSPS, HSC and public safety activity;
- protect the interests of the DHSSPS, HSC, Public Safety and the rights of employees, patients, clients, and present and future stakeholders;
- support and document current and future research, and document activities, developments and achievements, as well as historical research;
- establish and provide evidence of business, personal and cultural identity; and
- maintain the corporate, personal or collective memory.

What is Records Management

Records management is:

- the systematic and consistent control of all records, regardless of the media on which they are held, throughout their lifecycle. It includes setting up the infrastructure or system into which the records are created, received or added as well as the process of record creation itself.
- organising the records so that related records are grouped together, usually according to a file plan or classification scheme. (Managing groups of related records is more efficient than managing many individual records.)
- the retention and disposal actions such as destruction or transfer to PRONI at the appropriate time and procedures for documenting those actions.

Organisations must know what records they have in order to manage them. Control of the records depends on a range of carefully developed procedures applied to them before their creation through to their disposal.

There are five vital elements of records management:

- meeting business and patient/client needs;
- public records legislation;
- managing records as a valuable and expensive asset;
- accountability for practice and service provision; and
- accountability and quality of information and services.

Management and Organisational Responsibility

Records Management

Organisations should have in place organisational arrangements that support records management. The records management function should be recognised as a specific corporate responsibility within every Organisation. It should provide a managerial focus for records of all types in all formats, including electronic records, throughout their life cycle, from planning and creation through to disposal. It should have clearly defined responsibilities and objectives, and adequate resources to achieve them and should include records managed on behalf of the authority by an external body such as a contractor.

Records and information management should be included in the corporate risk management framework. Information and records are a corporate asset, the loss of which could cause disruption to the business of the Organisation. The level of risk will vary according to the strategic and operational value of the asset to the Organisation and risk management should reflect the probable extent of disruption and resulting damage.

Organisations should have a governance framework that includes defined roles and lines of responsibility. This should include allocation of lead responsibility for the records and information management function to a designated member of staff at sufficiently senior level to act as a records management champion, for example a board member, and allocation of operational responsibility to a member of staff with the necessary knowledge and skills. In smaller organisations it may be more practicable to combine these roles. Ideally the same people will be responsible also for compliance with other information legislation, for example the Data Protection Act 1998 and the Re-use of Public Sector Information Regulations 2005, or will work closely with those people. These roles should be formally acknowledged and made widely known throughout the Organisation.

The organisation should have in place clear instructions covering the creation, maintenance and management of records which apply to staff at all levels of the Organisation. In larger organisations the responsibilities of managers, and in particular heads of business units, could be differentiated from the responsibilities of other staff by making it clear that managers are responsible for ensuring that adequate records are kept of the activities for which they are accountable;

Organisations should identify information and business systems that hold records and provide the resources needed to maintain and protect the integrity of those systems and the information they contain.

Organisations must consider records management issues when planning or implementing ICT systems, when extending staff access to new technologies and during re-structuring or major changes to the Organisation.

All staff must be appropriately trained so that they can carry out their designated duties and responsibilities. Induction and other training should ensure that all staff are aware of the authority's records management policies, standards, procedures and guidelines and understand their personal responsibilities. This should be extended to temporary staff, contractors and

consultants who are undertaking work that it has been decided should be documented in the authority's records. This should include training for staff in the use of electronic records systems. Training should be provided through both generic and specific training programmes, complemented by organisational policies and procedures and guidance.

If the Organisation is large enough to employ staff whose work is primarily about records and information management, they should be given opportunities for professional development.

Senior Information Risk Owner

The Senior Information Risk Owner (SIRO) is an Executive Director or Senior Management Board Member who will take overall ownership of the Organisation's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Statement of Internal Control in regard to information risk.

The SIRO must understand how the strategic business goals of the Organisation and how other organisations' business goals may be impacted by information risks, and how those risks may be managed. The SIRO implements and leads the Information Governance (IG) risk assessment and management processes within the Organisation and advises the Board on the effectiveness of information risk management across the Organisation.

Information Asset Owner

Information Asset Owners (IAO) are senior individuals involved in running the relevant business. Their role is to understand what information is held, what is added and what is removed, how information is moved, and who has access and why. As a result they are able to understand and address risks to the information, and ensure that information is fully used within the law for the public good, and provide written input to the SIRO on the security and use of their asset.

Organisations need to be able to demonstrate progress in:

- enabling staff to conform to the records management standards;
- identifying resource requirements; and
- areas where organisational or systems changes are required.

Information Governance Performance Assessment and management arrangements facilitate and drive forward the necessary changes. Those responsible for monitoring HSC performance play a key role in ensuring that effective systems are in place.

Individual Responsibility

The PRA 1923 makes all employees responsible for any records that they create or use in the course of their duties. Staff are responsible for maintaining their records in accordance with their Organisation's Records Management Policy. In particular

1. following the procedures endorsed by senior management; and
2. only destroying records in accordance with the Organisation's Disposal Schedule and procedures.

Records Management Policy

Each Organisation should have in place a Records Management Policy defining how it manages all of its records, including electronic records. The policy should be endorsed by the Organisation's Board and made available to all staff at all levels of the Organisation, both on induction and at regular training.

The policy should provide a mandate for the performance of all records and information management functions. In particular, it should set out an Organisation's commitment to create, maintain and manage records and document its principal activities in this respect.

The policy should also:

- outline the role of records management within the Organisation, and its relationship to the Organisation's overall strategy;
- define roles and responsibilities within the Organisation, including the responsibility of individuals to document their actions and decisions in the Organisation's records, and to dispose of records appropriately when they are no longer required;
- provide a framework for supporting standards, procedures and guidelines; and
- indicate the way in which compliance with the policy and its supporting standards, procedures and guidelines will be monitored and maintained.

The policy should be reviewed at least once every two years and if appropriate amended to maintain its currency and relevance.

Information Quality Assurance

It is important that all Organisations train staff appropriately and provide regular update training. In the context of records management and information quality, Organisations need to ensure that their staff are fully trained in record creation, use and maintenance, including having an understanding of:

- what they are recording and how it should be recorded;
- why they are recording it;
- the need to differentiate fact from opinion and how to represent information supporting the opinion;
- how to validate information with the patient, client or carers or against other records – to ensure that staff are recording the correct data;
- how to identify and correct errors – so that staff know how to correct errors and how to report errors if they find them;
- the use of information – so staff understand what the records are used for (and why timeliness, accuracy and completeness of recording is so important); and
- how to update information and add information from other sources.

Section 4 Records Management Processes

Records Management Processes

Implementing and maintaining effective records management depends on the knowledge of what records are held, where they are stored, who manages them, in what format(s) they are made accessible, and their relationship to organisational functions (for example finance, estates, IT, healthcare or social care provision). An information survey or record audit is essential to meeting this requirement. This survey will also help to enhance control over the records, and provide valuable data for developing review and disposal policies and procedures.

There should also be audits of the content of clinical records. The Royal College of Physicians health informatics unit developed an audit tool to support the implementation of the generic medical record-keeping standards and it is available at

http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/audit-tool-generic-standards

Record Creation

Regardless of the media on which the records are kept, it is the responsibility of each Organisation to ensure that all records are complete, reliable, authentic and available. In addition, Organisations must be satisfied that all records are kept in an accessible format: The records must:

- provide adequate evidence of the conduct of business to account for a financial transaction including reasons for any decision(s) necessary for that transaction to take place;
- contain verifiable evidence that all transactions were appropriately undertaken and where necessary were properly authorised;
- provide complete information to document the transactions;
- evidence the delivery of care, treatment and services;
- comply with regulatory and accountability record-keeping requirements; and
- be comprehensive and document the complete activity i.e. contain a full audit.

Organisations should have in place a process for documenting its records management activities. Professional Record Keeping Standards, April 2008 provide guidance on the content structure of hospital admission records, handover and discharge communications.

Records should accurately reflect communications, decisions and actions taken to:

- allow employees and their successors to undertake appropriate actions in the context of their responsibilities,
- facilitate an audit or examination of the Organisation by anyone so authorised;
- protect the legal and other rights of the Organisation, its patients, staff and any other people affected by its actions; and
- provide authentication of the records so that the evidence derived from them is shown to be credible and authoritative.

Records should be arranged in a record-keeping system that will enable the Organisation to ensure the quick and easy retrieval of information.

Registration of Records

Registration is a system which allocates a unique identifier (numerical and alphabetical prefix) to each record and which annotates that sequentially in a 'register' or index. It provides evidence that a record has been created or captured and facilitates retrieval.

Paper and electronic record keeping systems should contain descriptive and technical documentation to enable the system to be operated efficiently and the records held in the system to be understood. The documentation should provide an administrative context for effective management of the records.

The record keeping system, whether paper or electronic, should include a documented set of rules for classification, titling, indexing and, if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information when it is needed and to maintain security and confidentiality.

A coherent file system for all types of records provides for faster and systematic filing, faster retrieval of information, greater protection of information and increased administrative stability, continuity, efficiency and public accountability.

Systems need to provide complete and accurate information on all transactions which occur in relation to a particular record including:

- registration;
- protective markings;
- changes in description, contents etc;
- disposal;
- activity levels; and
- pattern and duration of use.

The Northern Ireland Records Management Standard (NIRMS) - Filing Systems, gives guidance on the types of paper based systems.

An effective filing system has a classification method which reflects and supports the Organisation's business functions and activities. Registration must ensure:

- the file title is unique;
- the reference identity assigned to each file is unique and must include the year of opening as an element;
- that both are relevant to and easily understood by all users;
- each element should relate to a different hierarchical level of the file title;
- the details are recorded on the file cover and the register;

- at a *minimum* the file description must identify:
    - its title
    - its unique identifier.
    - the date it was registered (opened) and
    - the date it is due to be closed and reviewed, destroyed or arrangements made to transfer to PRONI.

Accurate file titling is essential for an efficient filing system. The title of every file should:

- accurately reflect its contents;
- be as specific as possible;
- indicate both the information content and the types of documents e.g. 'Personnel Committee – agenda and minutes' rather than just Personnel Committee.

If titles are inaccurate, ambiguous or imprecise retrieval of information will be difficult. Staff time will be wasted, staff will lose confidence in the system, leading to an increase in the duplication of files and the creation of unregistered files.

A structural approach to the titling of files relating to the functional areas of the Organisation or subject matter is recommended.

Titles should be meaningful. Words like 'general' (which indicates you do not know what it should be) or 'miscellaneous' (which indicates you cannot be bothered to think about it) should not be used. All abbreviations or acronyms should be spelt out in full.

Types of Files

Case files contain different types of documents which all relate to one individual person or matter e.g.

- employee files in personnel departments;
- supplier files in a purchasing department;
- patient files in a hospital or community setting;
- client files in a day centre or community setting.

Files not directly related to a patient/client/family/carer are routine registered files sometimes known as policy files.

Organisations must agree all registered file covers with PRONI and should incorporate the boxes shown below. The file cover should always record the year the file was opened and if it has been closed it should record the year it was closed. The cover should also record the date of the first paper; the date of the last paper and where appropriate the continuation number or former file number. The date of closure will determine the date of the First and Second Review. The retention period is normally calculated from the date the file is closed. In some cases this will differ but full details are given in Part 2 of GMGR.

FOR CLOSURE ACTION ONLY		
Year of First Paper		
Year of Last Paper		
	Year	**Initials**
First Review Due		
Due Destruction Date		
Date of Transfer to PRONI		

File / File Plan Contents

The following are examples of the type of material that must be held in a Registered File or in a File Plan in an approved Electronic Document and Record Management System (EDRMS):

- the origins of the Organisation, staffing, functions and procedures;
- correspondence;
- principal policy papers;
- submissions to the Chief Executive/Directors/Permanent Secretary/Minister;
- submissions to the DHSSPS;
- material prepared for the Assembly or an Assembly Committee (including drafts);
- bids for contracts;
- financial statements and accounts;
- details of patient/client care or treatment;
- material related to the delivery of services;
- statistical records;
- draft papers issued for comment together with comments received;
- final documents together with a record of any changes, the reason for the changes and the alternatives considered;
- notable events;
- events of contemporary interest or controversy;
- papers from bodies closely linked to the DHSSPS, Public Safety and HSC,
- guides, manuals and instructions.
- papers related to scientific, technological or medical research and development;
- projects, review and evaluation reports;
- contractual information; and
- original minutes of meetings.

The following are examples of the type of material that should not be placed in a Registered File or in a File Plan in an approved EDRMS:

- copies or duplicates of any record where the definitive record is already held on a registered file or fileplan e.g. personal expense claims, copies of minutes and papers sent for information only;

- publications received for information;

In relation to paper files the “reverse book” method of filing should be used, i.e. on opening the file; the latest paper should be filed on top. Files should not start with a paper referring to another paper that is not in the file (copy from another file if necessary). A reply should always be filed on the same file (and the same part of the file) as the paper to which it is responding. Attachments or enclosures to documents should be filed immediately below the document to which they relate. Plans, drawings or other bulky items should be put inside a brown envelope, and labelled with a brief description. The brown envelope should then be tagged to the file.

Papers should not normally be removed from files. In exceptional circumstances where it is necessary to permanently transfer papers between files, a cross reference should be made on the original file. Papers that are removed temporarily (e.g. for use at a meeting) should be returned as quickly as possible and a note of their removal should be inserted.

The lifespan of a registered file or an electronic container is limited to five years (with some exceptions, e.g. personnel files/containers, patient/client case files/containers) but where possible the lifespan should be restricted to calendar or financial years.

Electronic data may take the form of email, database systems, websites and other information systems. As data is created in these various ways, it becomes evidence (a record) of the Organisation’s activities and is required for legal, administrative, financial, accountability and potentially historical/research purposes.

Other good records management practices include:

Paper

- once a file has been closed, no further papers may be added. If necessary continuation files for the same subject matter may be opened;
- all papers should be filed at the right hand side of the file in date order, when the file is opened the most recent paper is at the top. For some types of records e.g. patient files this will not always be possible
- where possible, filed papers should have a hole punched for inserting a treasury tag, 2.5cm in, and 2.5cm down in the left-hand corner of the page, minimising the risk of detachment. For some file types especially patient records, personnel records, this will not always apply.
- all papers received for filing should bear the appropriate file number in which the record is to be filed;
- paper clips and pins must be removed from papers, before filing, as these will damage the paper, and when rusted can be a health hazard. Particular attention to this must be given to those records which, according to the disposal schedule, are to be preserved permanently by PRONI;
- flags, either adhesive tables or strips of paper attached to a page with sellotape, should be avoided – paper card dividers should be used;

- file covers should provide adequate protection for papers, and should be replaced if they become torn or damaged. The original cover should be tagged inside the replacement cover for reference;
- files must not contain any loose papers;
- metal tags should be replaced by plastic ended type;
- avoid duplication of papers – only one copy of papers need be filed;
- the copying of papers onto several different files must be kept to a minimum; and
- any bulky items, publications etc, which need to be filed should be placed in a pocket or envelope to the left, inside the file cover;

Electronic

- floppy disks and CDs must not be stored on paper files. The disk is an unstable media and is easily corrupted. Moreover its supporting software could be obsolete by the time the file and contents are subject to review or preservation;
- E-records must be structured into folders with other electronic records that form part of the same narrative to ensure that all evidence of business activity is grouped together and safeguarded;
- Isolated records are of minimal value; therefore records, including emails, must be saved into a structure of folders;
- The structure of the folders must be simple and logical. It should proceed from the general to the specific; dividing a broader theme into sub-themes;
- The electronic filing structure must capture all metadata needed to identify, access and retrieve the electronic record so that it is possible to establish the context of the records, who created it, during which business process, and how the record is related to the other records;
- The folder system must use the same file titles/index terms as the paper filing system, reflecting the relevant **retention schedule**. File titles should be as short as possible and care be taken to avoid repetition;
- Folders of e-records should be closed and reviewed for retention in the same way as records held in a paper format. These folders should not be deleted from the system except in relation to retention periods specified in approved retention schedules; and
- Appropriate references linking the electronic file to the paper file must be used in order that retention criteria can be applied consistently.

Record Maintenance

The movement and location of records should be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions.

Storage accommodation for records should be clean, tidy, secure, prevent damage to the records and provide a safe working environment for staff.

For records in electronic format, maintenance in terms of back-up and planned migration to new platforms should be designed and scheduled to ensure continuing access to readable information.

All equipment used to store records should be safe, secure from unauthorised access and meet health and safety and fire regulations, but also allow maximum accessibility of the information commensurate with its frequency of use.

When paper records are no longer required for the conduct of current business, their placement in a designated secondary storage area may be a more economical and efficient way to store them. There should be archiving policies and procedures in place for both paper and electronic records which should take account of the need to preserve important information and keep it confidential and secure.

A contingency or business continuity plan should be in place to provide protection for all types of records that are vital to the continued functioning of the Organisation. Key expertise in relation to environmental hazards, assessment of risk, business continuity and other considerations is likely to rest with information security staff and their advice should be sought on these matters.

Digital Continuity

Digital continuity is the ability to use electronically created records for as long as they are needed. In some cases this may mean having to manage electronic records which need to be permanently preserved.

Organisations who choose to install electronic record creation systems should take into account the need to manage the records created for the entirety of their lifecycles.

How Organisations use, and maintain, records created within electronic systems will largely depend on the nature of the Organisation and the information itself. In some cases full functionality will be required for the records for the entirety of their lifecycles, whereas for others the ability to read the records may be enough.

Scanning

For reasons such as business efficiency or to address problems with storage space, Organisations may consider the option of scanning into electronic format records which exist in paper format. Where this is proposed, the factors to be taken into account include:

- the need to protect the evidential value of the record by copying and storing the record in accordance with British Standards, in particular the 'Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically' (BIP 0008)[3];
- the need to consult PRONI in advance with regard to records which may have archival value, as the value may include the format in which it was created; and
- the costs of the initial and then any later media conversion to the required standard, bearing in mind the length of the retention period for which the records are required to be kept

The decision on whether or not the original paper documentation can be destroyed once it has been scanned is a decision that each Organisation as a Data Controller must make. The Department can only refer you to the standards which should be achieved. Compliance with the British Standard BIP 008 should be achieved. To help assess the status of compliance with the requirements of BIP0008 a compliance workbook (BIP0009) is published, consisting of a series of questions each of which needs to be reviewed and answered.

It cannot be assumed that because an EDRMS system is in place, all the documents within the system are necessarily admissible as evidence before a court. One of the key important steps is an audit of the system using the British Standard BIP 0009 workbook. EDRMS's are very configurable, but it is extremely important that they are configured in a way that complies with the criteria in the standard.

The process for transfer of the hard copy originals to an electronic media requires a great deal of control, and must be process driven with little margin for human error. Within the court setting, if there is a challenge to document authenticity it will be the system process documents which will be required as evidence alongside the document audit trail.

If a document is to be admissible in court, its authenticity must be provable. Even if a document is admissible in evidence, the weight which a court may give to it is likely to be greater if best practice set out in the following paragraphs is followed. Whilst compliance with BIP 0008 does not guarantee legal admissibility it enables organisations to demonstrate that they are following best practice.

The five principles of information management encapsulated in BIP0008 are:

1. Representation of Information

An information management policy document should describe the different types of information held within the organisation and, for each type, specify:

- the level of security
- appropriate storage media
- formats and version control
- information management standards, e.g. quality
- retention and destruction policy
- responsibilities and roles for information management functions
- responsibilities for compliance with the BIP0008

2. Duty of Care

Organisations need to have in place:

- an awareness of the legislative and regulatory bodies pertinent to its industry;
- a chain of accountability and defined responsibility for activities involving electronic document records management at all levels;
- a system to keep up to date with information management theory and practice; and
- a documented information security policy

3. Business Procedures and Processes

Organisations should have a user manual for each of its information management systems. The manual is the document that the organisation will produce, if it's electronic storage methods are ever challenged, to prove to auditors, lawyers or judges that the processes are precise, secure and approved for its normal business procedures.

The user manual will typically define the following:

- Document types
- Preparation of documents prior to scanning
- Photocopies
- Batch control
- Scanning processes
- Scanning specific documents
- Image Processing
- Compression Techniques
- How information is indexed

- Quality control
- Procedures for producing authenticated output
- Procedures for authenticating copies of documents
- How information is transmitted within the system
- Procedures for document retention and destruction
- System maintenance schedules
- Security and protection, including encryption and the use of digital certificates;
- Backup and system recovery procedures
- Use of bureau services
- Workflow
- Date/time stamping
- Version control

BIP 0008 insists that the procedures and processes be audited annually, or more frequently for legally sensitive archives, to make sure that the approved procedures are being observed or that new ones meet the requirements and are formally and properly incorporated in the manual

4. Enabling Technologies

A typical system will be comprised of many different technologies, each of which need to comply with BIP0008. These technologies include:

- storage media
- access control mechanisms
- system and data integrity
- image processing
- compression techniques
- compound documents
- data migration
- document deletion

5. Audit Trails

BIP0008 requires that a system must have full auditing functionality.

Without detailed audit trails authenticating a document, and therefore satisfying a legal body, may not be possible. The audit trail, as a minimum, should log details of each significant event in the life of a document in the system.

The audit trail should:

- be generated automatically by the system;
- contain date/time stamps for each event;
- be non-alterable;
- be stored in accordance with the organisation's information management policy;
- be subject to appropriate access control; and
- be securely stored and backed-up

[3] http://shop.bsigroup.com/ProductDetail/?pid=000000000030186227

Microfilming Records

Microfilm records can be certified as providing legally admissible archival documents but specific standards for microfilming of records need to be met. The National Preservation Office (allied to the British Library) has produced standards (Guide to Preservation Microfilming 2000) for preservation microfilming which are acceptable to archive institutions throughout the UK.

File Plans

A File Plan provides a structure for filing and retrieving records, generally using a controlled vocabulary. It may also be described as a classification scheme for arranging records based on the functions and activities of the Organisation. Such a scheme or file plan facilitates the creation and retrieval of electronic records, particularly where large amounts of data are involved.

A File Plan is an essential component of a records management programme developed in line with ISO 15489, the International Standard on Records Management. File plans and their associated metadata are vital to the successful implementation of any Electronic Document Records Management system (EDRMS).

EDRMS

An electronic document becomes an electronic record if it provides evidence of a business transaction and is saved and finalised within an EDRMS. An EDRMS provides a corporate filing structure and facilitates the automatic disposal and retention of records.

Disclosure of Information and Transfer of Records to other Organisations

There are a range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties, and similarly, a range of provisions that require or permit disclosure. The key statutory requirements can be found in Annex C. There are also a range of guidance documents (for example the Information Commissioner's Use and Disclosure of Health Information) that interpret statutory requirements and there may be staff within Organisations who have special expertise in, or can advise on, particular types of disclosure.

Personal Data Guardians or their support staff should be involved in any proposed disclosure of confidential patient information, informed by and in accordance with the DHSSPS, Code of Practice on Protecting the Confidentiality of Service User Information. Data Protection officers may be available to advise on subject access requests by members of the public. Guidance documents and additional materials on Freedom of information and Data Protection can be found on the Information Commissioner's website: http://www.ico.gov.uk/

The mechanisms for transferring records from one Organisation to another should also be tailored to the sensitivity of the material contained within the records and the media on which they are held. Information Security staff should be able to advise on appropriate safeguards.

The protocol for the hospital transfer of patients and their records http://www.gain-ni.org/Library/Guidelines/protocol.pdf should be adhered to when hospital patient records are being transferred. The regional discharge and patient transfer protocol for patients with clostridium difficile infection should be adhered to as appropriate. For standards of the handover and discharge record clinical content see http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/structure-and-content-medical-notes/de.

For GP records see Good Practice Guidelines for General Practice Electronic Patient Records (version 3.1), for guidance on the transfer of electronic patient records from one GP practice to another.

Retention and Disposal Arrangements

Detailed guidance on retention periods for a full range of records is provided in Part 2 of GMGR. This guidance applies to electronic and paper records. It has been agreed with PRONI who have identified records which they want to permanently preserve and records which are to be reviewed, to give Organisations and PRONI the chance to determine their evidential or historical importance at a later date. The classes of records to be reviewed will involve a consultation between PRONI, and Organisation medical and records management professionals. All Organisations are required to have internal procedures to ensure records listed for permanent preservation are transferred to PRONI, records listed for destruction are destroyed and records requiring review are reviewed.

It is particularly important under Freedom of Information legislation that the disposal of records – which is defined as the point in their lifecycle when they are either transferred to PRONI or destroyed – is undertaken in accordance with clearly established policies which have been formally adopted by the Organisation and which are enforced by properly trained and authorised staff.

The principles governing the closure and subsequent retention of electronic records are identical to those for paper records

If a file is to be deleted, then it is the data controller's responsibility to ensure it is also deleted from any back-up systems. Information in a deleted file or in a back-up, whether a server, disc or tape, may be regarded as being held by a public authority for the purposes of the FOIA depending on the particular circumstances of the individual case. The ICO position on this issue has been modified in the light of the Information Tribunal decision in Mr P Harper v The Information Commissioner EA/2005/0001. Similarly, individual rights of access to their personal information can also be invoked if data has not been securely deleted from all systems.

A public authority should consider how to keep a record of information held in this way and whether there are practical steps required to recover it. Information that has been deleted or sent to a back-up server is not likely to be readily retrievable for business purposes and retrieving it may not be a practical option. However, each public authority should consider what information in deleted files is still held, what information is held in back-ups and what steps are needed or required to retrieve it.

Transfer of Paper Records to PRONI

When an Organisation is ready to transfer files to PRONI, its Records Management Officer should contact PRONI giving contact details and a brief description of the records due to transfer. PRONI will then forward a schedule for completion. The schedule will be the Organisation's record of the transferred files and should be completed in detail (the reference number, file title, covering dates, and the terms of access to the file). A decision on the terms of access for each file needs to be made prior to transfer and this should be recorded on form PR14 (available from PRONI) to accompany every file, or in some cases, classes of records, if appropriate. Any queries about access should be referred in the first instance to the Records Management, Cataloguing and Access Section, PRONI. Arrangements should be made with PRONI to agree a convenient time and date to transfer the records. See also Part 2 of the Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000 which specifically relates to the transfer of public records.

PRONI will accept records for transfer when the completed schedule and access terms have been agreed. You and your contact in PRONI should check off the files against the schedule when the files are being transferred, sign the schedule and each retain a copy.

Transfer of Electronic Records to PRONI

PRONI is currently undertaking a project that will result in the establishment of a trusted digital repository capable of 'ingesting' digital records. A Business Case has been completed and work has begun on designing the systems required to operate the Digital Repository. PRONI's aim is to have the appropriate resources and infrastructure in place and running by July 2013.

Until the digital repository has been established at PRONI, electronic records deemed suitable for transfer for permanent preservation should be managed by the originating Organisation. As such the records should be maintained in live servers/environments until transfer can take place. Those records not required by PRONI for permanent preservation should be destroyed as soon as their business need comes to an end.

While the Disposal Schedule in Part 2 applies to both electronic and paper records, the creation of electronic disposal schedules within an Electronic Document Records Management System may require a separate project to ensure their operational viability.

The transfer of electronic records from Organisations to PRONI will be governed by a set of policy documents, including a digital preservation strategy that will be made available on the PRONI website, www.proni.gov.uk.

Organisations who have already implemented electronic record keeping systems should contact PRONI for the advice and guidance required to plan for the transfer of records.

Disposal Schedules

Not all papers of a "public nature" are worthy of preserving permanently. All papers created in, or received by, Organisations have to be examined in order that those which are of no administrative or historical value are not permanently preserved in high-cost storage.

PRONI has identified records which they want to preserve. Some records have been selected for review to give both the Organisation and PRONI the chance to determine their value. As medical technologies and care advances are made PRONI wish to preserve records of individually significant cases. These records should be identified at the earliest point and marked in some distinctive way to ensure they are transferred to PRONI after the minimum retention period has elapsed.

Records selected by PRONI for permanent preservation and no longer in use by the organisation should be transferred as soon as possible to PRONI. The 1923 PRA established the normal point of transfer as 20 years.

A disposal Schedule is the key document in a records management system which:

- enables the Organisation to meet legislative requirements;
- outlines the types of records held within an Organisation;
- outlines the associated legislative/policy guidance framework;
- identifies the minimum period for which records should be retained; and
- outlines the action required when the minimum retention period has been reached.

Disposal schedules define the minimum length of time specific types of records have to be retained before being reviewed, destroyed or transferred to PRONI. Records fall into four main categories of action:

- Records to be destroyed after an agreed period (e.g. a file containing receipts for registered and recorded delivery mail is retained for 2 years following the financial year to which they relate and then destroyed);
- Records selected for permanent preservation by PRONI;
- Records to be reviewed; and
- Records which are required to be kept permanently in the organisation i.e. benefactions, where the benefactory endowment trust fund/capital remains permanent.

Files with specified destruction dates included in the Disposal Schedule should be destroyed according to the agreed instructions.

There are 4 options when the minimum retention period has been reached:

Review
The appraisal of records to determine if there is a continuing business need and to determine if they are required for historical or research purposes.

Retain Permanently
This occurs rarely but it is necessary where organisations need to retain records permanently for business administrative need.

Permanent Preservation
PRONI have decided these records are of long-term historical research value and must be transferred to PRONI.

Destroy
Records considered to have no continuing business/legal value and are of no historical or research value to PRONI.

PRONI have the final decision on the preservation of records. They are particularly interested in:

- unpublished administrative histories – development of organisational structure – useful road map for researchers;
- policy files – decision making process;
- business plans – enactment of policy through targets, etc;
- inspection reports – delivery of services on the ground;
- annual reports – targets met, events, etc;
- precedent files – departures from the normal.
- Patient/Client records of significant cases.

PRONI will not make records available to the public until consultation has taken place with the functionally Responsible Authority on whether they can be opened. Where a file contains an access decision (see "Transfer of Paper Records to PRONI") PRONI will be able to apply that decision on transfer to the archives.

Process for the preparation and laying of Disposal Schedules

Legislation requires that the Minister of the Department of Culture Arts and Leisure (DCAL) must arrange for the preparation of disposal schedules which are to be laid before the Northern Ireland Assembly.

Information Management Branch in the DHSSPS will co-ordinate a process to lay GMGR before the Assembly on behalf of the following organisations:

- DHSSPS
- HSC Board;
- Public Health Agency (PHA);
- Business Services Organisation (BSO);
- HSC Trusts;
- Patient and Client Council (PCC);
- Regulation and Quality Improvement Authority (RQIA);
- Guardian AD Litem Agency;
- Blood Transfusion Service;
- Northern Ireland Fire and Rescue Service
- Northern Ireland Social Care Council (NISCC);
- Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC); and
- Northern Ireland Medical and Dental Training Agency (NIMDTA).

Chief Executives will be asked to provide the DHSSPS Permanent Secretary with a statement confirming that the organisation adopts GMGR as its disposal schedule.

The Permanent Secretary will forward GMGR to PRONI asking the minister of DCAL to lay it before the Assembly. Once PRONI is in receipt of schedule and the appropriate signatories page, a submission will be sent to the DCAL Minister as Keeper of the Records.

PRONI officials lay GMGR by sending copies to the Assembly Business Office on behalf of the DCAL Minister.

In the unlikely event that an organisation does not wish to endorse GMGR as its disposal schedule it should inform PRONI that a disposal schedule is being drawn up and they will assist the organisation. The name and contact details of the officer appointed to work with them should be given to PRONI. The DHSSPS Departmental Information Manager should also be informed as they will need to ascertain why the organisation does not wish to endorse GMGR.

The member of staff with lead responsibility for records management should be responsible for the preparation of such Disposal Schedules. Disposal Schedules should outline all classes of records created by the organisation.

PRONI provide guidelines on the development and requirements of Disposal Schedules. All Disposal Schedules should be agreed with PRONI.

Once the schedule is agreed it should be signed by the member of staff responsible for records management and the officer in PRONI.

Every schedule signed as above shall be submitted to the Departmental Information Manager in the DHSSPS for the approval of the head of the Department, i.e. Permanent Secretary.

Every schedule approved by the Minister of DCAL, acting as Keeper of the Records, shall be laid before the Northern Ireland Assembly.

Files and records of like nature to those covered by the Schedule will be deemed to be included, notwithstanding any technical discrepancy in a name given to them.

The disposal and retention schedule for a public authority will remain valid unless there is a transfer of functions from one authority to another or until such times as the Department undertakes a review. Any resulting changes must be discussed and agreed with PRONI before the revised schedule is signed and laid before the Northern Ireland Assembly.

The operation of the Disposal Schedule will only be successful if staff are aware of their records management responsibilities.

Appraisal of Records

Appraisal, commonly referred to as reviewing, refers to the process of determining whether records should be permanently preserved. Records are examined or reviewed in order to determine if they should be destroyed, retained for further consideration, or permanently preserved. This is because their full value could not be determined at an earlier stage.

Procedures should be put in place in all Organisations to ensure that appropriately trained personnel appraise records at the appropriate time. Records should be kept for as long as they are needed to meet the operational needs of the Organisation, and legal and regulatory requirements. PRONI has responsibility for assessing the value of records for historical/research purposes and deciding whether or not they should be permanently preserved

The Records Management Officer within the Organisation should decide the most appropriate person(s) to carry out file review(s) in line with the Organisation's Disposal Schedule. This should be a Senior Manager with an understanding of the subject area. If an officer of the appropriate grade is not available in the branch, the next appropriate highest-ranking officer with an understanding of the subject area should be selected to complete the review.

The reviewing officer should:

- understand the business process and the importance of the records to that process;
- assess its importance as evidence of what was done, why, when, where and by whom which forms the basis for public and internal accountability;
- understand the legal or regulatory retention requirements that must be complied with and what records need to be retained in order to do so.
- determine its value as a source of information about the Organisation, its operations, relationships and environment;
- consider only the administrative value of the records and ask these useful questions to arrive at their decision:

    1. Is there a continuing need to retain this record for the conduct of day-to-day business?
    2. Is there clear evidence of a future need for constant reference to this record?
    3. Will it be needed to deal with enquiries in the future?
    4. How many enquiries are likely?
    5. Is the information needed for statistical analysis within the organisation?
    6. Are there bodies of statistical information upon which future policies and forecasts may be based?
    7. Is the information required for conducting legal proceedings in the event of a legal action being taken by, or against the Organisation?

8. Is there a legal requirement to retain these records (e.g. Health and Safety regulations)?
9. Is there a financial need to retain these records (e.g. for audit purposes)?
10. Is there a professional reason (e.g. continuity of care, research, audit)?
11. Is the information significant because it provides precedents or is required for authorisation purposes?
12. Is the information otherwise available whether within the HSC, or in published form?
13. Are there unsubstantiated allegations which need to be removed?

Where there are records which have been omitted from the Disposal Schedule in Part 2 of GMGR, or when new types of records emerge, Information Management Branch (IMB) in the DHSSPS should be consulted.

A file may be reviewed a number of times:

On Closure - A file should be reviewed immediately when it is closed. The long term value may be quite clear at this stage

First Review - Review five years after the file was closed. Procedures need to be put in place to ensure that these records are reviewed at the appropriate stage.

Second Review - There may be occasions when it proves impossible to reach a decision on a file at first review. Such files may be put away for examination at a later stage. The “second review” should take place 20 years from the date of the last paper on the file and not more than 25 years from the date the file was opened.

The reviewing officer can make one of the following decisions at first review:

Immediate Destruction - Where the file has no further administrative value the reviewing officer should arrange for PRONI to examine and authorise destruction if they consider there is no need to preserve.

Retain for 5/10 years - If there is short to medium term administrative need the file can be retained for 5 or 10 years. When the retention period elapses the reviewing officer should arrange for PRONI to examine and authorise destruction if they consider there is no need to preserve.

Retain for 15 years - Where the file is required for long-term administrative reasons it is retained until second review is due.

The second review exercise gives PRONI the opportunity to decide if files, already retained for 15 years for administrative reasons, are suitable for permanent preservation. The file should be examined by PRONI first and if they decide it has no long-term preservation value, the file should be passed to the reviewing officer to decide if the file can be destroyed.

The reviewing officer must decide how long to retain records that are not required for preservation by PRONI and where possible consider destruction. If however an administrative need to keep them is established, then the reviewing officer must document the reasons why. The options available to the reviewing officer are:

Destroy Immediately - If the file has no further administrative value it should be destroyed

Retain - If the file is still required for administrative need, the reviewing officer must document the reasons for the specified retention. The file should then be destroyed on the disposal date, without further referral to the reviewing officer.

In exceptional circumstances a “Special Review” may be carried out by PRONI. This means that the records will be made available to PRONI, without prior investigation by the functionally responsible Organisation, in order to assess their value as historical records. Where the disposal schedule dictates a special review, the Records Management, Cataloguing and Access section of PRONI should be contacted to determine and agree the practical arrangements for the special review.

Organisations must have procedures in place for recording the disposal decisions made following appraisal. An assessment of the volume and nature of records due for appraisal, the time taken to appraise records, and the risks associated with destruction or delay in appraisal will provide information to support an organisation’s resource planning and workflow.

Record Closure

Records should be closed (i.e. made inactive) as soon as they have ceased to be in active use other than for reference purposes. An indication that a file of paper records or folder of electronic records has been closed, together with the date of closure, should be shown on the record itself as well as noted in the index or database of the files/folders. Where possible, information on the intended disposal of electronic records should be included in the metadata when the record is created.

All paper files should be closed:

- no later than 5 years after opening (with some exceptions e.g. patient/client case files, personnel files relating to individual employees);
- as directed in Disposal Schedules (Local disposal schedules should advise when files should be closed);
- when the depth of papers reaches 2.5cm limit. File covers are designed to be a protection for the records contained within. When the depth of papers reaches more than 2.5cm the file becomes hard to manage. Where this is the case the file should be closed and a continuation file opened;
- when the subject matter is finished;
- at the end of a calendar or financial year where the file title relates to a particular year; or
- when no new papers have been added to the file for two years. A new file can be opened again if it becomes appropriate. Exceptions to this rule will be patient/client case files, personnel files relating to individual employees.

Once a file is closed no further papers should be added. A yellow closure sheet (see Annex D, which should be reproduced locally on yellow paper) must be inserted to every file closed. This reminds staff requesting a closed file that no further papers should be added. At this stage you should record on the file cover the date:

- of the earliest and latest papers
- of first review;
- the file is due to be destroyed; or
- the file should be transferred to PRONI, whichever is appropriate.

The word closed should be stamped on the outside of the file, using a ‘closed’ rubber stamp. If, when a file is being closed, the subject to which it relates remains ‘live’ a continuation file should be opened.

The storage of closed records should follow accepted standards relating to environment, security and physical organisation of the files.

Record Disposal

Most Organisations' records, even administrative ones, contain sensitive or confidential information. It is therefore vital that confidentiality is safeguarded at every stage of the lifecycle of the record, including destruction, and that the method used to destroy such records is fully effective and ensures their complete illegibility.

Destroying Files

Care must be taken when destroying records.

The basic procedures for destruction are:

Non-sensitive files/records Information in public domain	**Rubbish bin**
Non senstive files/records Files/records not available to the public	Torn into small pieces, bagged for collection by approved disposal firm
Sensitive records restricted	Strip shredded, bagged for collection by approved disposal firm
Sensitive records confidential	Strip shredded, bagged for collection by approved disposal firm
Secret and Top Secret	Cross-cut shredded bagged for collection by approved disposal firm
Optical/Magnetic Media	The HSC and DHSSPS ICT/IT Security Policy should be consulted and followed in relation to the disposal of such media

Records (including copies) not selected for archival preservation and which have reached the end of their administrative life should be destroyed in as secure a manner as is appropriate to the level of confidentiality or protective markings they bear. This can be undertaken on site or via an approved contractor.

It is the responsibility of the Organisation to ensure that the methods used throughout the destruction process provide adequate safeguards against the accidental loss or disclosure of the contents of the records. Contractors, if used, should be required to sign confidentiality undertakings and to produce written certification as proof of destruction. Destruction should follow the British Standard BS EN 15713:2009 Secure destruction of confidential material Code of practice.

A record of the destruction of records, showing their reference, description and date of destruction should be maintained and preserved by the Records Manager, so that the organisation is aware of those records that have been destroyed and are therefore no longer available. Disposal schedules would constitute the basis of such a record.

If a record due for destruction is known to be the subject of a request for information, or potential legal action, destruction should be delayed until disclosure has taken place, or if the authority has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted or the legal process completed.

Each organisation should have a retention/disposal policy that is based on GMGR.

Section 5 Special Category Records

Special Category Records

There may be some classes of material that from time to time may need special arrangements to be made for their registration or review. Such records may be termed as 'special category records'.

Records may be treated as special category records for a variety of reasons including the:

- importance of the record;
- confidentiality of the record;
- use to which the record is put.

A record is not distinguished as a special category record simply because of its actual nature, rather it is distinguished because for official purposes it needs to be treated differently from the other records.

The Records Management Officer should be advised of the existence of any special category records and arrangements must be put in place to ensure that they are subject to the normal review procedure, or that a special review is agreed with PRONI. Special category records held on paper should not be held on unregistered files. However, if it is necessary to do so for administrative reasons (and they have been retained for five years), the papers should become registered at First Review.

Photographs, Sound Recordings, Cinematograph Files, Videocassette Recordings and Machine Readable Records

Photographs, sound recordings, cinematograph files, videocassette recordings and machine-readable records are public records and should be included in any Disposal Schedule. The Public Records Act (NI) 1923 is intended to preserve important information in whatever forms it is stored. Given the nature of these items, special storage arrangements might be required. Arrangements for storage, review and/or permanent preservation should be made with the Records Management Officer at the earliest possible opportunity, preferably before creation.

Further guidance about audiovisual records may be obtained from the National Archives (London) website:

- http://www.pro.gov.uk/recordsmanagement/standards/audiovisual.htm

Papers of Temporary Commissions, Committees and Review Bodies (including Non-Departmental Public Bodies)

Papers of temporary commissions, committees and review bodies (including those relating to non-departmental public bodies) are always exempt from normal review periods. They should be dealt with immediately after the body has finished its work. It is not necessary to wait until the papers reach the normal age for review. Indeed, normal review could be impossible in the future given that staff within the body are likely to be stood down when it has finished its work.

The Secretary of the body should inform the Records Management Officer, the DHSSPS Departmental Information Manager (DIM) and PRONI when the body is thought to be drawing to a close. Arrangements can then be made for the proper retention and disposal of records.

Statute-Barred Records

Many statutes e.g. the Food and Drugs Act (NI) 1958 require the general public or sections of it to furnish Government with personal or commercial information. The confidentiality of this information is guaranteed by the inclusion in the statute of a section barring those involved in collecting or collating of the information from divulging it, except where official duties so require. Individual files or records in a statute –barred class should be clearly identified in any disposal schedule and cannot under current legislation be released to the public at any time and are therefore not subject to the normal appraisal procedures.

The Rehabilitation of Offenders (NI) Order 1978 precludes the release of information about 'a living identifiable individual' who has been charged with or convicted of an offence resulting in a fine or in a sentence of imprisonment or corrective training for a term of up to 30 months. Depending on the age of the person at the time and the term of sentence, a person is considered to have been rehabilitated after a specified number of years and thereafter no details of 'spent convictions' may be made public. In accordance with a guideline set down by the Northern Ireland Office (now the Department of Justice) such material remains closed until the person would be deemed to have reached the age of at least 95 years.

Inquiries - Under Legislation

The Inquiries Act 2005 (c.12) provides as follows:

A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that -

(a) particular events have caused, or are capable of causing, public concern, or

(b) there is public concern that particular events may have occurred.

The papers, of such Inquiries should be dealt with immediately after the Inquiry is completed. It is not necessary to wait until the papers reach the normal age for review. The secretary to the Inquiry should inform both the DHSSPS DIM and PRONI when the Inquiry is thought to be drawing to a close. Arrangements can then be made for the proper retention and disposal of records. Retained records will be transferred to PRONI from the Inquiry secretary.

Departmental Inquiries - Administrative

An Internal Departmental Inquiry may be initiated by a Minister or Permanent Secretary, with no statutory basis. The records should be reviewed once the Inquiry is complete. The final action will be determined by PRONI on Review.

Further Guidance

Further information on special category records may be obtained on the PRONI website (www.proni.gov.uk).

Glossary of Records Management Terms

Glossary of Records Management Terms

A

ACCESS
The availability of or permission to consult records. (The National Archives, Records Management Standard RMS1.1)

ACCESS NI
Access NI was established by a joint programme between the Northern Ireland Office, the DHSSPS, the Department of Education and the Police Service of Northern Ireland.

Access NI enables organisations in NI to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in certain defined areas, such as working with children or vulnerable adults.

Access NI is part of central government and operates under the provisions of Part V of the Police Act 1997.

AGENCY
An "agency", under Article 8 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, is taken to mean:

a) a domiciliary care agency;

b) a fostering agency;

c) an independent medical agency;

d) a nursing agency:

e) a voluntary adoption agency; or

f) such other agency as may be specified by order under Article 8 Paragraph (3) of the Order.

ANNUAL ASSESSMENTS REPORTS
Document used for monitoring, assessing, reporting or reviewing the performance of a member of staff.

APPRAISAL
The process of evaluating an organisation's activities to determine which records should be kept, and for how long, to meet the needs of the organisation, the requirements of Government accountability and the expectations of researchers and other users of the records. (The National Archives, Records Management Standard RMS 1.1)

The process of distinguishing records of continuing value from those of no value so that the latter may be eliminated. (The National Archives, Definitions in the Context of the Seamless Flow Programme)[1]

ARCHIVES
Those records that are appraised as having permanent value for evidence of ongoing rights or obligations, for historical or statistical research or as part of the corporate memory of the organisation. (The National Archives, Records Management Standard RMS 3.1)

It is a legal requirement for HSC records selected as archives to be held by PRONI.

ARCHIVAL VALUE
The ongoing usefulness or significance of records, based on the administrative, legal, fiscal, evidential, or historical information they contain, justifying their continued preservation.

ASSEMBLY
The Northern Ireland Assembly is the devolved legislature for Northern Ireland. It is responsible for making laws on transferred matters in Northern Ireland and for scrutinising the work of Ministers and Government Departments. The Assembly sits at Parliament Buildings, Stormont Estate, in Belfast. Members (MLAs) meet to debate issues; question Ministers; and make laws for the benefit of people in Northern Ireland. Each MLA represents her or his constituency, and there are 6 MLAs for each constituency.

ASSEMBLY QUESTION
Assembly questions are questions which have been submitted by Assembly members for either written or oral answer. Questions may be tabled on a daily basis and it is for MLAs to decide the manner in which they wish their questions to be responded to i.e. orally or in writing. A rota is arranged for questions to allow Members to scrutinise the work of each Department.

ASHWORTH HOSPITAL
Ashworth Hospital is part of the National Health Service and is one of three special hospitals serving primarily England and Wales.

Postal address: Ashworth Hospital, Parkbourn, Maghull, Liverpool, Merseyside L31 1HW

AUDIT
The general definition of an audit is an evaluation of a person, organisation, system, process, enterprise, project or product. Audits are performed to ascertain the validity and reliability of information; also to provide an assessment of a system's internal control. An audit record is a record of an audit.

AUTHENTICITY
An authentic record is one that can be proven to:

- be what it purports to be;

- have been created or sent by the person purported to have created or sent it; and
- have been created or sent at the time purported.

To ensure the authenticity of records, organisations should implement and document policies and procedures which control the creation, receipt, transmission, maintenance and disposition of records to ensure that record creators are authorised and identifiable and that records are protected against unauthorised addition, deletion, alteration, use and concealment. (BS ISO 15489-1:2001(E))

B

BEST PRACTICE – BEST CARE
"Best Practice – Best Care" defines clinical and social care governance as a framework within which HSC organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.

BROADMOOR HOSPITAL
Broadmoor is a secure mental hospital in Crowthorne in Berkshire. It is the best known of the three high security hospitals in England. The complex houses 326 patients many of which have personality disorders, and/or have been convicted of serious crime.

Postal address: Broadmoor Hospital, Crowthorne, Berks RG45 7EG.

BUSINESS SERVICES ORGANISATION (BSO)
The Business Services Organisation has been established to provide a broad range of regional businesses support functions and specialist professional services to the health and social care sector in Northern Ireland.

BUSINESS PLANS
A yearly look at what the Organisation and its divisions plan to achieve in the forthcoming year.

C

CABINET OFFICE GUIDANCE
Guidance on Personnel record keeping issued by the Cabinet Office, Corporate Development Group, Admiralty Arch, The Mall, London

CCTV
Recordings made by Close Circuit Television cameras.

CARSTAIRS HOSPITAL
The only high security hospital in Scotland providing secure forensic psychiatric care, located in central Scotland midway between Glasgow and Edinburgh. The 550 staff provide this care 24 hours a day, every day of the year for around 250 patients from Scotland and Northern Ireland.

Postal address: The State Hospital, Carstairs, Lanark, Scotland ML11 8RP.

CENSUS YEAR
The year a census was carried out. A census is normally held every 10 years. Censuses were carried out in 1971, 1981, 1991 and 2001. The last census took place in 2011.

CHILD
Person under the age of 18.

CHILD HEALTH RECORD
A child health record is defined as a record consisting of information about the physical or mental health or condition of an identifiable child made by or on behalf of a health professional in connection with the care of that individual. The personal child health record (PCHR) is a record of a child's growth, development, and uptake of preventive health services, designed to enhance communication between parents and health professionals.

CHILD HEALTH SYSTEM
The Child Health Computing System (CHCS) was designed to provide a comprehensive record system which will suit the needs of clinicians, epidemiologists, statisticians, and managers within the NHS.

CHILD IN NEED
A child who is unlikely to achieve or maintain a reasonable standard of health or development, or his/her health or development is likely to be significantly impaired without the provision of services by an authority, or is disabled.

CHILD PROTECTION
Agreed procedures for use by people working with children to avoid or recognise abuse (physical emotional and sexual) and advising of steps to be followed to involve the appropriate agencies.

CHILD PROTECTION REGISTER
Health and Social Care Trusts maintain a Child Protection Register of children and young people resident in their areas who are subject to Child Protection Plans. The Register is a confidential list of children and young people who are, or believed to be, at risk of significant harm. The purpose of placing a child / young person's name on the Child Protection Register is to ensure their safety and welfare. A child's or young person's name is never included on the register without good reason. If a child's or young person's name is placed on the Register, only the professional workers directly involved with the family will know this.

Every child or young person on the Register has a child protection plan which is drawn up by professional staff working together with the parents, carers and the child (where old enough).

The purpose of the child protection plan is to help to ensure that the child and family are receiving appropriate help and support and that arrangements are in place to keep the child / young person safe. The child / young person's health, development and welfare are regularly checked. Every child on the child protection register has a social worker who is responsible for co-ordinating work with the child and the family.

Cases will be reviewed periodically to see if things have improved. However, if circumstances require it, a review may be held as required. When it is deemed that the child or young person is no longer at risk or they reach 18 years of age, their name will be removed.

CLASSIFICATION

The systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in a classification system. (BS ISO 15489-1:2001(E)).

CLINICAL AND SOCIAL CARE GOVERNANCE

Clinical and Social Care Governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care.

CLINICAL RESEARCH TRIALS

Trials to evaluate the effectiveness and safety of medications or medical devices by monitoring their effects on large groups of people. Clinical Research Trials may be conducted by government health agencies, researchers affiliated with a hospital or university medical programmes, independent researchers, or private industry.

Usually volunteers are recruited, although in some cases research subjects may be paid. Government agencies approve or disapprove new treatments based on clinical trial results. While important and highly effective in preventing obviously harmful treatments from coming to market, clinical research trials are not always perfect in discovering all side effects, particularly effects associated with long-term use and interactions between experimental drugs and other medications.

There are four possible outcomes from a clinical trial:

Positive trial - The clinical research trial shows that the new treatment has a large beneficial effect and is superior to standard treatment.

Non-inferior trial - The clinical research trial shows that that the new treatment is equivalent to standard treatment. Also called a non-inferiority trial.

Inconclusive trial - The clinical research trial shows that the new treatment is neither clearly superior nor clearly inferior to standard treatment.

Negative trial - The clinical research trial shows that a new treatment is inferior to standard treatment.

CLOSING A FILE
The action of closing a file containing documents on which action has been completed and to which no more documents will be added.

COMMUNITY DENTAL SERVICE (CDS)
The Community Dental Service serves the community by providing direct patient care and preventive programmes to people who, because of their special needs, are unable to access appropriate dental services elsewhere. The CDS is a salaried service, provided by the HSC Trusts.

COMMENDATIONS
A message expressing a favourable opinion of any officer.

COMPLAINT
A complaint is “an expression of dissatisfaction that requires a response”.

CONCLUSION OF TREATMENT
Discharge of the patient from the care of the consultant back to the GP.

CONSENT
"Consent is the voluntary and continuing permission of the patient to receive a particular treatment based on an adequate knowledge of the purpose, nature and likely risks of the treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent." (Department of Health 1993).

Consent to medical treatment may be oral or written, express or implied. For the purposes of surgery it is usual to obtain written consent from the patient except in an emergency.

CONTRACT
Legally enforceable binding agreement between parties.

CONVERSION (see also MIGRATION)
The process of changing records from one media to another, or from one format to another. (BS ISO 15489-1:2001(E)).

CORPORATE RECORDS
Records (other than health records) that are of, or relating to, an organisation’s business activities covering all the functions, processes, activities and transactions of the organisation and of its employees.

CURRENT RECORDS
Records necessary for conducting the current and ongoing business of an organisation.

D

DATA PROTECTION ACT 1998
The Act is concerned with personal data, that is, any data relating to an individual who can be identified.

DATA CONTROLLER
A person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed.

DATA SUBJECT
An individual who is the subject of personal data.

DEPARTMENT
The Department of Health, Social Services and Public Safety (DHSSPS).

DEPARTMENTAL INFORMATION MANAGER (DIM)
In accordance with the Disposal of Documents Order (NI) 1925 No. 167 each Government Department has a statutory duty to appoint an officer who is specially conversant with the records of the Department. This is the Departmental Information Manager, appointed by the Permanent Secretary with a duty to provide advice, guidance and general support to all grades of staff within the DHSSPS on matters relating to the Records Management, Freedom of Information, and Data Protection.

DEPARTMENTAL RECORDS OFFICER (DRO)
An officer, appointed by the Permanent Secretary, who has a duty to provide advice, guidance and general support to all grades of staff within the DHSSPS on matters relating to Records Management. The title of Departmental Records Officer has been changed to Departmental Information Manager with the approval of PRONI.

DE-REGISTERED PATIENT
Someone who no longer wants a GP for whatever reason and deregisters.

DESTROY
The record should be destroyed.

DESTROY UNDER CONFIDENTIAL CONDITIONS
Destruction of records should take place at a secure location and should be undertaken by authorised and approved staff. An irreversible method of destruction should be employed e.g. cross-shredding / pulping / burning and a destruction certificate should be created.

DESTRUCTION
The process of eliminating or deleting records beyond any possible reconstruction.

(BS ISO 15489-1.2001(E))

DIRECTOR
Officers next in line to the Chief Executive. This usually means those who form part of the Senior Management Team or Organisational Board.

DISPOSAL SCHEDULE
A Disposal Schedule is a document which outlines all types of records held, the period for which such records should be retained and the action required when the retention period has been reached.

DISPOSAL
Disposal is the implementation of appraisal and review decisions. These comprise the destruction of records and the transfer of custody of records (including the transfer of selected records to an archive institution). They may also include the movement of records from one system to another (for example, paper to electronic). (The National Archives, Records Management Standard RMS1.1).

DISPOSITION
A range of processes associated with implementing records retention, destruction or transfer decisions which are documented in disposition authorities or other instruments. (BS ISO 15489-1:2001(E)).

DIRECTORATE
The term can mean unit, operational business area, branch, division, service/service area, department. It is the term used to define the breakdown of groups of people with the same purpose within the organisation. The name used for the breakdown within organisations can differ.

DIVISION
The term can mean unit, business area, branch, service/service area, directorate, department. It is the term used to define the breakdown of groups of people with the same purpose within the organisation. The name used for the breakdown within organisations can differ.

DONOR RECORDS
Personal details and information relating to an individual and their donation of blood or tissue.

D.N.A.
Did Not Attend

E

EARLY YEARS
Babies, children or young people up to 14 (or up to 16 with Special Education Needs or a disability).

ELECTRONIC DATA
The term “Electronic data” refers to any original and any non-identical copies (whether non-identical because of notes made on copies or attached comments, annotations, marks, transmission notations, or highlighting of any kind), of mechanical, facsimile, electronic, magnetic, digital or other programs (whether private, commercial, or work-in-progress), programming notes or instructions, activity listings of electronic mail receipts or transmittals, output resulting from the use of any software program, including word processing documents, spreadsheets, database files, charts, graphs and outlines, electronic mail or “e-mail,” personal digital assistant (“PDA”) messages, instant messenger messages, operating systems, source code of all types, programming languages, linkers and compilers, peripheral drives, PDF files, PRF files, batch files, ASCII files, crosswalks, code keys, pull down tables, logs, file layouts and all miscellaneous files or file fragments, regardless of the media on which they reside and regardless of whether said electronic data consists of an active file, deleted file or file fragment.

The definition of “Electronic data” also includes any and all items stored on computer memory or memories, hard disks, floppy disks, zip drives, CD-ROM discs, Bernoulli Boxes and their equivalents, magnetic tapes of all types and kinds, microfiche, punched cards, punched tape, computer chips (including but not limited to EPROM, PROM, ROM and RAM of any kind) on or in any other vehicle for digital data storage or transmittal, files, folder tabs, or containers and labels appended to or associated with any physical storage device associated with each original and each copy.

ELECTRONIC RECORD
A record created, generated, sent, communicated, received, or stored by electronic means. Information recorded in a form that requires a computer or other machine to process it and that otherwise satisfies the definition of a record. Any record that contains machine-readable rather than human-readable information.

ELECTRONIC RECORD MANAGEMENT SYSTEM (EDRMS)
A system that manages electronic records throughout their lifecycle, from creation and capture through to their disposal or permanent retention, and which retains their integrity and

authenticity while ensuring that they remain accessible.

ENVIRONMENTAL INFORMATION REGULATIONS (EIR)

The Environmental Information Regulations 2004 (EIR) is a UK Statutory Instrument (SI 2004 No. 3391) that provides a statutory right of access to environmental information held by UK public authorities. The regulations came into force on 1 January 2005.

ESTABLISHMENT

An establishment, under Article 8 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, is taken to mean:

a) a children's home;

b) a day care setting;

c) an independent clinic;

d) an independent hospital;

e) a nursing home;

f) a residential care home;

g) a residential family centre; or

h) such other establishment as may be specified by order under Article 8

paragraph (3) of the Order.

EVIDENTIAL WEIGHT/LEGAL ADMISSIBILITY

When a charge is brought against persons on behalf of an organisation, the evidence produced for or against the accused will vary in quality and reliability. 'Legal admissibility' of evidence simply refers to whether or not the presiding judge or magistrate rules it permissible at all for use in the court case. Assuming it passes this first admissibility test, a jury or presiding judge will weigh up this evidence alongside other evidence in arriving at a judgment of guilt or innocence. So the court, in effect, questions the trustworthiness and reliability of each individual piece of evidence versus other supporting or conflicting evidence; their judgment as to its level of reliability loosely defines its 'real evidential weight'.

The evidence we are most concerned with here is electronically stored information. If it is legally admissible, an opposing lawyer may well, nevertheless, challenge its validity and reliability. Some of the questioning he or she may use can cover things such as:

- can you show that the record is entirely genuine and authentic?
- can you show that the record is the original (or a perfect copy, since electronic records are nearly always copies)?

- has the record been kept within a secure environment throughout its ‘lifetime’ since it was created?
- can you show that the record has never been tampered with?

EXPLICIT CONSENT
Explicit (i.e. express) consent is given by a patient agreeing actively, usually orally or in writing to a particular disclosure of information.

F

FILE CATEGORY THESAURUS
A class and folder naming mechanism that is based on controlled vocabulary terms and relationships. This controlled vocabulary or keywords should be chosen from a key list which is the File Category Thesaurus.

FILE
An accumulation of records maintained in a predetermined physical arrangement.

An organised unit of documents grouped together either for current use by the creator or in the process of archival arrangement, because they relate to the same subject, activity or transaction. A file is usually the basic unit within a records series.

FILING SYSTEM
A plan for organising records so that they can be found when needed. (The National Archives, Records Management Standard RMS 1.1)

FILE TITLING
Accurate file titling is essential for an efficient filing system. The title of every file should accurately reflect its contents.

FORENSIC MEDICINE
The branch of medical science that interprets or establishes medical knowledge for legal purposes.

FREEDOM OF INFORMATION ACT 2000 (FOI)
The Act allows for any person to make a request for information, and to be told whether the public authority holds the information, and subject to exemptions, to be supplied with the information.

G

GENERAL DENTAL SERVICES (GDS)
General Dental Service is the term for some 750 high street dentists who provide dentistry through some 350 dental practices in Northern Ireland. Most dentists operate a mixed economy of private and health service work, to varying degrees. Payment to health service GDS dentists is through the Statement of Dental Remuneration (SDR) which lists all payments, both item of service and other payments, such as continuing care and practice allowance, which are usually paid on a sliding scale according to health service commitment. (Health & Personal Social Services General Dental Service (Amendment) Regulations (Northern Ireland) 2008).

GP - RECORDS
Records maintained by a general practitioner by virtue of his obligations under The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004

H

HEALTH AND SOCIAL CARE (HSC)
Includes hospital services, community health services, social care services and general medical services.

HEALTH AND WELL-BEING INVESTMENT PLANS (HWIPS)
Health and Well-being Investment Plans are documents which provide the financial overviews of HSC organisations, and set out the objectives, targets and priorities for planned investments over a period of time.

HEALTH AND SOCIAL CARE RECORD
A single record with a unique identifier containing information relating to the physical or mental health of a given patient/client who can be identified from that information and which has been recorded by, or on behalf of, a health or social care professional, in connection with the treatment or care of that patient/client or service delivered to him/her and his/her family. This may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the ongoing care of the patient/client to whom it refers.

HEALTH RECORD[4]
A health record is any record of information relating to someone's physical or mental health that has been made by (or on behalf of) a health professional. This could be anything from the notes made by a GP in your local surgery to results of an MRI scan or X-rays.

Health records are extremely personal and sensitive. They can be held electronically or as paper files, and are kept by a range of different health professionals both in the HSC and the private sector.

For the purpose of the Data Protection Act, a registered health professional can be one of the following people:

A medical practitioner - this could be a GP, consultant or hospital doctor

A dentist

An optician

A pharmaceutical chemist

A nurse, midwife or health visitor

An osteopath

A chiropractor

A clinical psychologist, child psychotherapist or speech therapist

A music therapist

A scientist employed by a health service body as head of department

[4]Information Commissioner

HOSPITAL DENTAL RECORDS
The Hospital Dental Service has four main functions:

- The provision of consultant advice and treatment for cases of special difficulty referred to hospitals by general dental and medical practitioners, or for patients admitted to hospital as a result of trauma or disease.
- The dental care, including comprehensive treatment, of long-stay hospital in-patients.
- The dental care of short-stay patients when this is required for the relief of pain or other emergency, or as part of, or in support of their general treatment.
- The treatment of certain out-patients, where there are medical considerations which make it desirable for the treatment to be carried out in a hospital.

HSC
Health and Social Care

HSCB
Health and Social Care Board

HPSS ICT SECURITY POLICY
An ICT security policy for HPSS Organisations issued in August 2002 by the Directorate of Information Systems DHSSPS, which establishes the baseline security principles to which such organisations must conform.

I

IAO
Information Asset Owner

IMPLIED CONSENT
Implied consent is given where an individual takes some other action in the knowledge that in doing so he or she has incidentally agreed to a particular disclosure of information.

INDEX
A numerical scale used to compare variables with one another or with some reference number or an alphabetical listing of names and topics along access points to facilitate retrieval.

INDEXING
The process of establishing access points to facilitate retrieval of records and/or information. (BS ISO 15489-1:2001(E)).

INFORMATION ACCESS REQUEST
A request from a data subject for information. They are entitled to be told whether the public authority holds the information, and subject to exemptions, to be supplied with the information.

INFORMATION AUDIT
An information audit looks at the means by which an information survey, gathering of information about records created or processed by an organisation, will be carried out and what it intends to capture.

INFORMATION COMMISSIONER
The Information Commissioner enforces and oversees the Data Protection Act 1998 and the Freedom of Information Act 2000.

INFORMATION SURVEY/RECORDS AUDIT
A comprehensive gathering of information about records created or processed by an organisation. (The National Archives, Records Management Standards and Guidance – Introduction Standards for the Management of Government Records)

It helps an organisation to promote control over its records, and provides valuable data for developing records appraisal and disposal procedures. It will also help to:

- identify where and when health and social care and other records are generated and stored within the organisation and how they are ultimately archived and/or disposed of; and

- accurately chart the current situation in respect of records storage and retention organisation-wide, to make recommendations on the way forward and the resource implications to meet existing and future demands of the records management function.

INTEGRITY OF RECORDS

The integrity of a record refers to its being complete and unaltered. It is necessary that a record be protected against unauthorised alteration. Records management policies and procedures should specify what additions or annotations may be made to a record after it is created, under what circumstances additions or annotations may be authorised and who is authorised to make them. Any unauthorised annotation, addition or deletion to a record should be explicitly identifiable and traceable.

INTERVAL CANCERS
A cancer that develops in the intervals between routine screening for a particular cancer–e.g., prostate cancer, breast cancer, etc

J

JOINTLY HELD RECORDS
A record held jointly by health and social care professionals, for example in a Multidisciplinary team. A jointly held record should be retained for the longest period for that type of record, i.e. if social care has a longer retention period than health, the record should be held for the longer period.

K

KöRNER RECORDS
Patient activity data.

L

LOOKED AFTER CHILD (LAC)
A child who is in the care of the authority and provided with accommodation by the authority for a continuous period of more than 24 hours.

M

MASTER COPIES
Original creations – original documents from which copies can be made.

MATERNITY RECORDS
All obstetric and midwifery records including those of episodes of maternity care that end in still birth or where the child later dies.

MENTAL DISORDER
Mental illness, mental handicap and any other disorder or disability of mind as defined in Article 3 of the Mental Health (Northern Ireland) Order 1986.

METADATA
Data used to describe data.

Contextual information about a record. Defined in ISO 15489 as data describing context, content and structure of records and their management through time, metadata is structured information that enables the description, location, control and management of other information.

Metadata should include (amongst other details) elements such as the title, subject and description of a record, the creator and any contributors, and the date and format. For further information, see:

- http://www.nationalarchives.gov.uk/electronicrecords/reqs2002/pdf/metadatafinal.pdf

The e-Government Metadata Standard (e-GMS) lays down the elements, refinements and encoding schemes to be used by government officers when creating metadata for their information systems. The e-GMS forms part of the e-Government Information Framework (e-GIF). The e-GMS is required to ensure maximum consistency of metadata across public sector organisations.

- http://www.govtalk.gov.uk/schemasstandards/metadata.asp

MICROFORM
Records in the form of microfilm or microfiche, including aperture cards.

MIGRATION (see also CONVERSION)
The act of moving records from one system to another, while maintaining the records' authenticity, integrity, reliability and usability. (BS ISO 15489-1:2001(E)).

MINOR
An individual under the age of 18 years old.

MINUTES (MASTER COPIES)
A written account of what transpired at a meeting. Master copies are the copies held by the secretariat of the meeting, i.e. the person or branch who actually takes, writes and issues the minutes.

MINUTES (REFERENCE COPIES)
A written account of what transpired at a meeting. Copies held by individual attendees at a given meeting.

MLA
Member of the Northern Ireland Legislative Assembly. (see Assembly).

N

NATIONAL ARCHIVES
The National Archives (TNA) is a UK government department and an executive agency of the Secretary of State for Justice. It was created in April 2003 to maintain a national archive for "England, Wales and the central UK government". It is the central advisory body on the care of records and archives, in all media from creation to long –term preservation.

NORMAL REVIEW PROCESS
The reviewing of files when they reach 10 years old.

NORTHERN IRELAND RECORDS MANAGEMENT STANDARD (NIRMS)
Standard for Records Management produced by PRONI in March 2002 and revised in 2007. The standard is updated regularly to take account of emerging Freedom of Information issues.

O

OBSTETRIC RECORDS
Maternity care records including cases of stillbirth, Child Death and children born with a handicap.

OFFICE OF THE e-ENVOY
e Government Unit, Cabinet Office, Stockley House, 130 Wilton Road, London SWIV 1LQ.

ONE –OFF ENQUIRIES
Single enquiries not related to any previous issue or correspondence.

P

PATIENT RECORD
A collection of documents that provides an account of each episode in which a patient visited or sought treatment and received care or a referral for care from a health care facility. All recorded information regarding a patient's clinical history, examination findings, diagnosis, treatment, and consent.

PAPER RECORDS
Records in the form of files, volumes, folders, bundles, maps, plans, charts, etc.

PECS CHECKS
PECS stood for the Pre-Employment Consultant Service. The Pre-Employment Consultant

Service was operated by DHSSPS from 1983 until April 2005. A PECS check was a mechanism for organisations intending to employ individuals to work with children or adults with learning disability to carry out a check of individual's criminal record history and whether they were included on the PECS Register.

PECS was placed on a statutory basis by the Protection of Children & Vulnerable Adults (NI) Order 2003 (POCVA). From April 2005 PECS checks were replaced by POCVA checks. From April 2008 Access NI took over the disclosure process with POCVA checks being replaced by Enhanced Disclosures. POCVA was repealed in October 2009 (with exception of a few savings provisions) by the Safeguarding Vulnerable Groups (NI) Order 2007.

PERMANENT RETENTION

Records may not ordinarily be retained for more than 20 years. However, the Public Records Act provides for records which are still in current use to be legally retained. Additionally, under separate legislation, records may need to be retained for longer than 30 years, for example Occupational Health Records relating to the COSHH (Control of Substances Hazardous to Health) Regulations, or records required for variant CJD surveillance.

Section 33 of the Data Protection Act permits personal data identified as being of historical or statistical research value to be kept indefinitely as archives.

PERMANENT SECRETARY

The administrative head of the Department working directly to the Minister.

PERSONAL DATA GUARDIAN

The Personal Data Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that responsibilities with partner organisations satisfy the highest practicable standards for handling patient identifiable information.

POCVA

Protection of Children and Vulnerable Adults.

PROTECTION OF CHILDREN AND VULNERABLE ADULTS

Protection of Children and Vulnerable Adults (Northern Ireland) Order commenced on 1st April 2005 and enhanced the arrangements for safeguarding vulnerable members of society by providing a legislative basis (The Protection of Children and Vulnerable Adults (NI) Order 2003) for pre-employment checking and for maintaining two lists:

- The Disqualification from Working with Children (DWC (NI)) List which is a list of individuals who are considered unsuitable to work with children and;
- The Disqualification from Working with Vulnerable Adults (DWVA (NI)) List which is a list of individuals who are considered unsuitable to work with vulnerable adults."

PRECEDENT CASE
Something with a wider importance than its own immediate circumstances or something carried out, used, researched, trialled, which may serve as an example to authorise a subsequent act of the same kind e.g.:

- The first time a procedure was used;
- The first time a certain product or piece of equipment was used;
- The first time a new procedure, product or piece of equipment was used on certain groups of patients.

A case which establishes legal principles to a certain set of facts, coming to a certain conclusion, and which is to be followed from that point on when similar or identical facts are before a court.

PRESERVATION
Processes and operations involved in ensuring the technical and intellectual survival of authentic records through time. (BS ISO 15489-1:2001(E)).

PRIVATE PATIENTS
A patient who pays for medical treatment or advice, rather than receiving it free through the government's system.

Article 31 of the Health and Personal Social Services Order 1972 (known as the 1972 Order), authorises HSC hospital accommodation and services to be used by private patients - it appears that under this provision the patient continues to be treated as a private patient whilst in hospital. Article 33 of the 1972 Order provides for Trusts to be able to charge for hospital accommodation. A patient who pays for a single room under Article 33 of the 1972 Order is still receiving treatment under the HSC.

PROTECTIVE MARKING
The process of determining security and privacy restrictions on records.

PUBLIC RECORDS
Records as defined in the Public Records Act 1958 or subsequently determined as public records by The National Archives.

Records of NHS organisations (and those of predecessor bodies to NHS organisations) are defined as public records under the terms of the Public Records Act 1958 sections 3(1)–(2). NHS records are not owned by the NHS organisation that created them and may not be retained for longer than 30 years without formal approval by The National Archives. (The National Archives). Records of services supplied within NHS organisations but by outside contractors are not defined as public records, but are subject to the Freedom of Information Act.

PROTECTIVELY MARKED FILES
Categories of file markings depending on the level of security required for the material.

PUBLIC RECORDS ACT (NI) 1923
All files created by public servants as part of their everyday work, are defined as public records under the terms of the Public Records Act (NI) 1923.

PUBLIC RECORD OFFICE OF NORTHERN IRELAND (PRONI)
The Public Records Act (Northern Ireland) 1923 established PRONI as the national archive for Northern Ireland with authority to receive those records of government departments and public bodies which are deemed worthy of permanent preservation. PRONI is part of the Department of Culture, Arts and Leisure.

PUBLICATION SCHEME
A publication scheme is required of all HSC organisations under the Freedom of Information Act 2000. It details information which is available to the public now or will be in the future, where it can be obtained from and the format it is or will be available in. Schemes must be approved by the Information Commissioner and reviewed periodically to make sure they are accurate and up to date.

Q

R

RAMPTON HOSPITAL
Rampton Secure Hospital is home to some of the most dangerous people in Britain, with 3 out of 4 of its 400 patients responsible for very serious crime. Postal address: Rampton Hospital, Retford, Nottinghamshire DN22 0PD.

RECORDS
Information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations, or in the transaction of business. (BS ISO 15489.1) A record of an Organisation is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of its employees – including consultants, agency or casual staff.

RECORDS MANAGEMENT
Field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records. (BS ISO 15489-1:2001(E)).

RECORD SERIES
A series is the main grouping of records with a common function or subject – formerly known as 'class'. (The National Archives). Documents arranged in accordance with a filing system or maintained as a unit because they result from the same accumulation or filing process, or the same activity, because they have a particular form, or because of some other relationship arising out of their creation, receipt or use. (International Council on Archives'(ICA) General International Standard Archival Description or ISAD(G)).

- http://www.ica.org/10207/standards/isadg-general-international-standard-archival-description-second-edition.html

A series comprises the record of all the activities that are instances of a single process. A series may be large or small, it is distinguished not by its size, but by the fact that it provides evidence of a particular process. If an activity takes place that is unique, rather than an instance of a process, its records form a series in their own right. (Elizabeth Shepherd and Geoffrey Yeo, Managing Records: a handbook of principles and practice (Facet 2003)).

RECORD SYSTEM/RECORD-KEEPING SYSTEM
An information system which captures, manages and provides access to records through time. (The National Archives, Records Management: Standards and Guidance – Introduction Standards for the Management of Government Records) Records created by the organisation should be arranged in a record-keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information. Record-keeping systems should contain descriptive and technical documentation to enable the system and the records to be understood and to be operated efficiently, and to provide an administrative context for effective management of the records, including a documented set of rules for referencing, titling, indexing and, if appropriate, the protective marking of records. These should be easily understood to enable the efficient retrieval of information and to maintain security and confidentiality.

REDACTION
The process of removing, withholding or hiding parts of a record due to either the application of a Freedom of Information Act exemption or a decision by PRONI after consultation with the Responsible Authority to restrict access where sensitivity, copyright or data protection issues arise.

REGISTER
An official written (either on hard copy or computer) record of names or events or transactions.

REGISTRATION
Registration is the act of giving a record a unique identifier on its entry into a record-keeping system.

RETENTION
The continued storage and maintenance of records for as long as they are required by the

creating or holding organisation until their eventual disposal, according to their administrative, legal, financial and historical evaluation.

REVERSE BOOK METHOD
Practice of filing the latest paper on top of a series of papers.

REVIEW
The examination of records to determine whether they should be destroyed, retained for a further period or transferred to PRONI.

S

SERIOUS ADVERSE RELATED INCIDENT
An adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects involving the safety of patients, staff, users and other people.

SERVICE
The term can mean unit, business area, branch, division, directorate, department. It is the term used to define the breakdown of groups of people with the same purpose within the organisation. The name used for the breakdown within organisations can differ.

SERVICE LEVEL AGREEMENT
An agreement between parties setting out the agreed level of service. Usually a supplementary document to a contract.

SHANNON CLINIC
A medium secure unit within Knockbracken Health Care Park, Saintfield Road, Belfast BT8 8BH to accommodate 34 patients.

SIRO
Senior Information Risk Owner

SPECIAL CATEGORY RECORDS
A class of material that may need special arrangements for registration or review.

SPENT CONVICTIONS
"A spent conviction is one which is spent within the meaning of the Rehabilitation of Offenders (Northern Ireland) Order 1978".

That order provides that after a specified time has elapsed, varying in accordance with the severity of the sentence passed on the offender, a conviction is spent and must no longer be referred to. However a life sentence is never spent and for certain purposes such a vetting for

people to work with children even convictions which would ordinarily be considered " spent" are not.

SUBJECT ACCESS REQUEST
A written signed request for information made by an individual to a person or organisation that they believe holds the information, to see the information held about them.

SUPERVISION ORDER
A Supervision Order is one of the sentences that a Court can give to a young person aged between 10 and 17 years to help a young person so that they cannot re-offend.

T

TDPs
Trust Delivery Plans.

TRACKING
Creating, capturing and maintaining information about the movement and use of records. (BS ISO 15489-1:2001(E)).

TRANSFER OF RECORDS
Transfer (custody) – Change of custody, ownership and/or responsibility for records. (BS ISO 15489-1:2001(E)).

Transfer (movement) – Moving records from one location to another. (BS ISO 15489-1:2001(E)).

Records identified as more appropriately held as archives should be offered to PRONI, who will make a decision regarding their long-term preservation.

TRANSFER TO PRONI ALL FILES FOR EACH CENSUS YEAR
All files where the minimum retention period has expired during a census year e.g. patient/client died 1993 – minimum retention period expires in 2001. 2001 is a census year, so file is transferred to PRONI.

TRANSPLANT RECORDS
Personal details and information relating to an individual who has received a donation of tissue.

U

UNDER A DISABILITY
A person under a disability is defined as any person who is incapable by reason of mental illness or disorder from managing their own affairs (crucially whether they are capable of giving

instruction to solicitors in relation to the conduct of legal proceedings) – this may be as a result of a pre-existing condition or may have been caused as a result of clinical negligence.

UNIT
The term can mean service, business area, branch, division, directorate, department. It is the term used to define the breakdown of groups of people with the same purpose within the organisation. The name used for the breakdown within organisations can differ.

UNOCINI
Understanding of the needs of Children in Northern Ireland. A framework to support professionals in assessment and planning to better meet the needs of children and their families.

UNTOWARD EVENTS
An accident or incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided and where actions of health service staff are likely to cause significant public/media concern.

V

VIDEOS
Film recorded on video cassette.

W

WEEDING
The process of removing inactive/non-current health and social care records from the active/current or primary records storage area to a designated secondary storage area after a locally agreed timescale after the date of last entry in the record.

X

Y

Z

Annex A

Annex A - Contacts and Resources to Support Improvement

Contacts

Information and Records Management Society of Great Britain

The Records Management Society was launched in 1983, in recognition of the ever-increasing number of people working in the fields of records and information management. It changed its name to become the Information and Records Management Society. This change took place in August 2010. Anyone concerned with records and information, regardless of their professional or organisational status or qualifications, can join the society. Organisations wishing to develop records or information systems and those that provide services in these fields are also able to join.

Benchmark Communications
14 Blandford Square
Newcastle upon Tyne
NE1 4HZ
United Kingdom
Tel: 0191 244 2839
Fax: 191 245 3802
Web: www.irms.org.uk

Information Commissioner

Ken MacDonald
The Information Commissioner's Office – Northern Ireland
51 Adelaide Street
Belfast
BT2 8FE
Tel: 028 90269380
Fax: 028 90269388
E-mail: ni@ico.gsi.gov.uk
Web: http://www.ico.gov.uk/about_us/regional_offices/northern_ireland.aspx ;
www.informationcommissioner.gov.uk

Information Management Branch

Department of Health, Social Services and Public Safety
Room A3.7, Castle Buildings,
Stormont,
Belfast BT4 3SQ
Tel: 028 9052 3260
The Departmental Information Officer / Records Officer – Data Protection, Freedom of

Information or records management issues. Tel: 028 9052 2353
Web: www.dhsspsni.gov.uk

Institute of Health Record and Information Management (IHRIM)

Established in 1948, IHRIM provides qualifications at all levels, as well as career and professional assistance for members working in the field of health records, information, clinical coding and related professions.

IHRIM is an international, as well as national, organisation with members in many different countries around the world. Many members choose to study for the Institute's professional qualifications. IHRIM is also a founder member of The International Federation of Health Records Organisations (IFHRO) and the UK IFHRO Director serves on the General Assembly of the Federation.

- http://www.ihrim.org/

National Preservation Office

The British Library
96 Euston Road, London NW1 2DB
Tel: 020 7412 7612
Fax: 020 7412 7796
Email: npo@bl.uk
Web: www.bl.uk

International Council on Archives

The Committee on Best Practices and Standards (CBPS) serves as the professional home for the maintenance and development of standards and best practices and related activity within International Council on Archives. In the past attention was mainly concentrated on descriptive standards, but from 2004 onwards, the initiative was enlarged to encompass all those professional and related activities that would benefit from the development of standards and best practices and developing globally harmonised software specifications for records such as Principles and Functional Requirements for Records in Electronic Office. Module one, two and three.

- http://www.ica.org/

The National Archives

The National Archives, as both a government department and an executive agency, plays a central role in the public records system, in particular, in the selection of records. Their review work is undertaken across government, in accordance with the Public Records Act 1958, and is carried out under the supervision, guidance and co-ordination of the Keeper of Public Records.

This role was assigned to the Keeper in the light of the recommendations of the Grigg Committee on departmental records, which reported in 1954. Approximately 1.5km of shelving at The National Archives is filled with records from government departments each year. These records represent no more than 5% of the records created by these departments. Due to their strong local or specialist nature, some of the remainder are permanently preserved as public records, in 240 approved archives across the country. The great majority of records not selected for permanent preservation are destroyed.

For further information, see:

- http://www.nationalarchives.gov.uk/recordsmanagement/selection/acquisition.htm#5
- http://www.nationalarchives.gov.uk/recordsmanagement/advice/standards.htm

The Public Record Office of Northern Ireland

PRONI is a division of the Department of Culture, Arts and Leisure and operates under the statutory requirements set out the in the Public Records Act (NI) 1923. It plays a central role in identifying and ensuring that records of historical and other evidential importance are preserved for access. For further information, see:

- http://www.proni.gov.uk

Resources

1. Department of Health Information Governance Toolkit:

    - https://www.igt.connectingforhealth.nhs.uk/

    The Information Governance Toolkit is an online system which allows NHS Organisations in England to assess themselves against Department of Health Information Governance policies and standards. It provides the means by which such organisations can assess their compliance with current legislation, Government policy and national guidance. Organisations may wish to follow the requirements of the toolkit.

2. Section 46 of the Freedom of Information Act 2000 requires the Lord Chancellor to issue a Code of Practice on the management of records. First published in November 2002, the code was revised and re-issued in July 2009.

    - http://www.justice.gov.uk/guidance/foi-guidance-codes-practice.htm

    The code is in two parts: Part I sets out good practice in records management and applies to all public authorities covered by the Act, and also to bodies that are not FOI authorities but are bodies subject to the Public Records Act 1958 or the Public Records Act (Northern Ireland) 1923.

Part II sets out how public records (records subject to the two Public Records Acts) are to be reviewed and transferred to The National Archives, the Public Record Office of Northern Ireland or another place of deposit for public records.

To help public authorities comply with the Code of Practice, the National Archives has developed a series of implementation guides. These guides are for staff in public authorities who are responsible for records management and, in particular, for compliance with the records management Code issued under section 46 of the Freedom of Information Act. They provide an introduction to records management concepts, explain the good practice recommendations in the Code and give guidance on how to apply them within an organisation. They are aimed at people with little or no experience or knowledge of records management. There is a guide for each of the nine good practice recommendations in the Code and also an introductory guide. Four of the ten guides in the series have been issued:

Public authorities are required under the Freedom of Information Act 2000 to comply with requests promptly and within no more than 20 working days. Whilst public authorities are not obliged to release information which would be routinely deleted within that 20 day period, Section 46 of the Code of Practice recommends that destruction is delayed until the information has been disclosed, or if not disclosed until the complaint and appeal provisions of the Freedom of Information Act are exhausted.

If, for some reason, the public authority cannot delay the destruction, then under the duty to offer advice and assistance you should identify whether another authority holds the information and inform the applicant of this or, offer to provide similar or related information if this is appropriate.

3. The National Archives: A Model Action Plan for Developing Records Management Compliance with the 2002 Lord Chancellor's Code of Practice under Section 46 of the Freedom of Information Act 2000 can still be accessed for reference in the UK Government Web Archive:

    - http://collections.europarchive.org/tna/20090615141934/http://www.nationalarchives.gov.uk/recordsmanagement/code/model_action_plans.htm

4. The National Archives: Complying with the Records Management Code: Evaluation Workbook and Methodology (March 2005)

    - http://www.nationalarchives.gov.uk/documents/information-management/stan_file_creation.pdf

    An evaluation workbook intended to be used to assess compliance with Part 1 of the Lord Chancellor's Code of Practice, issued under section 46 of the Freedom of Information Act 2000. The workbook can be used to assess records management practices across any type of organisation.

5. The National Archives: File Creation

- http://www.nationalarchives.gov.uk/recordsmanagement/advice/

A document that provides advice and guidance on the creation of paper-based files, it does not cover the creation of electronic files. It deals with the creation of registered files including policy, administrative and case files but not staff personal files.

6. ISO 15489 – international record keeping standards.

7. e-Government Technical Standards

There are a number of Government standards which aim to ensure the consistency of electronic information transferred between public organisations or made available to the public through means such as websites. e-GIF is mandatory for all public sector bodies, including the NHS. Full details can be found at:

- http://www.cabinetoffice.gov.uk/govtalk.aspx

8. University of Edinburgh Records Management Section

- http://www.recordsmanagement.ed.ac.uk/InfoStaff/RMstaff/records_management_for_staff.htm

9. Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically (BIP 0008: 2004 – Copyright BSI). British Standards Institution.

- www.bsigroup.com

10. Royal College of Physicians Record Keeping Standards:

- http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/structure-and-content-medical-notes/de

11. Good Practice Guidelines for General Practice Electronic Patient Records (version 4) - prepared by the Joint Computing Group of the General Practitioners Committee and the Royal College of General Practitioners, sponsored by the Department of Health. It can be found at:

- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125310

12. The Royal College of Pathologists: The Retention and Storage of Pathological Records and Archives (3rd edition, 2005). See: The Royal College of Pathologists | Publications & media

The document contains guidance from The Royal College of Pathologists and the Institute of Biomedical Science regarding the management of pathology records.

13. Recommendations for the retention of pharmacy records (PDF 1.9KB)

14. (BASHH) Guidance on the Retention and Disposal of Hospital Notes:

    - http://www.bashh.org/groups/clinical_governance_committee
    - http://www.bashh.org/documents/2513%20bashh%20clinical%20standards%20committee%20faculty%20of%20sexual%20and%20reproductive%20healthcare

15. The Medical Protection Society has published guidance, Keeping Medical Records – A Complete Guide for Consultants. It is available on their website, see:

    - www.medicalprotection.org

16. The NHS Care Record Guarantee:

    - http://www.nigb.nhs.uk/guarantee

    A document outlining the NHS commitment to respect patient rights, to protect patient confidentiality and to use patient information only for the purpose for which it was provided.

17. Confidentiality and Disclosure of Information: General Medical Services (GMS) and Alternative Provider Medical Services (APMS) Code of Practice, 25 July 2006. See:

    - Code of Practice on Confidentiality (PDF 108KB)

    This Code of Practice sets out guidance on the confidentiality of information held by General Practitioner contractors who provide General Medical Services (GMS) and Alternative Provider Medical Services (APMS). It also sets out guidance on the provision of contractor-held information to Boards, and access by, and disclosure of, that information to Boards or a person authorised in writing by Boards.

18. Information Commissioner: Use and Disclosure of Health Data

    - http://www.ico.gov.uk/tools_and_resources/document_library/data_protection.aspx

19. Information Commissioner: CCTV Code of Practice

    - http://www.informationcommissioner.gov.uk

Images from CCTV should not be retained for longer than necessary. This requires that organisations look at the purpose of recording the images. The Information Commissioner outlines several scenarios that may require different retention periods. The document also sets out standards for storage of CCTV images that need to be retained for evidential purposes and for the access and disclosure of images to third parties.

20. Confidentiality: DHSSPS Code of Practice on Protecting the Confidentiality of Service User Information (PDF 249KB)

    This details an overview of record keeping best practice, in respect of confidentiality.

21. The Privacy Advisory Committee in Northern Ireland can advise on some considerations about using patient information; but it has no statutory powers and so cannot give lawful authority to disclosures of identifiable information without consent. In the event of a complaint or challenge, its advice on best practice might play an important part in any assessment of the propriety of a disclosure.

    Guidance from the General Medical Council, the Medical Research Council, the British Medical Association and draft guidance from the office of the Information Commissioner reflect the evolving legal position and reinforce the requirement for consent.

22. The Data Protection Act 1998.

    - www.parliament.the-stationery-office.co.uk

23. Information Commissioner. *Use and disclosure of health data: Guidance on the application of the Data Protection Act 1998*.

    - www.informationcommissioner.gov.uk

24. Information Commissioner: Data Sharing Code of Practice

    - http://www.ico.gov.uk/for_organisations/data_protection/topic_guides/data_sharing.aspx

25. Medical Research Council: *Human Tissue and Biological Samples for Use in Research: Operational and Ethical Guidelines*. (2001). MRC, London.

26. The Royal College of Physicians, The Royal College of Pathologists and British Society for Human Genetics. Consent and Confidentiality in Genetic Practice: Guidance on genetic testing and sharing genetic information. Report of the Joint Committee on Medical Genetics. London, 2005.

- http://www.rcoa.ac.uk/docs/Clinicians-Guide-Part-2-Standards.pdf
- www.rcpath.org/index.asp?PageID=1100
- www.publications.doh.gov.uk/pub/docs/doh/hgts.pdf

27. Human Genetics Commission:

    - www.hgc.gov.uk/Client/index.asp?ContentId=1

    Inside Information. Balancing Interests in the Use of Personal Genetic Data, 2002.

28. Medicines and Healthcare Products Regulatory Agency. *Management and Use of Point of Care Test Devices.* MDA DB 2002(03), 2002.

    - www.mhra.gov.uk

29. UK Newborn Screening Programme Centre - *Code of Practice for the Retention and Storage of Residual Newborn Blood Spots, 2005*.

    - http://newbornbloodspot.screening.nhs.uk/cms.php?folder=2547

30. Blood Safety and Quality Regulations, 2005, which incorporate into UK law Directive 2002/98/EC of the European Parliament and Council of 27 January 2003.

    (Setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components).

    - www.opsi.gov.uk/si/si2005/20050050.htm

31. Department of Health. Q and A on Disposal following Pregnancy Loss Before 24 Weeks Gestation, 2004.

    - www.dh.gov.uk/assetRoot/04/09/90/51/04099051.pdf

32. The Police and Criminal Evidence Act 1984:

    - http://www.homeoffice.gov.uk/publications/police/operational-policing/pace-codes/

33. The Human Tissue Act 2004:

    - http://www.legislation.gov.uk/ukpga/2004/30/contents

    with explanatory notes at:

    - http://www.legislation.gov.uk/ukpga/2004/30/notes/contents

34. GP Quality and Outcomes Framework

    GP organisational indicators on records and information about patients. See:

    - http://www.dh.gov.uk/assetRoot/04/08/86/93/04088693.pdf

35. Registration Authority governance arrangements. See:

    - http://www.connectingforhealth.nhs.uk/implementation/registrationauthorities/

36. The National Archives Employee Personnel Records – Records Management Retention Scheduling. This guidance issued by the National Archives in March 2006 reflects the position on the retention of personnel records for today's workforce. It can be viewed at:

    - www.nationalarchives.gov.uk

37. Guidance on the Microbiological Safety of Human Organs, Tissues and Cells used in Transplantation August 2000. This guidance updates and replaces the 'Guidance on the Microbiological Safety of Human Tissues and Organs used in Transplantation' issued in 1996.

    - http://www.dh.gov.uk/assetRoot/04/07/90/53/04079053.pdf

38. Information on ethical practice can be obtained from the British Medical Association at

    - http://www.bma.org.uk/_top/join_bma/jointhebmaintroduction.jsp?page=8

39. The Minimum Standards for Dental Care and Treatment

    These standards apply to you, and anyone attending with you for treatment, including a parent, guardian or carer. They set out what patients can expect from the dental team who provides their care and treatment.

    - http://www.dhsspsni.gov.uk/min_stds_dental_candt.pdf

Annex B

Annex B - ICT Programme - work programme

The implementation of the Information and Communications Technology Strategy (PDF 568KB) (published in March 2005) is bringing modern computer systems into the HSC to improve patient care and services.

Several new systems and services have been delivered since 2005, several systems and services are at implementation stage and others are planned over the new few years. The following is a summary of some of these new systems and services:-

Health + Care Number index

The Health + Care Number index provides a unique number for everyone using HSC services in Northern Ireland. This index is electronically linked to all of the major HSC ICT systems. Comprehensive use of this unique identifier is fundamental to creating service wide electronic care records as this number is the main link between records held on different ICT systems.

NIPACS – Northern Ireland Picture Archiving and Communications System

NIPACS enables images such as X-rays and scans to be stored electronically and viewed on video screens, so that doctors and other health professionals can access the information and compare it with previous images at the touch of a button.

NIPACS technology allows for a near filmless process, with all of the flexibility of digital systems. It takes away the need to distribute images manually; images can viewed at one, or across several, HSC locations, enabling clinicians and care teams working together to view common information and so speeding up diagnosis. NIPACS also removes all the costs associated with hard film and releases valuable space currently used for storage. Most importantly, however, NIPACS has the potential to transform patients' experience of the care they receive across the HSC.

Emergency Care Summary

This system is giving GP Out-of-Hours Centres and A&E departments access to information about patient medications and allergies. This information is extracted from the patient's GP records system and is used at the point of care. Previously doctors did not have access to this information and had to rely on the patient's recollection of his/her medication. The rollout of the system across NI will be completed during 2011.

Electronic Care Records (ECR)

Electronic Care Records are central to HSC reform and will transform the way that health and social care is managed. This service will provide an individual electronic care record for every patient in NI. It will give authorised health and care professionals access to service user information where and when it is needed. A very successful proof of concept pilot was

conducted during 2010. By the end of the pilot, more than 200 clinical staff in the Ulster and Belfast City hospitals were using the system. A business case is in preparation for the procurement and implementation of a NI wide Electronic Care Record system. The current timescale for beginning NI wide rollout is mid 2012. This system will subsume the functionality provided by the Emergency Care Summary.

Bowel cancer screening

The Bowel Screening Information Management System crown copyright software developed by Health Solutions Wales, was implemented in Northern Ireland in April 2010 to support the functions of the Call/Recall centre, bowel screening laboratory, pre-assessment in selected endoscopy units and the recording of management outcomes for screening participants. The call/recall centre is based in the BSO, Franklin Street, Belfast, linked to the existing Cervical Screening Centre and also provides a helpline facility to the programme.

Cancer Patient Pathways System (Capps)

Capps is a regional cancer care information system to monitor cancer waiting times and assure the timeliness of access to diagnosis and treatment services for cancer patients in accordance with the access standards. Capps is used routinely at Cancer multidisciplinary team meetings to assist in rapid decision on the patient's care and treatment plan. Capps was developed with very significant input from the Northern Ireland Cancer Registry.

Medicines Management Technology project

This system will be implemented in 2011 to support the Medicines Management initiatives being introduced across the HSC and prepare for the introduction of electronic prescribing. This project will modernise the hospital pharmacy ICT systems so they can support the necessary interfaces and functionality and a set of robotics systems for the larger pharmacies in the HSC.

Theatre Management System

The Theatre Management System has been implemented in all operating theatres in NI with the exception of theatres in Musgrave Park and the Royal Victoria hospitals. The core system has been in place for some time and provides functionality to manage theatres and schedule theatre sessions. Other modules, which add significant value, such as Stock Control, Surgeon's Assistant and CSSD are at implementation stage and will be implemented during 2011.

Regional Data Warehouse

The regional Data Warehouse is an important service provided by the HSC Business Services Organisation, that will protect the confidentiality of patients and will provide timely, pseudonymised patient-based data and information for purposes other than direct clinical care, including:

- planning and commissioning;

- public health and research;
- clinical audit and governance;
- benchmarking; and
- performance improvement.

Data is routinely extracted from operational systems across the HSC and loaded into the data warehouse. The data warehouse is used by staff at Trust, HSCB and DHSSPS levels. Access to the data is strictly controlled and where necessary the data is anonymised or pseudonymised. Each “type” of user has access to only the data that he/she is permitted to have access to.

GP ICT

All GP practices in Northern Ireland are now connected to the secure HSC data network. This network allows diagnostic test results (Radiology and Pathology) to be transferred electronically from Trust based diagnostic departments directly to the GP practice patient record system. All GP practices now have access to secure e-mail and have access to the internet.

Electronic referrals system

This system will provide the technology for referrals from Primary Care to Secondary Care to be made electronically. Initially this service will be only available for GP referrals to consultant led services in acute hospitals although the technology will support referrals from any service to any other service. The system uses Crown Copyright software developed by NHS Scotland where it is used to support the vast majority GP referrals. As well as speeding up the time that it takes for a referral to get from the GP practice to the hospital, the system will allow the introduction of structured referral protocols, ensuring that the referrer provides the required dataset to support the referral. Implementation will begin early in 2011.

The Payment Calculation and Analysis System (PCAS)

This system is similar to the English QMAS system. It is a single, NI wide IT system, which gives GP practices and the HSCB objective evidence and feedback on the quality of care delivered to patients. The system shows how well each practice is doing, measured against national achievement targets detailed in the General Medical Services (GMS) contract, which sets out the way GPs work and the way they are financially rewarded.

As GP practices are rewarded financially according to the quality of care they provide, it is essential that the payment rules that underpin the GMS contract are implemented consistently across all systems and all practices in the UK. PCAS ensures that this is achieved. PCAS allows GP practices to analyse the data they collect about the number of services and the quality of care they deliver, such as maternity services or chronic disease management clinics. This provides a positive incentive for GPs to treat patients in the community rather than referring them to hospital for treatment such as diagnosis or minor operations.

The above summaries were prepared at a point in time. For the latest update on ICT Programme Projects, please refer to the HSC ICT Programme website/.

Annex C

Annex C - Legal and Professional Obligations

There are a range of legal and professional obligations that limit, prohibit or set conditions in respect of the management, use and disclosure of information and, similarly, a range of statutes that permit or require information to be used or disclosed. Where necessary, organisations should obtain professional legal advice on the application of these provisions. The key legal and professional obligations covering personal and other information listed in this Annex are as follows:

- The Access to Health Records (Northern Ireland) Order 1993
- The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991
- Administrative Law
- The Adoption Agencies Regulations (Northern Ireland) 1989
- The Blood Safety and Quality Regulations 2005 (as amended)
- The Census (Confidentiality) (Northern Ireland) Order 1991
- The Civil Evidence (Northern Ireland) Order 1997
- The Common Law Duty of Confidentiality
  – Confidentiality: DHSSPS code of practice (PDF 111KB)
- The Computer Misuse Act 1990
- The Congenital Disabilities (Civil Liability) Act 1976
- The Consumer Protection (Northern Ireland) Order 1987
- The Control of Substances Hazardous to Health Regulations (Northern Ireland) 2003
- The Copyright, Designs and Patents Acts 1988
- The Data Protection Act (DPA) 1998
- The Data Protection (Processing of Sensitive Personal Data) Order 2000
- Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community Code Relating to Medicinal Products for Human Use
- The Electronic Communications Act 2000
- The Environmental Information Regulations 2004
- The Foster Placement (Children) Regulations (Northern Ireland) 1996
- The Freedom of Information Act (FOIA) 2000
- The Gender Recognition Act 2004

- The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) (No. 2) Order 2005
- The Health & Personal Social Services, General Dental Services (Amendment) Regulations (Northern Ireland) 2008
- The Health & Personal Social Services, General Medical Services Contracts Regulations (Northern Ireland) 2004
- The Health and Safety at Work (Northern Ireland) Order 1978
- The Health and Social Services (Reform) Act (Northern Ireland) 2009
- The Human Fertilisation and Embryology Act 1990, as amended by the Human Fertilisation and Embryology Act 2008
- The Human Rights Act 1998
- The Limitation (Northern Ireland) Order 1989
- Police Act 1997 and the Memorandum to A Code of Practice for Third Party recipients of Criminal Record Information
- The Privacy and Electronic Communications (EC Directive) Regulations 2003
- Public Health Act (Northern Ireland) 1967
- The Public Interest Disclosure (Northern Ireland) Order 1998
- The Public Records Act (Northern Ireland) 1923
- Disposal of Documents Order (Northern Ireland)1925
- The Radioactive Substances Act 1993
- The High-activity Sealed Radioactive Sources and Orphan Sources Regulations 2005
- The Re-use of Public Sector Information Regulations 2005
- The Sexual Offences (Amendment) Act 1992 (as amended by the Youth Justice and Criminal Evidence Act 1999)

Relevant Standards and Guidelines

- BSI DISC BIP 0008
- BS 5454:2000
- BS ISO/IEC 17799:2005 BS ISO/IEC 27001:2005 BS 7799-2:2005
- ISO 15489
- ISO 19005 – 1:2005
- The Records Management Controls Assurance Standard

- The Northern Ireland Records Management Standard

Professional Codes of Conduct

- British Association of Social Workers
- The British Dental Association (BDA) Northern Ireland
- The British Medical Association (BMA) Northern Ireland
- The Chartered Society of Physiotherapy: Rules of Professional Conduct
- The General Dental Council
- The General Medical Council
- The Health Archives Group (HAG)
- Health Professions Council
- NI Social Care Council: Codes of Practice for Social Care Workers and Employers
- The Nursing and Midwifery Council
- The Pharmaceutical Society of Northern Ireland
- The Royal College of General Practitioners
- The Royal College of Pathologists
- The Royal College of Physicians
- The Royal College of Surgeons of England

The Access to Health Records (Northern Ireland) Order 1993

This Order has been repealed to the extent that it now only affects the health records of deceased patients. It applies only to records created since 30 May 1994.

The Order allows access to:

a) the deceased's personal representatives (both executors or administrators) to enable them to carry out their duties; and

b) anyone who has a claim resulting from the death.

However, this is not a general right of access, it is a restricted right and the following circumstances could limit the applicant's access:

- if there is evidence that the deceased did not wish for any or part of their information to be disclosed; or
- if disclosure of the information would cause serious harm to the physical or mental health of any person; or
- if disclosure would identify a third party (i.e. not the patient nor a healthcare professional) who has not consented to that disclosure.

As with the Data Protection Act, a medical professional may be required to screen the notes before release.

Under the Order, if the record was made during the 40 days preceding the access request, access must be given within 21 days of the request. Where the record concerns information which was recorded more than 40 days before the application, access must be given within 40 days, however, as with the Data Protection Act 1998, organisations should endeavour to supply the information within 21 days.

No fee may be charged for providing access to the information if the records have been made, amended or added to in the 40 days before the application is made. The fee which may be charged where all the records were made more than 40 days before the application is made is that prescribed under section 7 of the Data Protection Act 1998 - the maximum fee which can generally be charged under this provision is currently £10 (see the Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000)

Where a copy is supplied, a fee not exceeding the cost of making the copy may be charged. The copy charges should be reasonable, as the doctor or organisation may have to justify them. If applicable, the cost of posting the records may also be charged.

Records management considerations

Organisations should have processes that address where and how the records of deceased persons are stored. Secure and environmentally safe storage is vital to ensure that records are maintained in good order and are available if required.

It is essential that organisations put in place processes and procedures to enable the efficient and effective retrieval of such records within the timescales specified by the Data Protection Act.

This applies to records in all formats.

The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

The aim of the Order is to allow individuals to see medical reports written about them, for employment or insurance purposes, by a doctor who they usually see in a 'normal' doctor/patient capacity. This right can be exercised either before or after the report is sent.

The patient may view the report by obtaining a photocopy, or by attending the organisation to read the report without taking a copy away. The patient has a right to view the report from the time it is written and has a window of opportunity to do so before the report is supplied, or he/she may view it after supply for up to six months.

However, in certain circumstances the patient may be prohibited from viewing all or part of the report if:

- in the opinion of the doctor, viewing the report may cause serious harm to the physical or mental health of the patient or others; or
- access to the report would disclose information concerning the identity of a third party where that third party has not consented to the disclosure.

The patient retains the right to withdraw consent to the report's preparation and/or supply at any time. Therefore, if the patient is unable to view any of the report due to one of the circumstances listed above, he/she can refuse to allow it to be supplied.

If a patient disagrees with the content of the report, he/she has several options.

He/she can:

- refuse to allow its supply;
- ask the doctor to correct agreed inaccuracies; or
- have a note added addressing the point(s) of disagreement.

Records management considerations

It is important that these reports remain accessible to the patient for at least six months after they have been supplied to the employer or insurer. After six months, organisations should consider whether retention is necessary; however, if they do decide to retain the report it must be accessible should a subsequent subject access request be made.

Administrative Law

Administrative law governs the actions of public authorities. According to well-established rules, a public authority must possess the power to carry out what it intends to do. If not, its action is 'ultra vires', i.e. beyond its lawful powers. It is also necessary that the power is exercised for the purpose for which it was created or is 'reasonably incidental' to the defined purpose.

It is important that all HSC bodies are aware of the extent and limitations of their powers and act 'intra vires'. The approach often adopted by Government to address situations where a disclosure of information is prevented by lack of function (the 'ultra vires' rule), is to create, through legislation, new statutory gateways that provide public sector bodies with the appropriate information disclosure function. However, unless such legislation explicitly requires that confidential patient/client information be disclosed, or provides for common law confidentiality obligations to be set aside, then these obligations must be satisfied prior to information disclosure and use taking place, for example by obtaining explicit patient/client consent.

Records management considerations

Staff should be trained in the legal framework covering the disclosure of confidential patient/client information. They should also be provided with procedures for obtaining explicit consent and guidance on where to seek advice if they are unsure whether they should disclose such information.

The Adoption Agencies Regulations (Northern Ireland) 1989

The Regulations require that adoption agencies keep records on the adopted children they have placed for at least 75 years and provide for disclosure of information in certain circumstances.

Blood Safety and Quality Regulations 2005 (as amended)

The Regulations implement the provisions of Directive 2002/98/EC and associated Directives so that the retention periods for data relating to human blood and blood components outlined in the Directive are now part of UK law. The retention periods are as follows:

- Blood establishments must retain certain information regarding donors, establishment activity and testing of donated blood for a minimum of 15 years (regulation 7).
- Blood establishments and hospital blood banks must retain data needed for full traceability for at least 30 years from the point of receipt of the blood or blood component (regulations 8 and 9).

The data that should be retained for 30 years in order to comply with the traceability requirements is as follows:

Data to be retained by blood establishments:

- blood establishment identification;
- blood donor identification;
- blood unit identification;
- individual blood component identification;
- date of collection (year/month/day); and
- facilities to which blood units or blood components are distributed, or subsequent disposal.

Data to be retained by facilities:

- blood component supplier identification;
- issued blood component identification;
- transfused recipient identification;
- for blood units not transfused, confirmation of subsequent disposal;
- date of transfusion or disposal (year/month/day); and
- lot number of the component, if relevant.

Blood establishments and hospital blood banks must retain a record of any serious adverse events which may affect the quality or safety of blood and blood components for a minimum of 15 years (regulations 7 and 9).

The Regulations also set out requirements for maintaining the confidentiality and security of data (regulation 14) and provide that identifiable information held by blood establishments and blood banks must not be disclosed to third parties unless it is for one of the following reasons:

- to comply with a court order;
- to assist an inspector appointed by the Secretary of State in accordance with the Regulations; or
- to enable tracing of a donation from donor to recipient or from recipient to donor.

Records management considerations

Organisations must ensure that they are able to provide full traceability of whole blood and blood components. There should be a record keeping system that:

- allows for identification of each single blood donation and each single blood unit and components thereof; and
- enables full traceability to the donor as well as to the transfusion and the recipient.

That is, the method of recording must unmistakably identify each unique donation and type of blood component, the location at which the donation was received and to whom that donation was given.

The Census (Confidentiality) (Northern Ireland) Order 1991

The Order makes it a criminal offence to unlawfully disclose personal census information.

If any officer of the DHSSPS or anyone acting on that Department's behalf discloses such information they are committing an offence.

If any person further discloses information knowingly acquired by unlawful disclosure, they are committing an offence.

The defences to a charge of unlawful disclosure are that at the time of the alleged offence the person believed:

- that he was acting with lawful authority; or
- that the information in question was not personal census information and that he had no reasonable cause to believe otherwise.

The penalties if convicted are:

- in the magistrates' court, up to six months' imprisonment and/or a fine; or
- in the Crown court, two years' maximum imprisonment and/or a fine.

Records management considerations

Any staff that may use census information for their work must be instructed on the lawful way in which they may use it and the processes put in place to ensure that unlawful disclosure does not occur.

The Civil Evidence (Northern Ireland) Order 1997

This Order provides the legal basis for the use of documents and records of any format to be admissible as evidence in civil proceedings. This includes electronic patient records.

Statements contained within documents may be admissible even where the original document has been lost and only a copy is available.

Documents that form part of a record are also admissible as long as the public authority supplies a signed certificate verifying the authenticity of the document.

Records management considerations

A public authority is making a legal statement by authenticating such documents and records, therefore the organisation must be sure of the quality and reliability of an electronic record. It will therefore be important to be able to verify that the computer was not misused and was operating properly at the time the record was produced.

The Common Law Duty of Confidentiality

Common law is not written out in one document like an Act of Parliament. It is a form of law based on previous court cases decided by judges; hence, it is also referred to as 'judge-made' or case law. The law is applied by reference to those previous cases, so common law is also said to be based on precedent.

The general position is that if information is given in circumstances where it is expected that a duty of confidence applies, that information cannot normally be disclosed without the information provider's consent.

In practice, this means that all patient/client information, whether held on paper, computer, visually or audio recorded, or held in the memory of the professional, must not normally be disclosed without the consent of the patient/client. It is irrelevant for example how old the patient/client is, or what the state of his/her mental health is; the duty still applies.

Three circumstances making disclosure of confidential information lawful are:

- where the individual to whom the information relates has consented;
- where disclosure is necessary to safeguard the individual, or others, or is in the public interest; or
- where there is a legal duty to do so, for example a court order.

Therefore, under the common law, a health or social care provider wishing to disclose a patient's/client's personal information to anyone outside the team providing care should first seek the consent of that patient/client.

Where this is not possible, an organisation may be able to rely on disclosure being in the overriding safeguarding interest of the individual or others or in the public interest. However, whether a disclosure is in the public interest is not a decision to be taken lightly. Solid justification is required before individual rights are set aside and specialist or legal advice should be sought before the information is disclosed. Any decision to disclose should be fully documented.

Disclosures required by court order should be referred to the organisation's legal advisors as promptly as possible, so that any necessary representations may be made to the court, for example to limit the information requested.

If a disclosure is made which is not permitted under common law the patient/client could possibly bring a legal action not only against the organisation but also against the individual responsible for the breach.

Records management considerations

All persons involved in the records management function should be aware of their responsibility for maintaining confidentiality of records. Employees should only have access to those parts of the record required to carry out their role. Requests for records access by other staff members

should be logged and periodically audited. Particular care should be taken during the transportation of health and social care records outside of the organisational site, for example security envelopes and approved carriers should be used where necessary.

Confidentiality: DHSSPS Code of Practice on Protecting the Confidentiality of Service User Information issued January 2009

The Confidentiality Code of Practice is a result of a major public consultation that included patients, clients, carers and citizens, the DHSSPS, other health and social care providers, professional bodies and regulators.

The Code offers detailed guidance on:

- protecting confidential information;
- informing service users about uses of their personal information;
- offering service users appropriate choices about the uses of their personal information; and
- the circumstances in which confidential information may be used or disclosed.

The Department of Health, Social Services and Public Safety, Code of Practice on Protecting the Confidentiality of Service User Information can be found at:.

- Code of Practice on Protecting the Confidentiality of Service User Information (PDF 249KB)

Disclosure after a patient's death

There are no clear legal obligations of confidentiality that apply to the deceased. Nevertheless the DHSSPS, Department of Health and the General Medical Council agree there is an ethical obligation requiring that confidentiality obligations continue to apply after death. The Common Law Duty of Confidentiality arguably applies to deceased patients' records, as per the Information Tribunal Appeal Number: EA/2006/0010 of 17 Sep 2007 between PAULINE BLUCK, the INFORMATION COMMISSIONER and EPSOM & ST HELIER UNIVERSITY NHS TRUST and **Lewis v Secretary of State for Health [2008]** EWHC 2196.

The General Medical Councils guidance can be found at:

- http://www.gmc-uk.org/guidance/current/library/confidentiality.asp

The Department of Health guidance can be found at:

- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112916

The Information Commissioner's guidance can be found at

- http://www.ico.gov.uk/upload/documents/library/freedom_of_information/detailed_specialist_guides/informationaboutthedeceased.pdf

The Computer Misuse Act 1990

The Act is relevant to electronic records in that it creates three offences of unlawfully gaining access to computer programmes.

The offences are:

- unauthorised access to computer material;
- unauthorised access with intent to commit or facilitate commission of further offences; and
- unauthorised acts with intent to impair, or with recklessness as to impairing, operation of computer, etc.

The Act also makes it an offence to make, adapt, supply or obtain articles for use in unlawfully gaining access to computer material or impairing the operation of a computer

Access is defined in the Act as:

- altering or erasing the computer programme or data;
- copying or moving the programme or data;
- using the programme or data; or
- outputting the programme or data from the computer in which it is held (whether by having it displayed or in any other manner).

Unlawful access is committed if the individual intentionally gains access; knowing he is not entitled to do so; and aware he does not have consent to gain access.

Records management considerations

It is important that all staff members are aware of and comply with all security measures put in place to protect all of the Organisation's records. The Organisation should have policies and procedures in place to facilitate compliance alongside disciplinary measures for failure to comply.

The Congenital Disabilities (Civil Liability) Act 1976

Where a child is born disabled due to negligent treatment of the mother during pregnancy, the child can bring a civil action for damages. This is a separate right to that of the mother. In such a case the limitation period only begins once the child has reached the age of 18 years. The period may be extended where material facts are not known.

Records management considerations

Organisations need to take the provisions of this Act into account and ensure that the health records of all children and, in particular, the records of children born with a disability are not prematurely destroyed.

The Consumer Protection (Northern Ireland) Order 1987

The Order allows persons who have suffered damage/injury to themselves or to their private property to make a compensation claim against the manufacturer or supplier of a product. The claimant does not need to prove that the manufacturer/supplier was negligent; merely that it was the product that caused the damage.

Article 8(3) of the Limitation (Northern Ireland) Order 1989 provides that actions in respect of damages for defective products shall not be brought after the expiration of 10 years from the date of supply/manufacture etc in accordance with terms of Article 7 of the Consumer Protection (Northern Ireland) Order 1987.

Article 8(4) provides that an action for damages for personal injury caused by a defective product, or of loss of, or damage to any property, shall not be later than:

- three years from the date the cause of action accrued; or
- three years from the date of knowledge of the injured person or property owner, whichever is the later.

However, it needs to be noted that Article 50 of the Limitation (NI) Order 1989 provides a discretion to allow an action for damages for personal injury or death to proceed (including damages in respect of personal injury/death caused by a defective product) if there would otherwise be prejudice to a party to legal proceedings. This discretion does not extend to a claim for loss or damage to property caused by defective products.

Records management considerations

A claimant generally has three years to begin legal action after the damage, however this period may be extended to ten years after the product was supplied. The HSC is affected by these provisions and may be liable as a supplier or user of a product. Therefore, it is important that accurate records are maintained for all products that may fall into this category in order that any claim can be defended.

The Control of Substances Hazardous to Health Regulations (Northern Ireland) (COSHH) 2003

(See: http://www.hse.gov.uk/coshh/index.htm)

The COSHH regulations specify the eight measures that employers must follow to prevent or limit their employees' exposure to hazardous substances.

The measures are:

- assess the risks.
- decide what precautions are needed.
- prevent or adequately control exposure.
- ensure that control measures are used and maintained.
- monitor the exposure.
- carry out appropriate health surveillance.
- prepare plans and procedures to deal with accidents, incidents and emergencies.
- ensure employees are properly informed, trained and supervised.

Records management considerations

The regulations require that organisations retain records of risk assessments, control measures, exposure monitoring and health surveillance. Some of these records must be kept for specified periods; these are detailed in the disposal schedule in Part 2 of GMGR.

The Copyright, Designs and Patents Act 1988

The Act protects the intellectual property of individuals and requires that permission of the owner of the intellectual property is sought before any use of it is made – this includes storage and display on the intranet, extranet, internet or other electronic information services.

Organisation web pages should not contain, or distribute, text or images to which a third party holds an intellectual property right, without the express written permission of the author. The author may have quoted other people's material and if this is the case, such a third party would also need to give permission.

Records management considerations

Corporate web pages where information is published should be checked for infringement of the Act and/or that necessary permissions or acknowledgements have been given. If there is any doubt, check with your legal advisers.

The Data Protection Act (DPA) 1998

The Act regulates the processing of personal data, held manually and on computer. It applies to personal information generally, not just to health records, therefore the same principles apply to records of employees held by employers, for example in finance, personnel and occupational health departments.

Personal data is defined as data relating to a living individual that enables him/her to be identified either from that data alone or from that data in conjunction with other information in the data controller's possession. It therefore includes such items of information as an individual's name, address, age, race, religion, gender, and physical, mental or sexual health.

Processing includes everything done with that information, i.e. holding, obtaining, recording, using, disclosure and sharing it. Using includes disposal, i.e. closure of the record, transfer to an archive or destruction of the record.

The Act contains three key strands. These deal with:

- notification by a data controller to the Information Commissioner;
- compliance with the eight data protection principles; and
- observing the rights of data subjects.

Notification by a data controller

The data controller is the person who determines how and why personal information is processed. The action of notification can be delegated to the most appropriate person within the organisation, for example the information management, or information governance lead.

Notification is the process of informing the Information Commissioner of the fact that processing of personal data is being carried out within a particular organisation. Its purpose is to achieve openness and transparency – notification entries are placed in a register so that members of the public can check the type of processing being carried out by a particular organisation. The notification process involves completion of a form stating the name of the data controller and detailing the types of processing being carried out.

There are three ways to notify

- On the internet
  https://www.ico.gov.uk/cgi-bin//dprproc?page=7.html
- requesting a notification form
  http://www.ico.gov.uk/upload/documents/library/data_protection/forms/request_for_notification_form.pdf

or

- by telephone
  You can telephone the notification helpline on 03031231113 between the hours of

9.00am and 5.00pm

Compliance with the eight data protection principles

The eight principles advocate fairness and openness in the processing of personal information. The principles are:

1. Personal data shall be processed fairly and lawfully and must be processed in accordance with at least one of the conditions in schedule 2 of the Act. Where the data being processed is sensitive personal information (such as data relating to the physical or mental health of an individual), it must also be processed in accordance with at least one of the conditions in schedule 3 of the Act.
2. Personal data shall be obtained only for one or more specified and lawful purpose.
3. Personal data shall be adequate, relevant and not excessive for its purpose(s).
4. Personal data shall be accurate and where necessary kept up to date.
5. Personal data shall not be kept for longer than is necessary for its purpose(s).
6. Personal data shall be processed in accordance with the rights of data subjects under this Act.
7. Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.
8. Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country or territory ensures an adequate level of data protection.

Records management considerations

Principle 1

The aim of this principle is to ensure that personal data are processed fairly and lawfully and in accordance with a relevant condition from the schedules to the Act.

To meet the fair processing requirement, individuals must be informed of the fact of processing, including what information will be collected, and how it will be held, recorded, used and shared. The Information Commissioner has issued guidance about the meaning of fair processing which indicates that the processing of personal data for purposes other than those for which the data has been provided may be unfair.

To meet the lawful processing requirement, personal data must be processed in accordance with all relevant laws, that is, other statutes such as Article 8 of the European Convention on Human Rights or the common law, such as the duty of confidence.

Health and social care records contain both personal and sensitive data within the terms of the Act, therefore processing can only be carried out if a condition from both schedules 2 and 3 is met.

The relevant condition to be satisfied for schedule 2 is likely to be one of the following:

- where the processing is necessary for the exercise of any functions conferred on any person by or under any enactment;
- where the processing is necessary for the exercise of any other functions of a public nature exercised in the public by any person;
- where the processing is necessary to protect the vital interests of the patient/client, i.e. a 'life or death' situation; or
- with the consent of the patient.

The relevant condition to be satisfied for schedule 3 is likely to be one of the following:

- for medical purposes by a health professional or by a person who owes the same duty of confidentiality as a health professional;
- where the processing is necessary to protect the vital interests of the patient/client or another person, i.e. a 'life or death' situation, where consent cannot be obtained or the data controller cannot reasonably be expected to obtain consent;
- where the processing is necessary to protect another person, where consent of the patient/client has been unreasonably withheld; or
- with the explicit consent of the patient.

Although the Act does not state that explicit consent is required for the processing of health and social care information, compliance with the 'lawful' requirement means that the common law duty of confidence must be taken into account. This duty requires that information given in confidence may not be disclosed without the consent of the giver of that information. Therefore, where health and social care information will be disclosed to someone outside the care team, consent to the processing is necessary – see Common Law Duty of Confidentiality.

Principle 2

This principle requires that personal data is not processed in a way that is incompatible with the purpose for which it was obtained. Organisations need to specify how they process information in their notification to the Information Commissioner. They are then required to ensure that all processing carried out is in accordance with those stated purposes. Patients/clients should be fully informed about the reason that their information is required, i.e. they are not misled into providing information for purposes of which they have no knowledge. If information is obtained for a specific purpose, it must not be used for anything else unless consent is obtained for further uses of the information. For example, identifiable patient information gathered to provide health or social care cannot be used for research unless patient consent is obtained or the information is anonymised. Similarly, employee information collected to enable salary payment should not be used for purposes unrelated to this, for example, marketing of products and services, unless consent is obtained. This principle reinforces the first principle in that it enables

patients/clients and the public to find out how a particular organisation states it will use their information.

Principle 3

The aim of this principle is to ensure that organisational records management policies and procedures are in place to support the gathering of relevant, adequate information that is not excessive for its purpose. Organisations should therefore ensure that the information collection procedures in place enable relevant questions to be asked and that training on information collection is made available to all relevant employees.

Systems and processes should be designed to ensure only relevant information is captured and processed.

The organisation should have procedures in place setting out 'need to know' access controls alongside processes that enable conformance to those controls for each member of staff.

Principle 4

Organisations may wish to follow the procedures and processes described in the Information Quality Assurance requirements of the Information Governance Toolkit at www.nhsia.nhs.uk/infogov/IGT which applies in England. The procedures and processes should ensure that information is accurate and kept up to date.

Principle 5

The organisation should have procedures and processes in place for records appraisal so that records are kept for no longer than necessary for the purpose for which they are processed. However, organisations should ensure that records are retained for the minimum periods specified in this Code.

The organisation should put in place disposal arrangements for the destruction, archiving and closure of records, and procedures to prevent unnecessary copying of information.

Archival bodies such as the Public Record Office of Northern Ireland are exempt from the 5th principle and are permitted to hold transferred public records indefinitely.

Principle 6

See Rights of data subjects.

Principle 7

Records storage conditions must provide environmentally safe protection for current and archived records.

Records must be protected by effective information security management and records management staff members should be aware of and comply with measures put in place.

Principle 8

This principle is not infringed if the explicit informed consent of the individual is obtained for the transfer. Organisations must ensure that their contract includes terms to cover the protection of the data by the agency to the equivalent of the protection provided by the Data Protection Act 1998.

Rights of the data subject

The Data Protection Act gives an individual several rights in relation to the information held about them.

Of particular relevance in a health and social care setting, is the right of individuals to seek access to their records held by the health or social care provider.

Access covers the right to obtain a copy of the record in permanent form, unless the supply of a copy would involve disproportionate effort or the individual agrees that his/her access rights can be met some other way, for example, by viewing the record.

Access must be given promptly and in any event within 40 days of receipt of the fee and request. If the application does not include sufficient details to identify the person making the request or to locate the information, those details should be sought promptly and the 40-day period begins when the details have been supplied.

If access has been given, there is no obligation to give access again until a reasonable period has elapsed. What is reasonable depends on the nature of the data, the purposes for which it is processed and the frequency with which it has been altered.

The right of access is exercisable by the individual:

- making a written application to the organisation holding the records;
- providing such further information as the organisation may require to sufficiently identify the individual; and
- paying the relevant fee.

The fee for providing the individual with a copy of a computerised record is £10. For healthcare records held partially or entirely on paper, the maximum amount that can be charged is £50.

If no permanent record is requested, no fee for access may be made to records that are accessible and contain at least some entries made in the 40-day time period preceding the request, and not, nor intended to be, automatically processed. A fee of £10 may be charged for viewing records that have not been added to in the 40 days prior to the access request.

There are two main exemptions from the requirement to provide access to personal data in response to a subject access request. These are:

- If the record contains third-party information (e.g. not about the patient or the treating clinician) where that third party is not a healthcare professional and has not consented to

their information being disclosed. If possible, the individual should be provided with access to the part of the record that does not contain the third-party identifier.

- If access to all or part of the record will seriously harm the physical or mental well-being of the individual or any other person. If possible, the individual should be provided with access to that part of the record that does not pose the risk of serious harm.

Records management considerations

Records management staff members have a key role in ensuring that health and social care records can be located, retrieved and supplied in a timely manner. It is important that document management structures are set up in such a way as to enable them to carry out this role.

The Data Protection (Processing of Sensitive Personal Data) Order 2000

This Order amends the Data Protection Act 1998 and provides that sensitive personal data (for example information relating to physical or mental health) may be lawfully processed without explicit consent where there is a substantial public interest in disclosing the data for any of the following purposes:

- for the detection and prevention of crime;
- for the protection of members of the public against malpractice, incompetence, mismanagement etc;
- to publicise the fact of malpractice, incompetence, mismanagement etc, for the protection of the public;
- to provide confidential counselling and advice where explicit consent cannot be given nor reasonably obtained, or where the processing must be carried out without explicit consent so as not to prejudice that confidential counselling or advice; or
- to undertake research that does not support measures or decisions with respect to any particular data subject unless the data subject has explicitly consented and does not cause, nor is likely to cause, substantial damage or substantial distress to the data subject or any other person.

Sensitive personal data may also be lawfully processed where:

- the information relates to the data subject or to specific relatives of the data subject and the processing is for the purposes of administering defined insurance business or occupational pensions schemes;
- the processing is carried out by a person authorised under the Registration of Political Parties Act 1998 in the course of their legitimate political business as long as the processing does not cause, nor is likely to cause, substantial damage or substantial distress to the data subject or any other person; or
- the processing is necessary for the exercise of any functions conferred on a constable by any rule of law.

Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community Code Relating to Medicinal Products for Human Use

The directive lays down rules governing the production, distribution and use of medicinal products. It is relevant here as it sets retention periods for information gathered in the course of clinical trials.

The trial investigator has a duty to retain patient identification codes for at least 15 years following the trial.

The healthcare organisation at which the trial was carried out must retain the health records of the patients involved for the maximum period possible, i.e. 30 years.

The sponsor of the clinical trial must retain all other documentation pertinent to the trial as long as the product is authorised.

The sponsor or successor must retain the final report of products that are no longer authorised for five years.

The Electronic Communications Act 2000

Part I of this Act which deals with the cryptography service providers never came into force and has now been repealed (see section 16(4) of the Act which provides for repeal of Part I if no order bringing it into force is made within 5 years of the passing of the Act). Section 8 of the Act provides a power to modify legislation to remove restrictions arising from other legislation which prevent the use of electronic communications or storage in place of paper. The Act increases confidence in electronic transactions by providing legal admissibility for digital signatures.

Records management considerations

Organisations should ensure that electronic information is held and transferred in accordance with the Act and other provisions to ensure that confidential information is accessed only by those with a need to know it in order to carry out their role.

The Environmental Information Regulations 2004

The Environmental Information Regulations 2004 came into force at the same time as the Freedom of Information Act 2000 and update and extend previous rights to environmental information.

Any request for information held by/on behalf of a public authority is initially treated as a Freedom of Information request. However, section 39 of the Freedom of Information Act exempts environmental information from being dealt with under freedom of information and provides for it to be dealt with under the Environment Information Regulations (EIR) 2004. This means that there may be cases where information is exempt under freedom of information but has to be released under these regulations.

The regulations are very similar to the Freedom of Information Act and requests for environmental information are dealt with in a similar way to those for other information. The key differences between EIR and the Freedom of Information Act are:

- A wider range of organisations are covered by the EIR, including some private organisations.
- The EIR relates to environmental information only.
- Requests for information do not have to be in writing under the EIR; they can be verbal.
- All exemptions for refusing an EIR request are subject to a public interest test.

Personal information of the applicant continues to be dealt with under data protection.

Records management considerations

As with the Freedom of Information Act the organisation needs a robust records management programme. The requirements of the two pieces of legislation are similar so it is advised that organisations deal with EIR requests in a like manner. The main difference is that requests for environmental information need not be in writing.

The Foster Placement (Children) Regulations (Northern Ireland) 1996

The Regulations provide that an authority must compile and maintain a record for each foster parent it has approved or placed a child with. It must also maintain a record for each prospective foster parent it has not approved. These records must be kept for at least 10 years from the date on which the approval is terminated, or until the person's death, if earlier. The Regulations also contain a requirement to ensure that the information is treated as confidential, subject to any statutory provision or court order under which the information may be given.

The Freedom of Information Act (FOIA) 2000

The FOIA lays down requirements for public bodies (including the HSC) to keep and make information available on request. The new rights of access in the FOIA signal a new recognition of, and commitment to, the public interest in openness about government. They are additional to other access rights, such as access to personal information under the Data Protection Act 1998, and access to environmental information under the EIR 2004.

The main features of the Act are:

- a general right of access to recorded information held by public authorities, regardless of the age of the record/document; and
- a duty on every public authority to adopt and maintain a scheme, which relates to the publication of information by the authority and is approved by the Information Commissioner.

Section 46 of the Act places a duty on the Lord Chancellor to issue a Code of Practice on records management. The Code has been published and although compliance is not obligatory, it provides guidance to all public authorities as to the practice which it would, in the opinion of the Lord Chancellor, be desirable for them to follow in connection with the discharge of their functions under the FOIA. Additionally, the Code will be used by the Information Commissioner when deciding whether a public authority has properly dealt with a case (in the event of a complaint).

General right of access

The Act confers two rights on the general public:

- the right to be informed whether a public body holds certain information; and
- the right to have that information communicated to it.

However, the Act recognises that there can be valid grounds for withholding information and provides a number of exemptions from the right to know, some of which are absolute exemptions and some of which are subject to a public interest test.

As regards exemptions subject to the public interest test, organisations must weigh up whether the public interest in maintaining the exemption in question outweighs the public interest in disclosure.

The request for information must:

- be in writing;
- state the name of the applicant and an address for correspondence; and
- describe the information requested.

The applicant can request that information be communicated by:

- a copy in permanent form (or other form acceptable to them, for example on CD-ROM or audio tape);
- examination of records; or
- a summary or digest of the information held.

Organisations may charge a fee for reasonably incurred costs to:

- inform the applicant whether it holds the information; and
- communicate the information to the applicant.

However, they are not obliged to charge a fee, and the Ministry of Justice suggests that where the costs incurred are minimal, the fee should be waived. If a fee is required, this should be notified to the applicant and paid within three months of receipt of the notice, otherwise the public authority need not comply with the request.

A fee may be charged to cover:

- the cost of putting the information into the applicant's requested format, for example CD, or audio tape;
- photocopying and printing costs (set at no more than 10 pence per page); and
- postage or other transmission costs.

In calculating the cost of the above, organisations are not permitted to take account of employee time required to carry out the work. Additionally, organisations may not charge for putting the information into another format if they are already under a duty to make information accessible under other legislation, for example the Disability Discrimination Act 1995.

There may be a few cases where the costs of meeting a request would exceed the appropriate limit, set at £450 (for central government the limit is £600). If this is the case, organisations are allowed to refuse to answer the request.

Public authorities must reply promptly to the request and no later than the 20th working day following receipt of the request or further information and/or the appropriate fee. This period can be altered by the Secretary of State (up to the 60th working day).

A public authority need not comply with vexatious requests and repeated requests for information already supplied, unless a reasonable period has elapsed between requests.

Publication scheme

A publication scheme should be a complete guide to the information routinely published by an organisation. It is a description of the information about the organisation which is made publicly available and which should act as a route map so that the public can easily find information about the organisation.

The publication scheme must specify:

- the classes of information published, or intended to be published;

- the manner in which publication is, or is intended to be made;
- whether the information is available free of charge or whether payment is required.

Records management considerations

The organisation should carry out an information audit to determine what records it holds, the locations of the records and whether they need to be kept – this should lead to a review of the organisation's retention schedules and provide information for its publication scheme.

As with Data Protection Act subject access requests, efficient and knowledgeable records management staff and effective records management procedures are crucial to compliance with this Act. There is a duty imposed on organisations to supply information in a timely fashion – currently within 20 working days. To facilitate this obligation to provide information within these time limits the organisation must ensure that all employees are aware of how an FOIA application should be progressed and of the requirement to respond to requests quickly.

Organisations should consider maintaining a log of requests with the view to making frequently requested information available through its publication scheme.

The Gender Recognition Act 2004

The Act gives transsexual people the legal right to live in their acquired gender. It established the Gender Recognition Panel, who have the authority to issue a Gender Recognition Certificate. Issue of a full certificate provides legal recognition of the transsexual person's acquired gender.

Under the Act, information relating to an application for a Gender Recognition Certificate is 'protected information' if it is acquired in a professional capacity. It is an offence to disclose protected information to any other person unless an exemption applies. Some of the exemptions are:

- the person has consented;
- the person cannot be identified from the information;
- information is needed for prevention and investigation of crime;
- information is needed to comply with a court order.

Records management considerations

Applicants to the Gender Recognition Panel are required to supply evidence from a medical practitioner in support of their application. As 'protected information' covers all information that would identify a person as being a transsexual, if successful in their application a new health record must be created so that protected information is not disclosed.

The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) (No. 2) Order 2005

It is not an offence to disclose the 'protected information' referred to under the Gender Recognition Act 2004 if:

- the disclosure is made for medical purposes to a health professional; and
- the person making the disclosure reasonably believes that the subject has given consent to the disclosure or cannot give such consent.

'Medical purposes' includes the purposes of preventative medicine, medical diagnosis and the provision of care and treatment.

The Health and Personal Social Services, General Dental Services (Amendment) Regulations (Northern Ireland) 2008

Health and Personal Social Services General Dental Services Regulations (NI) 1993 as amended by the Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008.

These Regulations provide for the arrangements under which general dental services are provided under Part VI of the Health and Personal Social Services (NI) Order 1972. The terms of service under which dentists provide general dental services to their patients are set out in Schedule 2 to the Regulations.

Records management considerations

Records in respect of care and treatment, including radiographs, photos and study models must be retained for a period of 6 years after the treatment to which they relate has been completed. By the amendment in 2008 the period of 6 years replaced a period of two years.

Records may be kept in computerised form. Dentists must compile, maintain accurate and make available a patient information leaflet to any person who may reasonably require one. The information to be included in the leaflets is set out in Schedule 6 to the Regulations.

The Health and Personal Social Services, (General Medical Services Contracts) Regulations (Northern Ireland) 2004

These Regulations set out the framework for general medical services under Article 57 of the Health and Personal Social Services (NI) Order 1972.

The Regulations set out the conditions which must be included in the terms of a general medical services contract between the Boards and a general medical practitioner. In particular Part 5 of Schedule 5 to the Regulations includes terms relating to patient records.

Records management considerations

Patients' records may be kept manually, in computerised form (with the Board's consent) or a combination of those two ways. The consent of the Board is required to give such consent where it is satisfied that the computer system has been accredited by DHSSPS, security measures have been enabled and the contractor has undertaken to have regard to guidelines issued from time to time by DHSSPS.

GP contractors must compile and make available to patients a patient information leaflet. The information to be included in the leaflet is set out in Schedule 8 to the Regulations.

The Health and Safety at Work (Northern Ireland) Order 1978

The Order imposes duties on employers to look after the health and safety of their employees and responsibilities on employees to comply with the measures put in place for their health and safety.

There are various regulations made under this Order concerned with health and safety at work including:

- Management of Health and Safety at Work Regulations (NI) 2000
- Workplace (Health Safety and Welfare) Regulations (NI) 1993
- Health and Safety (Display Screen Equipment) Regulations (NI) 1992
- Provision and Use of Work Equipment Regulations (NI) 1999
- Manual Handling Operations Regulations (NI) 1992
- Personal Protective Equipment at Work Regulations (NI) 1993.

The regulations require that employers carry out risk assessments and provide employees with information and training where necessary.

The Management of Health and Safety at Work Regulations (NI) 2000 sets out more explicitly what organisations must do to comply with the Health and Safety at Work (NI) Order. The Health and Safety Executive in GB has published an approved Code of Practice for use with the regulations, (Management of Health and Safety at Work Regulations 1999 Approved Code of Practice) which has been approved for use in NI by the Health and Safety Executive (NI). It can be downloaded from http://www.hseni.gov.uk/resources/codes-of-practice.htm or purchased from http://www.hsebooks.com/Books. The Code has a special legal status – a court will take account of whether an organisation has followed the Code in prosecutions for breach of health and safety legislation, unless the organisation can prove that they complied with the law in some other way.

Records management considerations

Organisations should retain equipment maintenance records, records of assessments and training records etc for appropriate periods, as proof that they are complying with the law and maintaining the safety of their employees. Retention of these records will also assist organisations to appropriately defend against any legal action and comply with investigations carried out by the Health and Safety Executive NI and/or RQIA.

The Human Fertilisation and Embryology Act 1990 (as amended by The Human Fertilisation and Embryology Act 2008)

The Act is retrospective and applies to information obtained before and after it was passed.

Information which has been obtained by any person as a member or an employee of the Human Fertilisation and Embryology Authority (HFEA), a person to whom a licence applies, including those covered by third party agreements, those to whom directions from the HFEA have been given, and authorised people who are carrying out functions which have been contracted out to them by the HFEA (and their members of staff or employees), may not be disclosed except to the categories of person or in the circumstances specified in the Act.

The Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004 (SI 1511) prescribe the information which the HFEA will provide to persons who have attained the age of 18 and who may have been born in consequence of treatment services under the Act.

Records management considerations

To meet the requirements of this Act, organisations must ensure they have processes in place to ensure that such information is available only to those permitted access. This is especially important as regards paper records, where information on this form of treatment is likely to be included within past medical history (particularly hospital records).

The Human Rights Act 1998

The Act became part of UK law on 2 October 2000. It does not contain new rights. It incorporates the European Convention on Human Rights into UK law, allowing an individual to assert their Convention rights in UK courts and tribunals, rather than at the European Court in Strasbourg.

The Act can be used only against a public body, therefore HSC organisations, as public bodies, are subject to the Act. Article 8 of the Convention – the right to respect for private and family life – is the most relevant to the health and social care setting.

The Right to Respect for Private and Family Life contains four rights. These are:

- the right to respect for private life;
- the right to respect for family life;
- the right to respect for one's home; and
- the right to respect for correspondence.

Article 8 is not an absolute right, in that the Act makes provision for interference with the rights (see below). It does, however, impact on subject access requests, consent, confidentiality and disclosure issues.

The right to respect for private life

The current approach is that the right to respect for private life includes an obligation on a public body to meet subject access requests. Denial of access could be interpreted as a breach of Article 8 as it prevents an individual gaining access to information held about him/her. This reflects the rights of the individual under the Data Protection Act 1998. Legislation must be read, as far as possible, in a way that is compatible with the Human Rights Act.

The right to respect for private life may also be invoked where treatment information is withheld from the individual. If an individual consents to treatment but has not been given sufficient information to make a fully informed decision that consent will not be valid. Arguably, the withholding of information is a breach of the Article 8 right.

The Article 8 right reflects the common law duty of confidentiality in that patient information should only be disclosed with that patient's consent. If information is inappropriately disclosed the individual can take legal action for breach against the public body concerned.

Not only must patient information be held confidentially, it must also be held securely. Failure to do so will also breach the right to respect for private life.

The right to respect for family life

This right may also be relevant, in that relatives of the ill often wish to be involved in the decision-making process, and kept informed of progress. However, this right must be balanced against the patient's right to confidentiality.

The right to respect for family life becomes even more relevant where the patient is a child or adult who lacks 'competence'. Failure to keep the family informed can be seen as an interference with this right, actionable under the Act. However, in a situation where the child is 'competent' and does not wish for information to be shared with their family, the young person's right to confidentiality is likely to outweigh the right of the family.

Explaining this may bring the professional into conflict with the family, but ultimately the right of the individual to have information held confidentially will outweigh the right of the family.

It may be possible to claim that one's rights in relation to respect for family life have been breached in an employment context. An employee under an excessive workload such that it impinges on his/her life outside of the work environment could possibly plead interference with his/her right to respect for family life.

The right to respect for correspondence

Correspondence includes written and telephone communications. It may be relevant for an individual to assert this right in relation to the monitoring of workplace e-mails. In particular, if the employee has not been informed that he/she 'has no reasonable expectation of privacy' and that workplace monitoring is taking place. To lessen the risk of being sued under this heading an employer should ensure that:

- the organisation complies with the advice from the Information Commissioner;
- all employees are informed of the organisational policy on 'private' e-mails (which should also include the use of the telephone and the internet); and
- consistent decisions are taken if policy breaches are discovered.

Interference with an Article 8 right

Article 8 rights are qualified rights; this means that in certain circumstances they can be interfered with by the state. However, this interference must be lawful, for a legitimate social aim and necessary to achieve that aim. Furthermore, the interference must not be disproportionate to the objective to be achieved.

Legitimate social aims are:

- national security;
- protection of public safety;
- protection of health or morals;
- prevention of crime or disorder;
- protection of the economic well-being of the country; and

- protection of the rights and freedoms of others.

The public body will have to weigh up the public interest necessity of breaching an Article 8 right against the rights of the individual.

Records management considerations

Current understanding is that if organisations comply with the provisions of the common law duty of confidence and the Data Protection Act 1998 they will meet the requirements of Article 8.

The Limitation (Northern Ireland) Order 1989

The Order sets out the law on the time limits within which legal actions may be brought. The limitation period for bringing actions for personal injuries or arising from death is three years. This period runs from when it is first realised that a person has suffered a significant injury that may be attributable to the negligence of a third party (or from 10 years after the application of a product that is found to be defective (see Consumer Protection (Northern Ireland) Order 1987).

For a child or young person, the limitation period runs from the time he/she attains the age of 18 years and may be extended where material facts are not known.

A person of 'unsound mind', as long as he remains under the disability in question, can bring an action without limit of time through his 'next friend'. After the person's death, the period of limitation will run against his personal representative(s). Discharge from hospital does not imply that the person has fully recovered from the disability. For the purposes of the Limitation Order, a person of 'unsound mind' is a person who, because of mental disorder within the meaning of the Mental Health (Northern Ireland) Order 1986, is incapable of managing and administering his property and affairs.

The limitation period of three years from the date of personal injury or death, or date of knowledge of a claim applies only to actions that include a claim for damages in respect of personal injuries. In the case of other claims different limitation periods apply, for example a claim by a mentally disordered patient that he has been falsely imprisoned, the appropriate limitation period prescribed by Article 6(1) of the Limitation (NI) Order 1989 is six years from the date when the patient ceases to be under a disability or dies.

Records management considerations

A claimant generally has three years to begin legal action after the injury; however, the lapse between the 'injury' and 'knowledge' of it is without limit of time. Therefore, it is important that accurate records are retained in accordance with Part 2 of GMGR and local policies. As with other statutory provisions, organisations must be able to locate and supply the information if requested and ensure that closed records are stored in accordance with, the Northern Ireland Records Management Standards (NIRMS) and British Standards.

Police Act 1997 and the Memorandum to A Code of Practice for Third Party Recipients of Criminal Record Information

Part V of the Police Act 1997 provides for information regarding a person's criminal record history to be disclosed to persons registered under the Act for certain purposes including engaging in regulated activity. Anyone who receives such information may pass this information to others, but only in line with the provisions of Section 124 of that Act. If information is passed to anyone who is not authorised to receive it the recipient of the information will be committing an offence under section 124 of the Act. The Memorandum to A code of Practice for Third Party Recipients of Criminal Record Information published by NIO (now Department of Justice) sets out obligations on the fair use and handling of information disclosed under the Act. Recipients of disclosure information:

- must ensure information is made available only to those who need to have access to it in the course of their duties
- must securely store the information
- must not retain the disclosures or a record of disclosure for longer than required and no longer than 6 months after a recruitment or other decision has been taken;
- must destroy certificates securely and not retain any photocopy or other image.

This 6 month period should only be exceeded:

- in very exceptional circumstances and in consultation with Access NI ; or

Where the RQIA require an assurance from their registered providers that all staff have been subject to an Access NI disclosure prior to employment, it is sufficient for a provider to maintain an accurate and up to date record of the :

- unique Access NI reference for certificates;
- date individual disclosures were applied for and received; and
- outcome of the registered provider’s consideration of that certificate.

Registered persons and others who countersign requests for disclosure information are required to have a written security policy covering the correct handling and safekeeping of disclosure information."

The Privacy and Electronic Communications (EC Directive) Regulations 2003

These Regulations revoke the Telecommunications (Data Protection and Privacy) Regulations 1999 and are concerned with the processing of personal information and the protection of privacy in the electronic communications sector.

The Regulations set out:

- circumstances under which direct marketing may be carried out;
- duties to safeguard the security of a communications network service;
- limitations on what may be stored or accessed; and
- restrictions on the processing of traffic and location data.

The Regulations are enforced by the Information Commissioner.

Public Health Act (Northern Ireland) 1967

Under this legislation, doctors in Northern Ireland have a statutory duty to notify the Director of Public Health if they are aware that, or have reasonable grounds to suspect that, a patient is suffering from one of the notifiable diseases. The doctor must complete a certificate stating:

- the name, age, sex and address of the patient;
- the address of the building where the examination took place;
- the notifiable disease from which the patient is, or is suspected to be, suffering;

The list of notifiable diseases can be found [in Schedule 1 to the Act/on the Health Protection Agency's website at:

- http://www.hpa.org.uk/HPA/Topics/InfectiousDiseases/InfectionsAZ/1234432664900/

Records management considerations

Organisations should ensure that copies of the notification certificate or counterfoils from a notification book are held securely and retained for the recommended minimum period.

The Public Interest Disclosure (Northern Ireland) Order 1998

The Order allows a worker to breach his duty as regards confidentiality towards his employer for the purpose of 'whistle-blowing'. A disclosure qualifying for protection under the Order is known as a 'qualifying disclosure'.

Such a disclosure is allowed in the following circumstances:

- where criminal activity or breach of civil law has occurred, is occurring, or is likely to occur;
- where a miscarriage of justice has occurred, is occurring or is likely to occur;
- where health and safety has been, is, or is likely to be compromised;
- where the environment has been, is being or is likely to be damaged; or
- where information indicating evidence of one of the above circumstances is being or is likely to be deliberately concealed.

It makes no difference whether the circumstance leading to the breach is within or outside of the UK, as long as either UK law or the law of the other jurisdiction prohibits it.

A qualifying disclosure must only be made:

- in good faith to the individual's employer, or to any other person having legal responsibility for the conduct complained of;
- for the purpose of obtaining legal advice;
- where the worker is employed by the Crown or a NI department, in good faith to a Minister of the Crown or the NI department; or
- in good faith to a person prescribed in subordinate legislation made under the Order.

Under this Order, the worker must reasonably believe that any allegation he makes is substantially true.

If it is the employer who is responsible for the conduct complained of, the Order allows a worker to make a disclosure to a person not noted above, provided the following conditions are met:

- it must be made in good faith, and not for personal gain, with a reasonable belief that the allegations complained of are true; and
- the worker reasonably believes he will suffer a detriment if he makes the disclosure to his employer; or
- he has previously complained of the conduct and no action has been taken; or
- he reasonably believes that evidence of the conduct has been or will be destroyed or concealed.

Such a disclosure will be subject to a test of reasonableness, which is tested with reference to:

- the person the disclosure was made to;
- the seriousness of the conduct complained of;
- whether the conduct is continuing;
- whether any previously made complaint was acted upon; and
- whether the worker followed any procedure laid down by the employer.

Records management considerations

Staff should be made aware of the correct procedures to be followed if circumstances arise that require them to breach confidentiality and any policy guidance/DHSSPS Circular on ‘Public Interest Disclosure’ available on the issue.

The Public Records Act (Northern Ireland) 1923

The Public Records Act (NI) 1923 established the Public Record Office of Northern Ireland for the reception and preservation of public records. It defined NI public records widely as 'all records of any court, Government department, authority or office in Northern Ireland with respect to which the Parliament of Northern Ireland has power to make laws'. It established a point of transfer of 20 years for public records and set out the basis for the disposal and retention of public records in Northern Ireland

Records management considerations

The Freedom of Information Act 2000 amended S5 of the 1923 Act by providing a statutory right of access to public records disclosed in accordance with Freedom of Information.

Disposal of Documents Order 1925

The Disposal of Documents Order 1925 sets out the provisions for the disposal and retention by public authorities of Northern Ireland public records. It provides the legal basis for disposal schedules and sets out the need for public bodies to have an officer who is responsible for their records and information.

The Radioactive Substances Act 1993

- http://www.opsi.gov.uk/acts/acts1993/Ukpga_19930012_en_1.htm

The High-activity Sealed Radioactive Sources and Orphan Sources Regulations 2005

- http://www.opsi.gov.uk/si/si2005/20052686.htm

The Radioactive Substances Act 1993 applies to organisations that keep, use or dispose of radioactive material or waste. It is supplemented by the High-activity Sealed Radioactive Sources and Orphan Sources Regulations (HASS), which applies additional requirements on organisations that use or dispose of sealed radioactive sources, for example those used for radiography and radiotherapy. Organisations who keep or use radioactive material or sources must obtain a certificate of registration from the Environment Agency, whilst those who dispose of radioactive waste or sources must obtain a certificate of authorisation.

Records management considerations

Records relating to radioactive substances and radioactive waste must be retained as specified by the Environment Agency. The Agency may also require that records be retained for a specified period after the activity has ceased. Once this period has expired, records should be filed with an appropriate repository, i.e. a Place of Deposit.

The Re-use of Public Sector Information Regulations 2005

The Regulations link with the Freedom of Information Act 2000, in that freedom of information is about access to information and these regulations are about how the information can be re-used. However, there is no automatic right to re-use merely because an access request has been granted. Information that is exempt under the Freedom of Information Act or other legislation is also exempt under the Regulations.

Health Service bodies are required to:

- publish the terms and conditions of standard licences for re-use;
- compile an information asset register detailing the information available for re-use;
- publish details of any exclusive re-use licences granted and review those licences every three years;
- notify the applicant of the reasons for refusal of a re-use application;
- provide contact details where complaints can be addressed;
- deal with all applicants in a non-discriminatory manner, for example applying the same charges for the same type of use; and
- respond to requests within 20 working days.

Further information about the regulations can be obtained from the Office of Public Sector Information at: www.opsi.gov.uk

Records management considerations

Employees responsible for re-use issues should work closely with those responsible for FOI for several reasons. These include:

- an information audit is required for both pieces of legislation to determine the records held and the locations of those records;
- information available for re-use and the terms and conditions of re-use can be included within the organisation's publication scheme (see Freedom of Information Act 2000); and
- if a request is made for access and re-use, the processes need to be coordinated so that the access issue is dealt with before permission to re-use is granted.

The Sexual Offences (Amendment) Act 1992 (as amended by the Youth Justice and Criminal Evidence Act 1999, and the Sexual Offences (Northern Ireland) Order 2008

This Act restricts the release of any information which could lead members of the public to identify victims of rape and other offences of a sexual nature.

Relevant Standards, Guidelines and Contact Details

BSI DISC BIP 0008

The current British Standard document relating to 'Legal Admissibility and Evidential Weight of Information Stored Electronically'. It sets a benchmark for procedures that should be followed in order to achieve best practice, and therefore, legal admissibility of their electronic documents. The document BIS DISC PD0008 is also referred to as BSI BIP0008.

BS 5454:2000

This makes recommendations for the storage of archival documents. These recommendations apply to the long-term, permanent storage of archival documents.

BS ISO/IEC 17799:2005 BS ISO/IEC 27001:2005 BS7799-2:2005

This Standard establishes guidelines and general principles for initiating, implementing, monitoring and improving information security management in an organisation. It is intended as a common basis and practical guideline for developing organisational security standards and effective security management practices.

ISO 15489

This is the international records management standard and is about best practice in records management. ISO 15489 aims to help organisations recognise the importance of their business records (whether electronic data, forms, images or documents) and promote best practice within records management

ISO 19005 – 1:2005 Document Management

This Standard provides for organisations to archive documents electronically for long-term preservation.

The Records Management Controls Assurance Standard

The Department has developed standards that focus on key areas of risk within the HSC and provide a vehicle for Accountable Officers to report the extent to which risk is being effectively controlled. The range of standards covers aspects of governance in the HSC, identifying and applying best practice and offering assurance that we are doing our reasonable best to control the risks to the achievement of our objectives. This ensures that resources are maximised for frontline services; that we provide a safe environment for care; and that the quality of care meets acceptable standards.

Compliance with standards, however, will not in itself provide all the necessary assurance about internal controls. The key to this is the organisation-wide system of risk management, fully embedded in the management activities of the body.

The introduction of Controls Assurance Standards by DHSSPS in 2003 put in place a system of monitoring the performance of HSC organisations and a means of reporting compliance levels on an annual basis, in support of the wider Statement of Internal Control. Initially, the standards focused on compliance with the three core standards; Finance, Governance and Risk Management. The introduction of the Records Management Controls Assurance Standard in 2005 set the basis for a systematic and planned approach to management of all records in HSC organisations, thereby supporting a system of risk management governing both corporate and administrative records. The controls assurance standard can be found at:

- Controls Assurance Standards

The Information Governance Toolkit return is required from all NHS organisations and provides guidance and best practice on all facets of information governance including:

- Data Protection Act 1998
- Freedom of Information Act 2000
- The NHS Confidentiality Code of Practice
- Records Management
- Information Quality Assurance
- Information Security
- Information Governance Management.

See: https://www.igt.connectingforhealth.nhs.uk/

The Northern Ireland Records Management Standard

PRONI drew up the Northern Ireland Records Management Standard in 2002 and was revised in 2007. This standard gives practical advice on all manner of records management issues pertinent to public record-keeping in Northern Ireland. Issues covered include filing systems, filing practices, disposal scheduling, reviewing records and special category records. For further information contact:

Records Management, Cataloguing and Access Team
The Public Record Office of Northern Ireland
Records Management , Cataloguing and Access
2 Titanic Boulevard, Titanic Quarter, Belfast, BT3 9HQ

Tel: 028 90534800

Email: access@dcalni.gov.uk

Web: www.proni.gov.uk

Professional Codes of Conduct

Profession organisations have their own codes of conduct setting out the standards of ethical behaviour owed by members of each profession. These standards typically include:

- respecting patients' decisions about their care, treatment and support;
- obtaining consent for treatment, service provision or for disclosure of patient/client personal information;
- protecting patient/client personal information by maintaining confidentiality; and
- ensuring continuity of care/support/service through good record-keeping practice.

Information on professional codes of practice can be obtained from the following organisations.

The British Association of Social Workers (BASW)

BASW is the only professional association for Social Workers in the UK. Its primary aim is to promote the best possible social work services for all people who may need them, whilst also securing the well-being of social Workers. By joining the Association, its members are committing to the values set out within their Code of Ethics:

- http://www.basw.co.uk/about/code-of-ethics/
- http://www.celticknot.org.uk/links/baswcode.html

The British Dental Association (BDA) Northern Ireland

The BDA is the professional association and trade union for dentists in the United Kingdom and was founded in 1880. Its mission is to:

- promote the interests of its members
- advance the science, arts and ethics of dentistry
- improve the nation's oral health

The Mount
2 Woodstock Link
Belfast, BT6 8DD

Tel: 02890 735 856
Fax: 02890 735 857

Web: http://www.bda.org/about-the-bda/offices-and-contracts/bda-northern-ireland/

The British and Irish Orthoptic Society

The British and Irish Orthoptic Society is the professional society for Orthoptists in Ireland and the UK.

Email: bios@orthoptics.org.uk

Web: www.orthoptics.org.uk

The British Medical Association (BMA) Northern Ireland

The BMA is the doctors' professional organisation established to look after the professional and personal needs of its members and represents doctors in all branches of medicine all over the UK. They are a voluntary association with over two-thirds of practising UK doctors in membership and an independent trade union dedicated to protecting individual members and the collective interests of doctors. They are in constant contact with ministers, government departments, members of the UK, Scottish, Welsh and Northern Ireland administrations and many other influential bodies and are committed to keeping members in touch with the profession's collective views and policies and to being at the forefront of healthcare development.

- http://www.bma.org.uk/ni/ethics/health_records/index.jsp

16 Cromac Place,
Cromac Wood,
Ormeau Road
Belfast BT7 2JB

Tel: 028 90269666
Fax: 028 90269665

E-mail: BMANorthernIreland@bma.org.uk

Web: http://www.bma.org.uk/ni/

The Chartered Society of Physiotherapy: Rules of Professional Conduct

- http://www.csp.org.uk/publications/rules-professional-conduct-2nd-edition

General Dental Council

37 Wimpole Street,
London
W1M 8DQ

Tel: 020 7887 3838~
Fax: 020 7224 3294

Web: www.gdc-uk.org

The General Dental Council has been established as the statutory regulatory body for the dental profession since 1956. Council members as individuals and in their corporate capacity, have a responsibility to ensure that the functions of the Council, as set out in legislation, are effectively discharged in the interests of the public. This Code provides guidance for Members and anyone else acting on behalf of the Council, to assist them in carrying out these functions in accordance with currently accepted standards of public service.

Conduct of Council and Committee Members

- Code of Conduct for members approved March 2004

The General Medical Council

The General Medical Council is the independent regulator for doctors in the UK.

The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

General Medical Council
9th Floor Bedford House
16-22 Bedford Street
Belfast
BT2 7FD

Email: gmcnorthernireland@gmc-uk.org

Telephone: 028 9031 9945

Regent's Place
350 Euston Road
London
NW1 3JN

Tel: 0161 923 6602

Web: www.gmc-uk.org

- http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

The Health Archives and Records Group (HARG)

HARG is a representative body for archivists and records managers working in the health sector, including but not limited to the NHS. It has been an affiliated group of the Society of Archivists' Specialist Repositories Group since 2001. HARG aims to raise the profile of health archives and to improve the level of awareness in the NHS and elsewhere about record-keeping issues.

Further information about HARG, including current contact details, can be found on the Specialist Repositories Group section of the Society of Archivists' website: http://www.archives.org.uk/

Health Professions Council

Council for Professions Supplementary to Medicine
Park House,
184 Kennington Park Road,
London
SE11 4BU

Tel: 020 7582 0866
Fax: 020 7820 9684

Email: policy@hpc-uk.org

Web: http://www.hpc-uk.org/

Northern Ireland Social Care Council

7th Floor,
Millenium House,
Great Victoria Street,
Belfast
BT2 7AQ

Tel: 028 9041 7600
Fax: 028 9041 7601

Web:Error! Hyperlink reference not valid.

Codes of Practice for Social Care Workers and Employers

- http://www.gscc.org.uk/codes

The Nursing and Midwifery Council (NMC)

23 Portland Place,
London
W1B 1PZ

Tel: 020 7637 7181
Fax: 020 7436 2924

Email: advice@nmc-uk.org

Web: www.nmc-uk.org

Code of Professional Conduct - The NMC Standards 07.04 informs the professions of the standard of professional conduct required of them in the exercise of their professional accountability and practice.

See link:

- http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full/

Guidance on Record Keeping 01.05 - Guidelines prepared by the NMC on records and record-keeping practices for nurses and midwives.

- http://www.gdc-uk.org/governanceandcorporate/governancemanual/Pages/default.aspx

Midwives' Rules and Standards – NMC Standards 05.04 - The Nursing and Midwifery Order 2001 requires the NMC to set rules and standards for midwifery. The rules and standards document provides guidance on the interpretation of these rules and standards and includes record keeping. See:

- http://www.nmc-uk.org/Publications

The Pharmaceutical Society of Northern Ireland

73 University Street,
Belfast
BT7 1HL

Tel: 028 9032 6927
Fax: 028 9043 9919

Web: http://www.psni.org.uk

The Pharmaceutical Society of Northern Ireland is the regulatory and professional body for pharmacists in Northern Ireland. It protects public safety in pharmacy by:

- setting and promoting standards for pharmacists' admission to the register and for remaining on the register;
- maintaining a publicly accessible register of pharmacists, and pharmacy premises, in Northern Ireland;
- handling concerns about the Fitness to Practise of registrants, acting as a complaints portal and taking action to protect the public; and
- ensuring high standards of education and training for pharmacists in Northern Ireland.

As the professional body it seeks to develop the pharmacy profession in Northern Ireland in the public interest. The Code of Ethics for Pharmacists in Northern Ireland sets the standard of professional conduct for all pharmacists and is regarded as governing the conduct of all

pharmacists. Supporting professional standards and guidance documents have been developed to expand upon the principles of the Code of Ethics for specific areas of practice or professional activities.

- http://www.psni.org.uk/professionals/code-of-ethics.php

The Royal College of General Practitioners

- http://www.rcgp.org.uk/default.aspx?page=1376

The Royal College of Pathologists

- http://www.rcpath.org/resources/pdf/g031_retentionstorageofrecords_oct06.PDF

The Royal College of Physicians

A Clinician's Guide to Record Standards Parts 1& 2:

- http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/structure-and-content-medical-notes/de

The Royal College of Surgeons of England

The guidelines for Clinicians on Medical Records and Notes have been prepared to assist clinicians with the medical records which are fundamental for clinical care and the audit of surgical services.

- http://www.rcseng.ac.uk/publications/docs/med_records.html

Disposal Schedule

Disposal Schedule

A. Work Area - Accident / Incidents / Untoward Events

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
A1	Accident Register	10 Years		Determined on review
A2	Record sheets/book, Forms, Reports	10 years from the occurrence or last entry or until the patient's 25th birthday whichever is the later.		Destroy
A3	Adverse Incidents	10 years normal review process. Files should be reviewed in accordance with the principles in part 1.		Determined on review
		Where the adverse incident relates to blood the records should be kept for 15 years.	Blood Safety and Quality Regulations(BSQR) 2005 http://www.legislation.gov.uk/uksi/2005/50/contents/made http://www.legislation.gov.uk/uksi/2005/1098/contents/made http://www.legislation.gov.uk/uksi/2005/2898/contents/made	Determined on review
		Where the incident has resulted in litigation the records relating to the litigation should be managed as per GMGR Section I1.		Determined on review
		Where the incident has resulted in any form of disciplinary preceding the personnel records should be managed as per GMGR Section L12. Independent contractors should seek their own legal advice.		Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
A4	Homicide/'serious untoward incident' records	30 years		Determined on review
A5	Emergency Plans /Major Incident Plans/business continuity plans	8 years after the plan is superseded or where it has been put into action 8 years after the event.		Determined on Review
A6	Record sheets/book, Forms, Reports (where litigation has commenced)	Where a legal action has commenced, records should be managed as per GMGR Section I1.		Determined on review
A7	(RIDDOR) register	3 years from the occurrence.	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997	Destroy

B. Work Area - Complaints

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
B1	Enquiries which do not give rise to formal complaints	3 years	www.nationalarchives.gov.uk/documents/sched_complaints.pdf	Destroy
B2	Correspondence, investigation and outcomes	Review 10 years from completion of the action. Files should be reviewed in accordance with the principles in part 1. No less than 15 years for complaints dealt with under the Residential Family Centres Regulations (NI) 2007 Where the complaint has resulted in litigation the records relating to the litigation should be managed as per GMGR Section I1. Where the complaint has resulted in any form of disciplinary preceding the personnel records should be managed as per GMGR Section L12. Where more than one retention period applies the longest of them should be used.	www.nationalarchives.gov.uk/documents/sched_complaints.pdf	When the retention period has expired, PRONI to determine on review.
B3	Complaints investigated under the Representations Procedure (Children) Regulations (NI) 1996 in respect of:	These records are the records relating to the investigation of the complaint which should be kept separate from the case record. The case record should however contain a note that a complaint under the regulations was made, a broad outline on the nature of the complaint, its outcome, and where the investigation records are retained.	Representations Procedure (Children) Regulations (NI) 1996	When the retention period has expired, PRONI to determine on review.
	A looked after child	75 years from date of birth of the child to whom it relates or, if the child dies before age 18, then for a period of 15 years beginning with the date of his/her death.	Representations Procedure (Children) Regulations (NI) 1996	When the retention period has expired, PRONI to determine on review.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	A Child in Need	20 years after closure of case.	Representations Procedure (Children) Regulations (NI) 1996	When the retention period has expired, PRONI to determine on review.
	Child Protection	75 years after closure or 15 years after death of child if child dies before attaining the age of 18.	Representations Procedure (Children) Regulations (NI) 1996	When the retention period has expired, PRONI to determine on review.
B4	Returns made to the Department (CH8 statistics)	See GMGR Section Q1.		Destroy

C. Work Area - Contracts / Service Level Agreements

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
C1	Approval files	15 years		Determined on review
C2	Approval files (contracts)	6 years after end of the year the contract expired		Destroy
C3	Approved suppliers lists	11 years	Consumer Protection (Northern Ireland) Order 1987 Where the records are potentially relevant to the issue of proceedings **by** an organisation legislation requires retention of 10 years. However an extra year has been added to allow time for any proceedings to be served **against** an organisation.	Destroy
C4	Contracts – non sealed (property) on termination	6 years from date of practical completion	The Limitation (Northern Ireland) Order 1989	Destroy
C5	Contracts – non sealed (other) on termination	6 years after termination of contract	The Limitation (Northern Ireland) Order 1989	Destroy
C6	Contracts (including capital works contracts) – sealed (and associated records)	Contracts under seal and associated records should be kept for a minimum of 15 years. When they reach 15 years old they should be reviewed and PRONI invited to examine them.		Determined on review
C7	Contractor Applications to provide general practitioner, Dental, Ophthalmic & Pharmaceutical services	6 years after end of contract for approvals 6 years for non-approvals.		Destroy
C8	**Contractor Records**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Ophthalmic Opticians	See GMGR Section G81		Destroy
	Dentists	See GMGR Section G30 - G34		Destroy
	Pharmacists, Pharmacy Premises	See GMGR Section M		Destroy
	General Practitioners	See GMGR Section G49		Destroy
C9	Contractors On – Call Rotas managed by HSCB	6 years		Destroy
C10	GP retirements/moved away	6 years after individual leaves service, at which time a summary of the file must be kept until the individual's 70th birthday or 6 years after the individual leaves the service whichever is the longer		Destroy
C11	Contractual arrangements with hospitals or other bodies outside the HSC including papers relating to financial settlements made under the contract	6 years after end of financial year to which they relate		Destroy
C12	**Tenders**			
	successful	Tender period plus 6 year limitation period	The Limitation (Northern Ireland) Order 1989	Destroy
	unsuccessful	6 years	The Limitation (Northern Ireland) Order 1989	Destroy

D. Work Area - Equipment

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
D1	Records of equipment/instruments (fixed and un-fixed) including installation, specification, maintenance records and logs, records of service inspections, test records, Calibration Certificates products liability, procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment, and disposal records.	Lifetime of the equipment plus 11 years If the records relate to vehicles (ambulances, responder cars, fleet vehicles etc) and where the vehicle no longer exists, providing there is a record that it was scrapped, the records can be destroyed.	Consumer Protection (NI) Order 1987 Where the records are potentially relevant to the issue of proceedings **by** an organisation legislation requires retention of 10 years. However an extra year has been added to allow time for any proceedings to be served. **against** an organisation.	Destroy
D2	Forms – Surgical Appliances – AP1, 2, 3 and 4	5 years from completion of audit (see also GMGR Section G20)		Destroy
D3	Daily checking of Crash Trolleys	This is a check for accounting purposes, only current and previous record require to be held. If a record of Equipment used in treatment, it may need to be kept for 11 years in line with period for litigation. (see GMGR Section D1) If check shows action required this needs to be recorded and kept for 11 years as above.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
D4	Internal requests for supplies equipment.	Once approved the record will either fall into a buying order, inventory, delivery notice or approval file. The records should be placed in the appropriate file and retained for the documented period. Administrative records not appropriate for other files - retain for the current year plus 1.		Destroy
D5	Inventories (not in current use) of items having a life of less than 5 years	$1^1/_2$ years or if in book form $1^1/_2$ years after the last entry		Destroy
D6	Inventories of plant, vehicles and permanent or fixed equipment	Permanent		Retain permanently within organisation
D7	Inventories of furniture, medical and surgical equipment not held on store charge having a minimum of life of 5 years	Until Revised		Destroy
D8	Medical device/equipment alerts	Until reviewed or withdrawn by Northern Ireland Adverse Incident Advice Centre (NIAIC) (check MHRA website)	www.mhra.gov.uk	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
D9	Records relating to the security of the systems (see also GMGR Section H5 and (GMGR Section J22 security of the records))	Decommissioning of the system plus 5 years	Approved Disposal Schedules http://www.bangor.ac.uk/ar/ro/recordsmanagement/InformationCommunicationTechnologyICTSystemsManagement-RecordsRetentionSchedule.php.en	Destroy

E. Work Area - Estates

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
E1	**Biomedical Engineering** Sterilix Endoscopic Disinfector daily water cycle test Sterilix Endoscopic Disinfector daily water purge test, nynhydrin test	11 years	Consumer Protection (Northern Ireland) Order 1987 Where the records are potentially relevant to the issue of proceedings **by** an organisation legislation requires retention of 10 years. However an extra year has been added to allow time for any proceedings to be served. **against** an organisation,	Destroy
E2	Buildings and engineering works, inclusive of major projects abandoned or deferred – key records, (e.g. final accounts, surveys, site plans, bills of quantities).	30 years		The Public Record Office of Northern Ireland should be invited to review these records. If they decide not to preserve them the records should be destroyed.
E3	Buildings and engineering works, inclusive of major projects abandoned or deferred – town and country planning matters and all formal contract documents (e.g. executed agreements, conditions of contract, specifications, “as built” record drawings and documents on the appointment and conditions of engagement of private buildings and engineering consultants.	Retain permanently		Retain permanently within organisation
E4	Buildings – papers relating to occupation (but not Health and Safety information) of the building	Review 3 years after occupation ceases		Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
E5	Deeds of Title/Title Deeds	Permanent Retain while the organisation has ownership of the building unless a Land Registry certificate has been issued, in which case the deeds should be placed in an archive. If there is no Land Registry certificate, the deeds should pass on with the sale of the building.		Retain permanently within organisation The Public Record Office of Northern Ireland should be invited to review these records. If they decide not to preserve them the records should be destroyed.
E6	Environmental Cleanliness Audits Health and Safety Audits	10 years		Destroy
E7	Fire training records	5 years		Destroy
E8	Fire Officers Register	5 years		Destroy
E9	Fire Inspections	5 years		Destroy
E10	Health and Safety Information / documentation	Until cancelled or superseded		Destroy
E11	Inspection/Insurance reports – e.g. boilers. Lifts etc	Lifetime of an installation. Normally retain for the lifetime of an installation. However, it is necessary to assess whether obligations incurred during the lifetime may not be invoked until afterwards, in which case a judgement must be made. If there is any measurable risk of a liability in respect of installation beyond their operational lives, records of this kind should be retained indefinitely.		Destroy
E12	Land surveys/registers	30 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
E13	Leases, the grant of leases, easements, licences and other rights over property.	Retain for the lifetime of the ownership of any right over the property	The Limitation (Northern Ireland) Order 1989	Destroy
	Leasing a property from another owner	12 years after the lease expires	The Limitation (Northern Ireland) Order 1989	Destroy
E14	Maintenance contracts - routine	6 years from end of contract		Destroy
E15	Maintenance requisition books/job dockets	6 years after last entry in the book		Destroy
E16	Manuals operating/maintenance	Lifetime of equipment		Destroy
E17	Maps	Retain permanently		The Public Record Office of NI should be invited to review these records. If they decide not to preserve them the records should be destroyed.
E18	**Plans** Building (as built), Drawings (architect signed not copies) Engineering works	Lifetime of Building		The Public Record Office of NI should be invited to review these records. If they decide not to preserve them the records should be destroyed.
E19	Property Acquisition Dossiers	Retain for the lifetime of ownership of the property		Determined on review
E20	Property Disposal Dossiers	30 years		Determined on review
E21	Records relating to the security of the estate (see also GMGR Section D9, and GMGR Section J23 security of	5 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	the records)			
E22	Site files	Lifetime of site		Destroy
E23	Specifications (e.g. equipment, services)	6 years		Review if issues (e.g. HSE) are outstanding
E24	Structure plans (organisational charts) i.e. the structure of the building plans	Lifetime of Building – then review		Determined on review
E25	Surveys – building and engineering works	Lifetime of building or installation		Destroy
E26	Visitors Books (other than those specifically required in legislation)	3 years	National Archives - Retention Scheduling Press and Public Relations Records	Determined on review
	Reception desk Rotas			Destroy

F. Work Area - Finance

Where a publicly funded organisation has been the subject of an investigation which has led to significant criticism or prosecution, the relevant records should be retained for at least 10 years from the date of conclusion of the investigation. Addendum to DAO (DFP) 08/07.

Any records pertaining to European Union(EU) funding must, by EC Regulation, be retained for at least seven years after EU Programme spend has been completed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
F1	**Accounts**			
	a. Minor Records Pass-books, bank statements of accounts, pay-in slips, lodgement slips counterfoils, cancelled and discharged cheques, (for cheques bearing printed receipts, see Receipts), cheque counterfoils, accounts of petty cash expenditure, travelling and subsistence accounts, minor vouchers including duplicate receipt books, income records, receipt for registered and recorded delivery mail, forms used in connection with the supply of surgical appliances, laundry lists and receipts.	2 years (from completion of the audit)		Destroy
	b. Working Papers	3 years (from completion of the audit)		Destroy
	c. Debtors records – cleared	2 years (from completion of the audit)		Destroy
	d. Debtors records - uncleared	6 years (from completion of the audit)	The Limitation (Northern Ireland) Order 1989	Destroy
	e. Cost Accounts	3 years after end of financial year to which they relate		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
F2	Advice notes [Delivery statement, or note advising what is in a package, or what is coming: They are usually received in advance of the invoice].	2 years		Destroy
F3	Annual Accounts (final one set only)	30 years		A copy of the final published accounts should be sent to The Public Record Office of Northern Ireland
F4	**Asset Management**			
	Asset registers – assets/equipment registers, records	6 years after the asset is disposed of		Destroy
	Depreciation registers – records relating to the calculation of annual depreciation	6 years after the asset or last one in the register is disposed of		Destroy
F5	Audit records – original documents (e.g. Organisational Audits, Records Audits, Systems Audits) – Internal & External in any format (paper, electronic etc)	3 years from the date of completion of the audit	The National Archives Internal Audit Records retention Schedule	Destroy
F6	Audit reports (including management letters, Value for Money Reports and system/final accounts memorandum) internal and external	6 years after formal clearance by Statutory Auditor	The National Archives Internal Audit Records retention Schedule	Destroy
F7	**Benefactions/Endowments/Trust Fund**			
	Documents relating to benefactions, special donations and memorials of any sort covered by HSC Legislation.	5 years after the end of the financial year in which the Trust monies become finally spent or the gift in kind was accepted.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Documents relating to benefactions, special donations and memorials of any sort covered by HSC Legislation, where the fund/capital/interest, remains permanent.	The records should be permanently retained by the organisation.		Retain - permanently
F8	Bills, receipts and cleared cheques	6 years		Destroy
F9	Primary Care HSC Prescriptions received by the BSO	6 years		Destroy
F10	Business Case Documentation	10 years after completion of project or handover of facility in terms of larger projects (see also GMGR Section J41)		Destroy
F11	Budgets (including working papers, reports, virements and journals)	2 years from completion of audit		Destroy
F12	Buying orders for Goods and Services	6 years		Destroy
F13	Capital Charges Data	2 years from completion of the audit		Destroy
F14	Capital Paid Invoices	6 years following the end of the financial year to which they relate	The Limitation (Northern Ireland) Order 1989	Destroy
F15	Cash Books	6 years following the end of the financial year to which they relate	The Limitation (Northern Ireland) Order 1989	Destroy
F16	Cash Sheets	6 years following the end of the financial year to which they relate	The Limitation (Northern Ireland) Order 1989	Destroy
F17	**Clients Financial Records**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Documents relating to the Trust Management of the finances of individuals admitted to residential or nursing homes or their own home.	6 years following the settlement of the accounts to which they relate		Destroy
	Deeds and Correspondence relating to the transfer of property, the purchase disposal and leasing of property and the acquisition, transfer and disposal of mortgages.	See GMGR Section F33 and retain as advised by legal advisor		Determined on Review
	Correspondence with legal department and solicitors	It should be noted that financial records are usually held for 6 years after the close of the financial year to which they relate. As all the bills are cleared and the remaining monies paid back to the family or solicitor after the client's death, it would be wise to retain all financial records for 6 years after that date.		Destroy
F18	Creditor payments	6 years after end of financial year to which they relate		Destroy
F19	Delivery notes	2 years following the end of the financial year to which they relate		Destroy
F20	Demand notes	6 years following the end of the financial year to which they relate		Destroy
F21	Estimates including supporting calculations and statistics	3 years following the end of the financial year to which they relate		Destroy
F22	Expense claims including travel and subsistence claims – claims and authorisation	6 years following the end of the financial year to which they relate		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
F23	Excess Fares	6 years after payment ceases		Destroy
F24	**Finance Statements**			
	Statements /summaries /reconciliations prepared for inclusion in quarterly/annual reports	6 years following the end of the financial year to which they relate	http://www.nationalarchives.gov.uk/documents/information-management/sched_accounting.pdf	Destroy
	Periodic financial statements prepared for management on a regular basis	Destroy when cumulated into quarterly/annual reports	http://www.nationalarchives.gov.uk/documents/information-management/sched_accounting.pdf	Destroy
	Adhoc statements	1 year	http://www.nationalarchives.gov.uk/documents/information-management/sched_accounting.pdf	Destroy
F25	Formula records for calculating employee variation of hours	1 year after entry		Destroy
F26	Fraud Report papers used in the course of a Fraud investigation – theft, fraud, misappropriation irrecoverable debts and overpayments, write – offs. Recovery of debt, wavering of debt.	6 years after the audit where the matter was resolved internally, otherwise 10 years after the action/investigation is completed	Addendum to DAO (DFP) 08/07	Destroy
F27	Funding data (including monitoring)	6 years following the end of the financial year to which they relate **Any records pertaining to European Union(EU) funding must, by EC Regulation, be retained for at least seven years after EU Programme spend has been completed**		Destroy
F28	General Medical Services payments	6 years after year end		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
F29	Income and expenditure journals	6 years following the end of the financial year to which they relate		Destroy
F30	Invoices	6 years following the end of the financial year to which they relate	The Limitation (Northern Ireland) Order 1989	Destroy
F31	Ledger Records: including such documents as ledgers, income and expenditure journals, nominal rolls.	6 years following the end of the last financial year to which they relate		Destroy
F32	Monitoring of Financial records	6 years following the end of the last financial year to which they relate		Destroy
F33	Mortgage documents (acquisition, transfer and disposal)	6 years after repayment		Determined on review
F34	Non-exchequer funds records (i.e. funding received by the organisation that does not directly relate to patient care e.g. charitable funds)	6 years from the end of the financial year in which they are made	Part 8 of the Charities Act (NI) 2008	Although technically exempt from the Public Records Act, it would be appropriate for authorities to treat these records as if they were not exempt. Destroy
F35	Patient Monies (i.e. smaller sums of donated money)	6 years		Destroy
F36	PAYE records	6 years after termination of employment		Destroy
F37	Payments	6 years after the end of the financial year to which they relate		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
F38	Private Finance Initiative (PFI)	30 years		Determined on Review
F39	Receipt for registered and recorded delivery mail	see GMGR Section F1		Destroy
F40	Receipts	6 years after end of financial year to which they relate	The Limitation (Northern Ireland) Order 1989	Destroy
F41	Requisitions	2 years (organisations may wish to review before destruction		Destroy
F42	VAT records	6 years following the end of the financial year to which they relate		Destroy
F43	**Value for money (VFM)**			
	Reports created or instigated internally in the organisation.	6 years following the end of the tax year to which the papers relate		Determined on review
	Reporting on financial exercises, reviews monitoring.	6 years following the end of the tax year to which the papers relate		Determined on review

G. Work Area - Health Acute and Community

These records are patient focused increasingly multi-disciplinary in nature, and could be created by any Health Care Professional e.g. Nursing, Medicine, or Allied Health Professional working either in community or acute settings.

A patient record is a collection of documents that provide an account of each episode in a patient's clinical history where they visited, sought treatment, or received care.

It can be made up of many components such as: Referral letters; Patient Personal Measurements Chart; Sleep Charts; Temperature, Pulse and Respiration charts; Weight Charts; Blood Pressure Chart; Health history; Laboratory and radiologic reports; Kardexes Notes by consultants; Examination findings; diagnosis etc.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G1	Abortion	Records to be maintained within the Primary or Secondary Patient Care Record and retained for the period of time appropriate to that record.		Destroy
G2	**Accident and Emergency**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	A&E records (where these are stored separately from the main patient record)	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
	Accident and Emergency Registers	8 years after the year to which they relate		Determined on review
G3	Admission Books	8 years after last entry		Destroy
G4	Ambulance records –patient identifiable component (including paramedic records made on behalf of the Ambulance Service)	10 years (applies to ALL Ambulance Clinical Records) NB Where a patient is transferred to the care of another HSC organisation all relevant clinical information must be transferred to the patients' health record held at that organisation)		Destroy
G5	Angiography tapes and disks	8 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G6	Asylum seekers and refugees	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy
G7	Audio tapes of calls requesting care	Retain taped calls for 3 years providing all relevant clinical information has been transferred to the appropriate patient record. Where the information is NOT transferred into a health record, the tapes should be retained for 10 years.	The Limitation (Northern Ireland) Order 1989	Destroy
G8	Audiology records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.	General Medical Council guidance on making and using visual and audio recordings of patients, can be found at: http://www.gmc-uk.org/guidance/current/library/making_audiovisual.asp#12	Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G9	Audit Trails (Electronic Health Records) see also G51	Organisations are advised to retain all audit trails until further notice.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G10	Birth Notification (to Child Health Department)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death.		Destroy
G11	Birth notification sheets	10 years		Special Review by PRONI
G12	Birth registers (i.e. register of births kept by the hospital)	Lists sent to GRO on a monthly basis. 1 year		Determined on review
G13	Body Release Forms maintained as part of the patient record	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		As per the final action for the patient record
G14	Cervical screening slides	10 years		Destroy
G15	Chaplaincy records	3 months		Destroy
	Baptismal, Blessing, naming records, memorial cards / books	75 years		Transfer to PRONI

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G16	Child and family guidance	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G17	Child Health Records (notification of Visitors/New Entrants either from abroad, or from within the UK from Airports, the Home Office Immigration Centre and the Housing Executive.)	Database of notifications is recorded on both NIMATs and the CHS Where a health visitor visits the child the record of the visit should become part of the patient's record and retained until their 25th birthday or 26th birthday if an entry was made when the patient was 17 **or** 10 years after the patient's death if patient died while in the care of the organisation. This also applies to any other information that relates to patient care recorded by the health visitor for these purposes. Other information should be retained for a period of 2 years from the end of the year to which it relates.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G18	Child Health System – Electronic system record	100 years		Determined on review after consultation with Trust professional and records management staff
G19	Children and Young people (Health Records) including school health records but see GMGR Section G78 for children's oncology records	Until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment or 8 years after last entry, if longer, or 8 years after death if death occurred before 18th birthday. 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 whether to retain records for longer period.		Determined on review after consultation with Trust professional and records management staff
G20	Clinical audit records	5 years		Destroy
G21	Clinical Protocol (GP, in-house)	25 years		Destroy
G22	Clinical psychology	20 years		Destroy
G23	Consent Forms	Retain as part of the patient clinical record.		Destroy
G24	Contraception and sexual health records	See Family Planning GMGR Section G45		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G25	Crash Trolleys – record that a check on the trolley has been completed and any subsequent action	8 years		Destroy
G26	Death Registers (i.e. register of deaths kept by the hospital)	Lists sent to GRO on a monthly basis 2 years		Destroy
G27	Discharge books (i.e. register of those discharged by the hospital)	8 years after last entry		Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G28	DNA (health records for patients who **did not attend** for appointments as out-patients)	Where there is a letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the person did not attend and that no further appointment has been given, retain for 2 years after the decision is made. Where there is **no** letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the person did not attend and that no further appointment has been given, retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G29	Death Certificate Stubs	1 year from the last stub		Destroy
G30	**Dental, and orthodontic records (see GMGR Section G103 - G106 for X-Rays)**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Community Dental Service	11 years Until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment or 11 years after last entry, if longer, or 8 years after death if death occurred before 18th birthday	http://www.bda.org/dentists/advice/practice-mgt/laws/ethics/records/storage-retention-disposal.aspx	Destroy
	Hospital Dental Records			
	Adults	8 years	http://www.bda.org/dentists/advice/practice-mgt/laws/ethics/records/storage-retention-disposal.aspx	Determined on review after consultation with Trust dental and records management staff
	Children	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	http://www.bda.org/dentists/advice/practice-mgt/laws/ethics/records/storage-retention-disposal.aspx	Determined on review after consultation with Trust dental and records management staff
G31	Dental records of a serving prisoner	11 years after release from prison		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G32	General Dental Services Patient records	6 years	General Dental Services Regulations (Northern Ireland) 1993 as amended by the General Dental Service (Amendment) Regulations (Northern Ireland) 2008 http://www.legislation.gov.uk/nisr/2008/395/contents/made	Destroy
G33	Orthodontic Records	6 years	General Dental Services Regulations (Northern Ireland) 1993 as amended by the General Dental Service (Amendment) Regulations (Northern Ireland) 2008 http://www.legislation.gov.uk/nisr/2008/395/contents/made	Destroy
G34	Dental and Epidemiological surveys	Review after 30 years		Determined on review
G35	De-registered patients records	Records for de-registered patients, which are received by the HSCB, should be retained for at least 10 years. After the retention period has elapsed a decision must be taken by the HSCB as to whether to destroy the records or retain them further.		Destroy
G36	Diagnostic Image Data (for diagnostic imaging undertaken in the private sector under contract to the HSC or private providers treating patients on behalf of the HSC).	Retain for the life of the National Diagnostic Imaging Services Contract and then return the data to the HSC after which the retention period in this retention schedule will apply.	National Diagnostic Imaging Services Contract; Records Management: NHS Code of Practice	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G37	District nursing records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G38	Discharge nursing team assessments of patients' homes and nursing homes. NB The documents should be part of the patient record as they relate to the discharge of the patient.	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G39	**Donor Breast Milk Bank**			
	Donor Milk Batch	30 years	Para 1.2.71 National Institute for Health and Clinical Excellence Donor breast milk banks: the operation of donor milk bank services February 2010	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Donor Milk used	30 years	Para 1.2.74 National Institute for Health and Clinical Excellence Donor breast milk banks: the operation of donor milk bank services February 2010	Destroy
G40	Donor records (blood and tissue)	30 years post transplantation See also Pathology GMGR Section 'K' See GMGR Section G97 for records of patients who receive an organ transplant.	Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)	Destroy
G41	Drug trials, records	see GMGR Section J57 and GMGR Section J58		see GMGR Section J57 and GMGR Section J58
G42	Duplicate patient record notification forms	2 years after the decision of whether or not to merge unless there is a business need to retain for longer.		Destroy
G43	Electrocardiogram (ECG) Records	8 years NB Each chart should be labelled with the patient's name and unique identifier. Any over-sized charts could then be stored separately where a report is written into the health records.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G44	Endoscopy Records including: Sterilix Endoscopic Disinfector Traceability Strips, Traceability Stickers for PEG/Stents (Endoscopy)	Retain for standard retention periods i.e. 8 years for adults and in the case of 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
G45	Family Planning (also Contraception and sexual health records)	For records of adults – retain for 10 years after last entry. For clients under 18 – retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years). Records of deceased persons should be retained for 8 years after death.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists NB The longest license period for a contraceptive device is 10 years www.bashh-org/communities/aga/servicespec/guidance-retention-disposal-notes-0606pdf	Determined on review after consultation with Trust medical and records management staff.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G46	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 see GMGR Section G56, Post mortem reports see GMGR Section K43.	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/resources/pdf/g031_retentionstorageofrecords_oct06.pdf http://www.rcpath.org/resources/pdf/g031retentionstorageaugust09.pdf	Destroy
G47	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.	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G48	Genito Urinary Medicine (GUM) Includes sexual health records	For records of adults - retain for 10 years after last entry. For clients under 18 - retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years). Records of deceased persons should be retained for 8 years after death.	Clinical Standards Committee, Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/documents/1062/1062.pdf	Destroy
	GP Medical Records		http://www.bma.org.uk/ethics/health_records/retentionrecords.jsp	

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G49	GP Medical Records	GP Medical Records should be returned to the HSCB when: • a patient dies • the person is no longer a patient of the GP GP Records should be held by the HSCB other than the records listed below 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.	The Health & Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004, S.R. 2004 No.140	Destroy
	GP Medical Records - Maternity records	25 years after last live birth	The Health & Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004, S.R. 2004 No.140 Congenital Disabilities (Civil Liability) Act 1976, Consumer Protection (Northern Ireland) Order 1987	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	GP Medical Records - Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health (NI) Order 1986	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.	The Health & Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004, S.R. 2004 No.140 Royal College of Psychiatrists	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G50	GP Medical Records, relating to HM Armed Forces. This refers to GP records of serving military personnel that were inexistence prior to them enlisting.	GP Medical Records should be returned to the HSCB when a patient becomes a member of HM Armed Forces. The medical records should be marked “not for destruction” within the HSCB. 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.		Not to be destroyed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	GP Medical Records, relating to HM Armed Forces. This refers to GP records of serving military personnel that were inexistence prior to them enlisting and held by HSCB.	These records should not be destroyed, however if the HSCB is notified of the death of such a patient the “not for destruction” marking should be removed and the records retained in the same way as for any other deceased patient.		Following the death of the patient, the records should be retained for 10 years after their death.
G51	GP Electronic Patient Record including those serving a period of imprisonment and Out of Hours Services	GPs must not destroy or delete their electronic patient records for the foreseeable future, unless and until such times as these records are transferrable in their entirety (including the audit trail) between clinical systems and from a GP system to the HSCB/BSO.	Good Practice Guidelines for General Practice Electronic Patient Records (version4)	Not to be destroyed
G52	GP Medical Records of those serving a prison sentence of more than 2 years, in existence prior to their imprisonment	GP Medical Records relating to those serving a prison sentence of more than two years should be sent to the HSCB The HSCB should mark the records “not for destruction”. If the HSCB is notified of the death of such a patient the “not for destruction” marking should be removed and the records retained in the same way as for any other deceased patient.		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.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G53	Health Visitor Records (for children these become school nursing records).	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. 10 years for all other cases		Destroy
G54	Hospital acquired infection records	6 years		Destroy
G55	Human fertilisation records, including embryology records	**Treatment Centres** The following retention periods apply to data held by clinics as established by HFEA General Directions 0012 version 1. 1. Where it is known that a birth has resulted from treatment – 30 years after the child's birth. 2. Where it is known that no birth has resulted from treatment – 30 years after conclusion of treatment. 3. Where the outcome of treatment is unknown – 50 years after the information was first recorded.	HFEA Data Protection Policy Version 2 February 2009 Directions given under the Human Fertilisation and Embryology Act 1990, 24 January 1992 (this Act is subject to review by the Government: http://www.hfea.gov.uk/docs/2009-09-07_General_directions_0012_-_Record_retention.pdf	Determined on review after consultation with Trust medical and records management staff

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Human fertilisation records, including embryology records	**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/storage licence.	Determined on review after consultation with Trust medical and records management staff
	Human fertilisation records, including embryology records	**Research centre** (a) the total number of embryos or human admixed embryos created, used or disposed of during the research project; (b) the results of the research project; and (c) the conclusions drawn from the research project.	Such Records are to be kept for 3 years from the date of final report of results/conclusions to Human Fertilisation and Embryology Authority (HFEA). Where a research project involves the derivation of stem cells for human application, a record of the information specified must be retained for a period of at least 30 years from the date the final report of any research project is submitted to the Authority.	Determined on review after consultation with Trust medical and records management staff
G56	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.	Human tissue (within the meaning of the Human Tissue Act 2004)	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G57	Immunisation and vaccination records – This information is held in Health Visitor and GP records for preschool children and also on the Child Health System. When a child goes to school and receives immunisations at school these are only recorded on the Child Health System, and not in GP records. GPs may also record information about immunisations for travel for people of all ages, in their own records which is not recorded on the Child Health System.	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
G58	Intensive Care Unit charts	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G59	Joint replacement records	10 years For joint replacement surgery the revision of a primary replacement may be required after 10 years and there is a need to identify which prosthesis was used originally. There is only a need to retain the minimum of notes with specific information about the original prosthesis for the full 10 years.	http://www.njrcentre.org.uk Consumer Protection (NI) Order 1987 and Article 8(3) The Limitation (Northern Ireland) Order 1989	Destroy
G60	Learning difficulties – (records of patients with) NB Specific Learning Difficulty is where a person finds one particular thing difficult but manages well in everything else.	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.	Royal College of Psychiatrists	Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G61	Learning Disabilities NB A general learning disability is not a mental illness – it is a life-long condition, which can vary in degree from mild to profound.	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.	Royal College of Psychiatrists	Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G62	Medical Records of those serving a period of imprisonment	Records wherever they are held other than the records listed below retain for 10 years after the 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. Maternity records – 25 years after last live birth Where the prisoner was suffering from a mental health disorder within the meaning of the Mental Health (NI) Order 1986, 20 years after the date of the last contact; **or 10** years after patient's death if sooner.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G63	Hospice Care (For Example Macmillan Marie Curie, NI Hospice, The Palliative and End of Life Care patient records– community and acute)	Organisations regulated under The Independent Health Care Regulations (Northern Ireland) 2005 see GMGR Section O16 Otherwise retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G64	Maternity (all obstetric and midwifery records including those of episodes of maternity care that end in still birth or where the child later dies). Where the baby receives donor milk the baby's record should be kept for 30 years.	25 years after last entry or update.	**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 United Kingdom Central Council for Nursing, Midwifery and Health Visiting Para 1.2.74 National Institute for Health and Clinical Excellence Donor breast milk banks: the operation of donor milk bank services February 2010	Determined on review after consultation with Trust medical and record management staff.
G65	Mental Health Records – Child & Adolescent (includes clinical psychology records) not listed elsewhere in this schedule.	20 years from the date of last contact, or until their 25th/26th birthday, whichever is the longer period. Retention period for records of deceased persons is 8 years after death.		Destroy
G66	**Mammography screening**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Mammograms & Reports	Normal packet – 9 years after date of final attendance Screen detected cancers – Indefinitely Interval cancers – Indefinitely Interesting cases – Indefinitely Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record.	BFCR (06)4 Royal College of Radiologists	Destroy
	Research cases	15 years after date of final attendance Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record.	BFCR (06)4 Royal College of Radiologists	Destroy
	Age Trial Cases	9 years after date of final attendance Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record.	BFCR (06)4 Royal College of Radiologists	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Deaths	9 years after final attendance Retention periods should be calculated from the end of the calendar year following the conclusion of treatment or the last entry in the record.	BFCR (06)4 Royal College of Radiologists	Destroy
G67	Medical illustrations	See photographs GMGR Section G90 Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G68	Mentally disordered persons (within the meaning of the Mental Health (Northern Ireland) Order 1986)	20 years after no further treatment considered necessary; or 8 years after the patients death if the patient died while still receiving treatment With regard to the selection of records for medical research purposes, PRONI advises that medical staff should recommend records for permanent preservation. Decisions should be based on the medical research potential of the records, e.g. on the different forms of mental disorder (genetic or otherwise) and on the		Transfer to PRONI all files for each Census Year (see Glossary) beginning with 1951 and in addition all files related to: a) suicide cases or where the cause of death was uncertain; b) cases which have already been

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
		different treatments. 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.		the subject of medical research by doctors or record drug trials; c) cases of medical research potential; d) social worker's reports and related records (e.g. personal "life testimonies" by patients – retained because of their social historical content); e) criminal mentally disordered offender cases where the person is convicted of a serious crime e.g. homicide; and f) mentally disordered offender cases where the person has been transferred to the following high

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
				secure or medium secure units: Ashworth Hospital; Broadmoor Hospital; Carstairs Hospital; Rampton Hospital; Shannon Clinic, Knockbracken.
G69	Microfilm/microfiche records relating to patient care	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.	See GMGR Part 1 Guide to preservation Microfilming 2000	Determined on review See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G70	Midwifery records	see (Maternity) GMGR Section G64 25 years after the entry or update	Midwives rules and standards 05.04 (rule 9)	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G71	Mortuary registers (where they exist in paper format)	30 years	The Royal College of Pathologists. The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
G72	Music therapy records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G73	Neonatal screening records	25 years		Destroy
G74	Nicotine Replacement Therapy (dispensed as smoking cessation aid)	2 years unless there are clinical indications to keep them for longer		Destroy
G75	Notifiable diseases book	6 years		Destroy
G76	Occupational therapy records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G77	Occupationally Related Diseases e.g. asbestosis, pneumoconiosis, byssinosis)	10 years after date of last entry in the record	British Thoracic Society's Occupational and Environmental Lung Disease Specialist Advisory Group	Destroy
G78	**Oncology (All records)**			
	Paediatric Oncology Records where condition was diagnosed prior to the 18th birthday	Until 65th birthday	BFCO (06)2 issued by the Royal College of Radiologists with the support of the Joint Council for Clinical Oncology	Determined on review after consultation with Trust medical and Records Management Staff
	All other oncology records	50 years or 8 years after death.	BFCO (06)2 issued by the Royal College of Radiologists with the support of the Joint Council for Clinical Oncology	Determined on review after consultation with Trust medical and Records Management Staff
G79	Operating Theatre Lists	4 years		Destroy
G80	Operating theatre registers	8 years after the year to which they relate		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G81	Ophthalmic Screening and General Ophthalmic Services (GOS)	A contractor shall keep a proper record in respect of each patient to whom he provides general ophthalmic services, giving appropriate details of sight testing, for 7 years from and including the date of the last recorded sight test "… but it is recommended for best practice, in line with the professional bodies, that GOS records are retained for 12 years"	Paragraph 7 Schedule 1 Health and Personal Services General Ophthalmic Services Regulations (NI) 2007 –S.R.2007 No.436 http://www.legislation.gov.uk/nisr/2007/436/contents/made	Destroy
G82	Orthoptic records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.	British and Irish Orthoptic society http://www.orthoptics.org.uk/orthoptists/Orthoptic_competency_standards.pdf	Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G83	Out-patient lists	2 years after the date to which they relate		Destroy
G84	Paediatric records	see Children and young people GMGR Section G19		Determined on review after consultation with Trust professional and records management staff

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G85	Parent-held records (i.e. records for sick/ ill children being cared for at home by community teams NOT the records of newborn children. These records are HSC records that belong to clinical staff but which are held by the parent.	At the end of an episode of care the HSC 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
G86	Patient/Client Clinical/Medical Case Records (not covered in other categories)	8 years after conclusion of treatment		Determined on review after consultation with Trust medical and record management staff.
G87	Patient Group Directions (PGDs) master copies, lists of authorised Practitioners, and records of version numbers	25 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G88	Patient-held records	At the end of an episode of care the HSC 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
G89	Patients involved in clinical trials	15 years after conclusion of treatment.		Determined on review after consultation with Trust medical and records management staff
G90	Photographs – (where the photograph refers to a particular patient it should be treated as part of the case health record) NB: In the context of GMGR a "photograph" is a print taken with a camera and retained in the patient record.	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68. Unless there is a clinical or legal reason for retaining the digital image and a print is placed on the patient's record, there is no requirement to retain the digital image.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G91	Physiotherapy records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy. See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G92	Podiatry Records	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68.		Destroy See GMGR Section G19 for children's records and GMGR Section G68 for mentally disordered persons' records
G93	Pre 1948 Records	Records in this category may already have been destroyed or sent to PRONI for permanent preservation. Any records which still exist and do not fall within any other category should be referred for a special PRONI Review.		Special Review by PRONI

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G94	Private patients records admitted to hospital under Article 31 of the Health and Social Services (Northern Ireland) Order 1972	Although technically exempt from the Public Records Act (Northern Ireland) 1923, it is appropriate to treat as if they were not exempt in which case retention periods relevant to the condition apply.		Destroy
G95	Radiation dose records for classified persons	50 years from the date of the last entry or age 75, whichever is the longer	Ionising Radiation Regulations (NI) 2000, SR 2000 No 375. (reg. 19(3)(a))	Destroy
G96	Record of patients property handed in for safe keeping Patients' property	6 years after the end of the financial year		Destroy
G97	Transplant records – Patient who has received an organ transplant	11 years beginning on the date of the patient's death or discharge whichever is the earlier. Precedent Cases should be transferred to PRONI.		Determined on review after consultation with Trust Medical and Records Management staff.
G98	Ultrasound records(e.g. vascular, obstetric)	Retain for the period of time appropriate to the patient/specialty, e.g. children's records see GMGR Section G19, for mentally disordered persons see GMGR Section G68, or 8 years after the patient's death if patient died while in the care of the Organisation.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G99	Video records/voice recordings relating to patient care/video records/video-conferencing records related to patient care/DVD records related to patient care Includes: Telemedicine records Out of hours records (GP cover) NHS Direct records	8 years subject to the following exceptions or where there is a specific statutory obligation to retain records for longer periods: **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.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G100	Waiting List Information Letters and responses to and from clients/ patients/Service user asking if they wish to remain on a waiting list.	Keep in the patient records according to speciality.		Destroy
G101	Waiting List	See Reference GMGR Section Q1 for returns sent to the Department. The actual list should be kept on a three year rolling cycle.		Destroy
G102	Ward Registers including daily bed returns	1 year		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G103	X-ray films (including other image formats for all imagining modalities/diagnostics)	General Patient Records – 8 years after conclusion of treatment. Children & Young People – Until the patient's 25th birthday, or if the patient was 17 at conclusion of treatment, until their 26th birthday or 8 years after the patient's death if sooner. Maternity – 25 years after the birth of the child, including, still births. Clinical Trials – 15 years after completion of treatment. Litigation – Records should be reviewed 10 years after the file is closed. Once litigation has been notified (or a formal complaint received) images should be stored until 10 years after the files has been closed. Mental Health – 20 years after no further treatment considered necessary or 8 years after death. Oncology – see GMGR Section G78 Oncology Records.	BFCR(06)4 – Royal College of Radiologists Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (para 2.1), but goes on to say: "It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (para 2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules" (para 7.1): http://www.rcr.ac.uk/publications.aspx?PageID=310&PublicationID=234 The Ionising Radiation (Medical Exposure) Regulations 2000	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
G104	X-Ray Referral/Request Cards	8 years providing there is a record in the patient's health record that a referral /request was made for an x-ray.	Guidance from the Royal College of Radiologists regards "images and request information (to be) of a transitory nature" (Para 2.1) but goes on to say: "It is now considered that best practice should move towards retention of image data for the same duration as report and request data" (Para2.2) and recommends that "the retention period for text and image data are equal and comply with the published retention schedules"(para7.1): http://www.rcr.ac.uk/index.asp?PageID=310&PublicationID=234 The Ionising Radiation (Medical Exposure) Regulations 2000	Destroy
G105	X-ray registers	8 years	The Ionising Radiation (Medical Exposure) Regulations 2000	Destroy
G106	X-ray reports (including reports for all imaging modalities)	To be considered as a permanent part of the patient record.	The Ionising Radiation (Medical Exposure) Regulations 2000	As per the final action for the patient record

H. Work Area - ICT

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
H1	Software licences	Lifetime of software		Destroy
H2	Documentation relating to computer programmes written in-house.	Lifetime of software		Destroy
	Minor administrative records	Current plus 2 years		Destroy
H3	Products (liability)	11 years	Consumer Protection (Northern Ireland) Order 1987 Where the records are potentially relevant to the issue of proceedings **by** an organisation legislation requires retention of 10 years. However an extra year has been added to allow time for any proceedings to be served **against** an organisation.	Destroy
H4	Records documenting the development and establishment of ICT systems management policies and procedures.	See GMGR Section J34 and GMGR Section J39		Determined on Review
H5	Records documenting the security arrangements for ICT systems.	See GMGR Section D9	http://www.bangor.ac.uk/ar/ro/recordsmanagement/InformationCommunicationTechnologyICTSystemsManagement-RecordsRetentionSchedule.php.en	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
H6	Records relating to the monitoring of **Display Screens** and related workstations in the workplace.	3 years		Destroy
	Eyesight Tests	See GMGR Section L32		Destroy
H7	Records documenting helpdesk services including faults reported, requests for technical and application support and action taken to resolve and assistance provided.	Last action plus 1 year		Destroy
H8	Web Management	3 years		Destroy
H9	Records relating to the ongoing management, and changes to system support including user accounts, and monitoring use of systems.	5 years		Destroy
	Management of all Networks	7 years		Destroy
H10	Telecommunications management	6 years		Destroy

I. Work Area - Legal

Ref	Record Type	Minimum Retention Period	Relevant legislation / Derivation	Final Action
I1	Records/documents related to any form of litigation.	6 years from the date of the last action on the file or settlement of the case whichever is the later and as advised by legal advisors. Specific legal advice should be sought from the organisation's legal advisors to determine whether the records should be retained further within the organisation. In cases where the proceedings relate to a minor (i.e anyone under the age of 18) records should be maintained until their 25th birthday. In cases involving a person under a disability (see definition in Part 1) records should be retained for a period of six years after the death of the individual concerned.	HSC (SQSD) 05/10 Handling Clinical and Social Care Negligence and Personal Injury Claims	When the organisation's retention period has expired, PRONI should be asked to review.
	Database containing information on all claims (HSC (SQSD) 05/10 Para 39 refers).	50 years	HSC (SQSD) 05/10 Handling Clinical and Social Care Negligence and Personal Injury Claims	Destroy
I2	Police Statements (made in the context of Accident and Emergency episodes. Statements are requested by the Police to the A&E staff in relation to alleged injuries of or by patients coming through A&E).	10 years (congruent retention period as Incident Forms)		Destroy
I3	Family Health Service Appeals Authority tribunal and case files.	Case files – 10 years Decision records – until individual's 80th birthday		Destroy

J. Work Area - Organisation

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J1	Agendas and Minutes of Trust/HSCB/Agency/Departmental Board Meetings (Master Copies including associated papers)	20 years		Transfer to PRONI
J2	Agendas and minutes of major committees, sub-committees (master copies, including associated papers)	10 years - Normal Review Process		Transfer to PRONI
J3	Agendas, meeting papers, minutes–committees, sub committees, predecessors, professional staff/team meetings (Master Copies)	10 years - Normal Review Process		Determined on review
J4	Meetings and minutes papers (other, including reference copies of major committees)	2 years		Destroy
J5	Advance letters (e.g. DH guidance)	6 years		Destroy
J6	Ambulance Administrator Records (i.e.) records containing non-clinical details only e.g. records of journeys.	2 years from the end of the year to which they relate.		Destroy
J7	Annual/Corporate Reports (Background papers)	3 years		Destroy
	Annual/corporate reports (published report)	3 years		PRONI should be added to the circulation list and a copy of each published Annual / Corporate Report sent to them.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J8	Assembly Questions(AQ), Parliamentary Questions(PQ) MLA/MP Enquiries These documents include all information provided by the organisation in response to a AQ/PQ (e.g. background note to the Minister or the Minster may amend the response) all of which may not be used in the response and therefore it will not be in the public domain.	5 years		Permanently preserve electronic, review paper
J9	Business Plans including Health and Well Being Investment Plans (HWIPs) and Trust Delivery Plans (TDPs) Strategic Plans	20 years		Destroy PRONI should be added to the circulation list and a copy of each published HWIP/TDP sent to them.
J10	Close Circuit TV Images	To be retained for 28 days and then permanently erased unless required for evidential purposes (in line with DATA Commissioner's Code of Conduct) 31 days	Information Commissioner's Code of Conduct	Destroy Erase permanently
J11	**Commissioning decisions**			
	Appeal documentation	6 years from date of appeal decision		Destroy under confidential conditions

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Decision documentation	6 years from date of decision		Destroy under confidential conditions
J12	Contact details	1 year after details change or no longer required		Destroy
J13	**Library Services**			
	Copyright declaration forms	6 years	Copyright, Designs and Patents Act 1988	Destroy
	Acquisition, Catalogues Circulation Customer Services, Advice and Guidance	2 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J14	Correspondence and other papers of minor or ephemeral importance not covered elsewhere e.g. • advertising matter • printing • covering letters • Compliments and appreciations • queries • reminders • letters making appointments • anonymous or unintelligible letters • drafts • duplicates of documents known to be preserved elsewhere (unless they have important minutes on them) indexes and registers compiled for temporary purposes • routine reports • punched cards, and other documents which have ceased to be of value on settlement of the matter involved.	3 years after the settlement of the matter to which it relates		Destroy
J15	Data Input Forms (where the data/information has been input to a computer system)	2 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J16	Departmental Enquiries	10 years - Normal Review Process		Determined on review
J17	**Diaries**			
	Chief Executive	Review 5 years following the calendar year to which they relate		Destroy
	Minister and Ministers private secretary	See GMGR Section J35		Destroy
J18	Diaries which contain details of staff travelling	6 years following the calendar year to which they relate		Destroy
J19	Diaries – professional e.g. health visitors, district nurses, social workers and Allied Health Professionals	2 years after the end of the year to which the diary relates. Patient specific information should be transferred to the patient record. Any notes made in the diary as an 'aide memoire' must also be transferred to the patient record as soon as possible.		Destroy
J20	Diaries (office)	1 year after the end of the calendar year to which they refer.		Destroy
J21	**Records Management**			
	Disposal Schedules/Indexes (documents describing public records marked for permanent preservation or containing the management of public records) correspondence and papers relating to the compilation of disposal schedules	Review at 10 years	Public Records Act (Northern Ireland) 1923 Information management records retention schedule	Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Disposal Schedules (Actual Signed Schedule) or indexes.	Permanent		A copy is permanently retained in the organisation and a copy should be sent to PRONI
	Registry lists of public records marked for permanent preservation, or containing the record of management of public records	30 years		Retain
	File lists and document lists where public records or their management are not covered	30 years	Information management records retention schedule	Determined on review
	Review Lists	5 years		Destroy
	Lists, certificates, docket books or databases of records destroyed	Retain permanently		Retain
	Records relating to the transfer and retrieval from and to off-site storage	2 years		Destroy
	Records relating to contracts with storage providers	6 years from the end of the contract		Destroy
	Disaster planning records	Until superseded		Destroy
	Information Surveys record audits and registry inspections	5 years		Destroy
	Public Access Requests	See GMGR Section J28 Freedom of Information Requests	FOI model retention schedule	Destroy
	Records relating to the control of record keeping systems	When the system is superseded	Information management records retention schedule	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Documentation of record series	Preserve permanently for series from which records have been transferred to PRONI, Destroy when all records in the series have been destroyed.		Destroy
	General administrative records, including routine correspondence relating to the provision of information management services	2 years		Destroy
	Security of records	5 years		Destroy
J22	Documents more than 100 years old	Any records currently held should be referred for a special PRONI Review		Special review by PRONI
J23	Equality and good relations: documents created or used specifically for the purposes of meeting statutory duties placed on public bodies regarding the promotion of equality and good relations, inc. Equality Schemes and background documents; documents relating to the equality-screening of policies and Equality Impact Assessments; annual statements to the Equality Commission on the implementation of the duties; equality training plans and materials.	7 years		Determined on review
J24	Garden Parties and Public Functions	5 years		Destroy
J25	Honours	75 years		Destroy
	Awards and prizes	7 years		Destroy
J26	**Hospitality**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Gifts and Hospitality Registers including the offers of gifts	6 years	DAO(DFP)10/06 Acceptance and Provision of Gifts and Hospitality DFP Guidance on the Acceptance and Provision of Gifts and Hospitality	Destroy
	Catering forms	6 years		Destroy
	Guidance on the provision and acceptance of gifts	See GMGR Section J31	HSS(F) 49/2009 Gifts and Hospitality	Destroy
J27	Records of Incoming mail	3 years		Destroy
J28	**Information Access Requests and Responses**			
	Data Protection Act and Access to Health Records- Subject Access Requests – record of requests	3 years after last action		Destroy
	Policy and procedures for handling FOI Requests. Case records which lead to the development of precedents and best practice.	5 years after the policy or procedures have been superseded.	FOI model retention schedule	Destroy
	Freedom of Information and Environmental Information Request case file records, detailing the FOI request, the consideration of possible exemptions and subsequent appeals.	3 years after last action.	FOI model retention schedule	Destroy
	Details of access decisions taken and any redacted versions of documents released	This information may be required for longer as it could be considered current until superseded by a subsequent decision. Retain 10 years	FOI model retention schedule	Destroy
	Monitoring records. Statistical data about the number of requests and outcomes.	10 years	FOI model retention schedule	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Records relating to Data Sharing arrangements between organisations including Data Access Agreements	7 years		Destroy
J29	Inquiries Under Inquiries Act 2005	See guidance on Special Category Records in Part 1		PRONI to determine on review after completion of the Inquiry
J30	**Governance and quality assurance/controls records**			
	Annual report on the discharge of delegated Statutory functions and corporate parenting report	3 years		Destroy
	Quality assurance records (e.g. Healthcare Commission, Audit Commission, King's Fund Organisational Audit, Investors in People NIMDTA)	15 years		Destroy
	Controls Assurance Standards	5 years		Destroy
	Controls Assurance Exercise Documents	2 years		Destroy
	Assessment of performance against controls Assurance Standards	5 years		Destroy
	Liaison between organisations relating to governance	5 years		Destroy
	Monitoring of performance by the Department	5 years		Destroy
	Records relating to internal organisational, team standards	5 years		Destroy
	Risk Registers	5 years after cancelled or superseded		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Accountable Officer Records			
	• Declaration and self assessment	5 years		Destroy
	• Records of auditing and monitoring	5 years from formal approval of the audit.		Destroy
	• Occurrence reports	10 years		Destroy
	• Records of concern and the assessment and investigation of concerns	See GMGR Section A2 – A4 and GMGR Section A6		Destroy
	Local Intelligence Network Records	Review the records (see Part 1 for guidance) after 10 years to consider whether the records should be destroyed or retained up to the death or end of working life of any individual concerned.		Destroy
	Medicines Regulatory Group (DHSSPS) (previously Inspection and Enforcement Group)			
	• Inspections	5 years from the date of the inspection	Addendum to DAO (DFP) 08/07	Determined on Review
	• Investigations	10 years (see GMGR Section F26)	Addendum to DAO (DFP) 08/07	Determined on Review
J31	**Guidance and Circulars**			
	received by organisations (e.g. from the Department)	Until cancelled or superseded		Destroy
	Creator' background papers	See GMGR Section J39		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J32	**Legislation**			
	Actual sealed copy		Paragraph 9.1.4 of OFMDFM'S Handbook on Subordinate Legislation advises the "Original of a Statutory Rule is retained permanently by the Department in a secure place." The DHSSPS Departmental Records Officer has approved that all Statutory Rules and Sealed Directions should be sent to PRONI	transferred to PRONI within 3 months
	Background papers			
	• Primary Legislation	Permanent Preservation		Determined on Review
	• Subordinate legislation	Review 20 years. Papers should be considered for destruction if the legislation has been superseded		Determined on Review
	• Administrative records associated with the legislation process	5 years after closure		Destroy
J33	Mailing lists	1 year after list changes or no longer applicable		Destroy
J34	Manuals – policy and procedure (administrative and clinical, strategy documents)	10 years after life of the system (or superseded) to which the policies or procedures refer		Determined on review
J35	**Ministerial Records**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Ministers Diary (paper diary or electronic diary) Ministers notebooks	Pass to the Departmental Information Manager at the end of a minister's tenure in Office. The DIM should transfer all electronic records to PRONI and request PRONI to review any paper records.	The National Archives guidance on the Management of Private Office Papers	Permanently preserve electronic, paper to be determined by DIM and PRONI
	Private secretary's notebooks	6 months	The National Archives guidance on the Management of Private Office Papers	Destroy
	Submissions and Invitations May include Ministerial policy or media briefings; speeches; visits by dignitaries, politicians, ministers invited guests; private secretaries e-mails conveying Minister's views/decisions to policy areas; Private Secretaries' notes of Minister's meetings and telephone conversations. Policy briefings, speeches, press releases, interviews.	Pass to the Departmental Information Manager at the end of a minister's tenure in Office. The DIM should transfer all electronic records to PRONI and request PRONI to review any paper records.	The National Archives guidance on the Management of Private Office Papers	Permanently preserve electronic, paper to be determined by DIM and PRONI
	Records of formal meetings with outside interest groups /lobbyists	Pass to the Departmental Information Manager at the end of a minister's tenure in Office. The DIM should transfer all electronic records to PRONI and request PRONI to review any paper records.	Recommendations 27 and 28 of the Sixth Report of the Committee on Standards in Public Life (CMD 4817)	Permanently preserve electronic, review paper
	Photographs Image Library records	See GMGR Section J40		Destroy
J36	Organisational Charts	2 years after cancelled or superseded		Destroy
J37	Patient/customer information leaflets	6 years after the leaflet has been superseded		Destroy
J38	Patient/ client/ customer surveys	2 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J39	Policy, procedures and guidelines – (development background papers including Cross Border Initiatives)	Until policy or procedures are revised. Review at change/ revision and or first and second review procedures. Libraries will retain a copy as reference.		Determined on review
J40	**Press and Public Relations Records**			
	Events, Exhibitions and Fairs	2 years		Destroy
	Media Briefing	7 years		Destroy
	Official Briefings – responses Briefing requests and their responses from private offices, select and standing committees	See GMGR Section J35 Pass to the Departmental Information Manager at the end of a minister's tenure in Office. The DIM should transfer all electronic records to PRONI and request PRONI to review any paper records.	The National Archives guidance on the Management of Private Office Papers	Permanently preserve electronic, paper to be determined by DIM and PRONI
	Photographs Image Library records	1 year or sooner if no longer required	National Archives Records Management Retention Scheduling Press and Public Relations Records	Destroy
	Press Conference reports	3 years	National Archives Records Management Retention Scheduling Press and Public Relations Records	Destroy
	Reports on media/public relations, correspondence with media, press reports	7 years	National Archives Records Management Retention Scheduling Press and Public Relations Records	Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Press Cuttings (paper)	1 year	National Archives Records Management Retention Scheduling Press and Public Relations Records	Destroy
	Press Cuttings Electronic Copies	28 Days	National Archives Records Management Retention Scheduling Press and Public Relations Records	Destroy
	Press Releases	7 years	National Archives Records Management Retention Scheduling Press and Public Relations Records	Destroy
	Speeches and Interviews – preparation and delivery of speeches and interviews on behalf of ministers, permanent secretary, and chief executives as well as other officials.	For ministerial records see See GMGR Section J35 Pass to the Departmental Information Manager at the end of a minister's tenure in Office. The DIM should transfer all electronic records to PRONI and request PRONI to review any paper records. For all others 4 years. The DIM should transfer all electronic records to PRONI and request PRONI to review any paper records.		Permanently preserve electronic, review paper
J41	Project Initiation Documents and supporting documentation including business cases	10 years after completion of the project	Records Management Retention Scheduling - Project Records	Determined on Review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J42	European Projects	15 years	Article 90 of the Council Regulations (EC) No 1083/2006 requires that supporting documents regarding expenditure and audit should be kept available for a period of seven years following the closure of the Programme.	Determined on Review
J43	**Project board files (excluding estates)**			
	Project files (over £100,000 on termination, including abandoned or deferred projects)	Review – 6 years after project completed	Records Management Retention Scheduling - Project Records	Determined on review
	Project files (less than £100,000 on termination include)	Review – 2 years after project completed	Records Management Retention Scheduling - Project Records	Destroy
J44	**Project Team files**			
	Project files (over £100,000 on termination, including abandoned or deferred projects)	Review - 6 years after project completed or abandoned	Records Management Retention Scheduling - Project Records	Determined on Review
	Project Team files (less than £100,000) on termination, including abandoned or deferred projects	Review - 2 years after project completed or abandoned	Records Management Retention Scheduling - Project Records	Destroy
J45	Project team files (summary retained)	3 years		Destroy
J46	Publications internal, corporate identity. translations	When superseded See GMGR Section J37 for Patient/customer Information publications		Destroy
J47	Publication Scheme background papers relating to the development of the Publication Scheme	10 years. Close when Publication Scheme finalised.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J48	Finalised Publication Scheme	Permanently within the HSCB/Trust/Agency		Retain permanently
J49	Records related to recognised chartermarks, standards, models e.g. investors in people	Until standard or chartermark has been reassessed or 10 years		Destroy
J50	Requests for access to records, other than Freedom of Information or subject access requests	6 years after last action		Destroy
J51	Phone Message Books	2 years NB Any clinical information should be transferred to the patient health record		Destroy
J52	Record of custody and transfer of keys	6 years		Destroy
J53	Register of Board members' and Senior Managers' interests	6 years after the person leaves the organisation		Transfer to PRONI
J54	Registered Staff Lists	1 year		Destroy
J55	Reports (major)	30 years		Transfer to PRONI
J56	Research and development records (scientific, technology, medical and other)	Review 5 years after the research has been completed. Where possible review of this material should be made in consultation with medical professionals involved in the trials.		Determined on Review
J57	**Clinical Trials of Investigational Medicinal Products (CTIMPs)**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Trial Master File (responsibility of Sponsor & Chief Investigator to ensure that documents are retained)	Five years after the conclusion of the trial	Regulation 31A(7) of the Medicines for Human Use (Clinical Trials) Regulations 2004 (as inserted by regulation 18 of the Medicines for Human Use (Clinical Trials) Amendment Regulations 2006	Destroy
	Research Ethics Committee Records	An ethics committee shall retain all the documents relating to a clinical trial on which it gives an opinion for: where the trial proceeds, at least three years from the conclusion of the trial; or where the trial does not proceed, at least three years from the date of the opinion. Five years after the conclusion of the trial.	Governance Arrangements for NHS Research Ethics Committees (GAfREC)	Destroy under Confidential conditions
	Trial Subject's Medical Files (Sponsor & Chief Investigator's responsibility to ensure retained)	There should be a flag or divider in health records for documents pertaining to research indicating that the patient has been recruited to a clinical trial or other research.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Marketing authorisation (holders must arrange for essential clinical trial documents (including case report forms) other than subject's medical files, to be kept by the owners of the data):	15 yrs after completion or discontinuation of the trial, or two years after the granting of the last marketing authorization in the European Community and when there are no pending or contemplated marketing applications in the European Community. or two years after formal discontinuation of clinical development of the investigational product.	Paragraph 5.2(c) of Annex 1 to Commission Directive 2001/83/EC (as amended by Commission Directive 2003/63/EC (implemented in UK by the Medicines for Human Use (Marketing Authorisations Etc.) Regulations 1994 (as amended by regulation 7 of the Medicines for Human Use (Fees and Miscellaneous Amendments) Regulations 2003)	Destroy
	Trial subject's medical files	Retain in accordance with applicable legislation and in accordance with the maximum period of time permitted by the hospital, institution or private practice. NB: Documents can be retained for a longer period, however, if required by the applicable regulatory requirements or by agreement with the sponsor. It is the responsibility of the sponsor to inform the hospital, institution or practice as to when the documents no longer need to be retained.		Destroy
	All other documentation pertaining to the trial (retention of documentation is the responsibility of the sponsor or other owner of the data)	Retain as long as the product is authorised.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Final Report (responsibility of sponsor or subsequent owner's to retain documents)	Five years after the medicinal product is no longer authorised.		Destroy
	Data collected in the course of research	Retain for an appropriate period, to allow further analysis by the original or other research teams subject to consent, and to support monitoring by regulatory and other authorities.	Research Governance Framework for Health and Social Care – paragraph 2.3.5 Good Research Practice (MRC Ethics Series, 2000, updated 2005) – paragraph 5.2 Personal Information in Medical Research (MRC Ethics Series, 2000, updated 2003) – chapter7 Data Protection Act 1998 – Part IV, Section 33 (3)	Destroy
J58	Research and development (organisation) i.e. all the organisation's records associated with research and development and not individual trial records or information on patients.	30 years	Medical Research Council	Determined on review
J59	Security Pass	Retain current only		Destroy
J60	Security policy covering the correct handling and safekeeping of Disclosure Information in line with Access NI Code of Practice (See also GMGR Section L1)	See GMGR Section J39	Access NI Code of Practice	Destroy
J61	Stock Control reports Stock Orders and Non Stock Orders	2 years following the end of the financial year to which they relate		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
J62	Stores records - major (stores ledgers etc)	6 years following the end of the financial year to which they relate		Destroy
J63	Stores records - minor (requisitions, issue notes, transfer vouchers, goods received, books etc)	2 years following the end of the financial year to which they relate		Destroy
J64	Supplies records - minor (e.g. invitations to tender and inadmissible tenders, routine papers relating to catering and demands for furniture, equipment, stationery and other supplies)	2 years following the end of the financial year to which they relate		Destroy
J65	Training evaluation - general feedback provided at the end of training by the trainee	2 years		Destroy
J66	Training materials - manuals, videos, photographs created for the purposes of training clinical staff	Retained for as long as required for training purposes		Destroy
J67	Training Plans	2 years		Destroy
J68	Trust documents without permanent relevance/not otherwise mentioned	6 years		Destroy
J69	Unpublished material of the history of the Organisation or its predecessors, the organisation and procedures.	10 years - Normal Review Process		Determined on review
J70	Hospital (trust) services i.e. service that the Trust provides e.g. catering, hotel services.	10 years		Destroy

K. Work Area - Pathology

Documents, Records, Specimens and Preparations - Transfusion Laboratories

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K	Pathology Records		The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009) Human Tissue Act 2004 Human Tissue Act's Code of Practice 5, Removal Storage and Disposal of Human Organs and Tissue http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice/code5disposal.cfm EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	
K1	Accreditation documents; records of inspections	10 years or until superseded	Para 55 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K2	Annual reports (where required by EU directive)	15 years	The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50) Para 125 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K3	Archived blood donor samples	3 years		Destroy
K4	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		Destroy
K5	Batch records results (relating to products)	10 years	Para 52 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009) Consumer Protection (Northern Ireland) Order 1987	Destroy
K6	Blood bank register, blood component audit trail and fates	30 years to allow full traceability of all blood products used	EU Directive N 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50) Para 122 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K7	Blood donation session slips	15 years	The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	Destroy
K8	Blood Donor Health Check	15 years	The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50)	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K9	Blood for grouping, antibody screening and saving and/or cross-matching	1 week at 4ºC	Para126 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K10	Blocks for electron microscopy	30 years	Para 92 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K11	Blood gas results	Retain for the period of time appropriate to the patient/specialty, e.g. 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 (Northern Ireland) Order 1986) 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
K12	Body fluids/aspirates/swabs	48 hours after the final report issued by laboratory	Para 82 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K13	Bound copies of reports/records, if made	30 years		Destroy
K14	Cleaning Records	2 years	MHRA Guidance Note 14	Destroy
K15	Daily Work Logs, Day books and electronic equivalents and other records of specimens received by a laboratory	2 calendar years from receipt of specimen	Para 35 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K16	Donor lymphocyte preparations in cell or tissue transplantation	For the lifetime of all recipients	Para 84 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K17	Electrophoretic strips and immunofixation plates	5 years unless digital images taken, in which case 2 years and stored as a photographic record	Para 118 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K18	Equipment/instruments maintenance logs, records of service inspections Procurement, use, modification and supply records relevant to production of products (diagnostics) or equipment	See GMGR Section D1	Para 56-58 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K19	External quality assessment records	5 years but see Paras 134-136 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009) for external quality assessment schemes	Para 54 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K20	Foetal serum	30 years	Para 77 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K21	Forensic material – criminal cases	Permanently, not part of the health record	Para 128 (see also Para 29) The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Permanently Preserve

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K22	Frozen tissue for immediate histological assessment (frozen section)	Stained microscope slides – 10 years Residual tissue – kept as fixed specimen once frozen section complete	Para 85 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K23	Frozen tissue or cells for histochemical or molecular genetic analysis	10 years	Para 86 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K24	**Grids for electron microscopy**			
	• Grids for human tissue diagnosis	10 years	Para 93 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
	• Grids for virus identification	48 hours after final report has been issued provided that all derived images are retained for 30 years	Para 93 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K25	Human DNA and RNA	4 weeks after final report for diagnostic specimens. 30 years for family studies for genetic disorders (consent required)	Paras 111-112 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K26	Internal quality control records (relating to products)	10 years	Consumer Protection (Northern Ireland) Order 1987	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K27	Laboratory file cards or other working records of test results for named patients	One year from Specimen Receipt if all results transcripted into a separately issued and stored formal report. Otherwise 30 years.	Para 39 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K28	Microbiological cultures	24–28 hours after final report of a positive culture issued. 7 days for certain specified cultures – see RCPath document	Paras 113-116 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K29	Museum specimens (teaching collections)	Permanently. Consent of the relative is required if it is tissue obtained through post mortem	Paras 98-100 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K30	Near-patient (Point-of-Care) test data	Result in patient record, log retained for lifetime of instrument		Destroy
K31	Newborn blood spot screening cards	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	Para 80 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009) Code of Practice of the UK Newborn Screening Programme Centre and http://www.screening.nhs.uk	Destroy
K32	Paraffin, Wax or Resin embedded blocks	30 years and then appraise for archival value	Paras 87-91 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K33	Pathological archive/museum catalogues	30 years, subject to consent For as long as the specimens are held or until updated, subject consent	Para 47 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K34	Photographic records	30 years where images present the primary source of information for the diagnostic process	Paras 48-51 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K35	Protocols of Standard operating procedures (current and old)	30 years	Para 37 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Determined on review
K36	Records of serious events	15 years	EU Directive 2002/98/EC The Blood Safety and Quality Regulations 2005 (SI 2005 No. 50) Para 124 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Determined on review
K37	Records of telephoned reports	2 calendar years	Para 40 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K38	Records relating to donor or recipient sera	11 years post transplant		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K39	Records relating to the collection, testing, storage and issue of cord blood which contribute to traceability	30 years after unit is issued or discarded		Destroy
K40	Records relating to /resulting from, the testing of blood which are not required for traceability purposes	15 years		Destroy
K41	Records relating to investigation or storage of specimens relevant to organ transplantation, semen or ova	30 years if not held with health record	Paras 60 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K42	Refrigeration and freezer charts	15 years		Destroy
K43	Reports, copies Post mortem reports	6 months Held in the patient's health record for 8 years after the patient's death		Destroy
K44	Request forms for grouping, antibody screening and crossmatching	1 month	Para 119 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K45	Request forms that are not an unique record	1 month after final checked report received by requestor	Paras 32-34 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K46	Request forms that contain clinical information not readily available in the health record	30 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K47	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) Para 121 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K48	Separated serum/plasma, stored for transfusion purposes	Up to 6 months	Para 127 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K49	Serum following needlestick injury or hazardous exposure	2 years	Para 78 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K50	Serum from first pregnancy booking visit	2 years	Para 76 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K51	Stained slides	Depends on the purpose of the slide – see RCPath document for further details	Paras 101-110 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K52	Storage of material following analyses of nucleic acids	30 years See Royal College of Pathologists document for further guidance	The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
K53	Surgical (histological) reports	30 years	Para 42 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K54	Validation projects	15 years or the life time of the process, equipment, facilities or systems, whichever is the longest.	http://www.bcshguidelines.com/documents/Guidelines_for_validation_bcsh_13082010.pdf http://www.bcshguidelines.com/documents/Appendices_Validation_11.11.10_bcsh.pdf http://www.bcshguidelines.com/4_haematology_guidelines.html	Destroy
K55	Wet tissue (representative aliquot or whole tissue or organ)	4 weeks after final report for surgical specimens Cases where a supplementary report is anticipated, specimens should be retained until the additional report is finalised.	Paras 94-97 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy
K56	Whole blood samples, for full blood count	24 hours		Destroy
K57	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) Para 120 The Royal College of Pathologists - The retention and storage of Pathological records & specimens (4th Edition, 2009)	Destroy

L. Work Area - Personnel

This section covers the information held on individuals, commonly called Personnel Files. The records held in Personnel Files cover six broad areas:

Employment and career, Health, Pay, Pension, Welfare, and Security.

All six areas of information may not be held on one central file but may be retained as separate collections The retention of the records should follow these guidelines regardless of how or on what medium the records are held. Personal files of Chief Executives, Directors should always be transferred to PRONI.

Where a type of record has not been named specifically it may be possible to determine which category it best fits.

A previous retention period of until “age 72” for records required for pension purposes has been increased and such records should now be kept for 100 years from birth. Organisations are free to seek their own legal advice where there are cases of doubt. A personnel record can be kept longer than the recommended retention period if this is in accordance with legal advice. These retention periods are based on the guidance issued by the National Archives and endorsed by Cabinet Office. Both Medical Staff Records and Agency locums staff records should be treated as personnel and retained accordingly.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L1	**Access NI checks with effect from April 2008** (see Glossary)			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	original information and all copies (See also GMGR Section J60). Prior to these arrangements, checking processes were accommodated under PECS (1982 – March 2005, See Glossary), which was replaced by POCVA (April 2005 – March 2008, See Glossary)"	Until final decision about the applicants suitability is determined. This should not exceed 6 months. Access NI will approve the retention of the disclosures for a longer period in exceptional circumstances and where there is a requirement to retain so that the RQIA can have access to fulfil its statutory duties.	Access NI Code of Practice in accordance with section 122(2) of the Police Act 1997 Explanatory Guide to the Code	Destroy immediately by shredding, pulping or burning
	A record should be kept on the personnel file of: • The date of the disclosure • The name of the subject of the disclosure • The type of the disclosure namely, whether it is the Basic, Standard or Enhanced type • The position which the disclosure was applied for • The unique number that was issued by Access NI for that Disclosure; and • The recruitment decision taken	Age 100 The records should be signed and dated by a person of sufficient authority and seniority who could represent the organisation in court.	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy immediately by shredding, pulping or burning
L2	**Annual/Assessment/Appraisal or Summary of Performance**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Reports	5 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.
	Chief Executive/Directors Annual/Assessment Reports	Retain permanently in personal file	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.
	Assessment Report where appeal or legal proceedings are underway	5 years from the result of the appeal	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Report of Appeal	5 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.
	Reports for last 5 years of service	Age 72	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.
	Assessment/ Performance Appraisal Interview/meeting Sheet	5 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.
	Assessment of Board Members (by Chairman)	7 years	http://www.afmdni.gov.uk/ pubs/DAOs/daodfp0807.doc	Destroy
	GP Appraisal Appraisee / Appraiser Records	6 years after the appraisal year to which it relates.	In line with revalidation periods	Destroy
L3	**Annual Leave**			

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Cards (held by individual members of staff)	2 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
	Annual leave records	2 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
	Copy of Annual leave entitlement	As part of the contract of employment until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L4	Attendance Book/Register	2 years		Destroy
L5	Career Summary– Consolidated record of whole career, location detail	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
	Career Development	See GMGR Section L53	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L6	Change of address	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L7	Change of grade notification	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L8	Commendations	Until age 100		Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L9	Consultants, Senior staff (records relating to the recruitment of)	5 years	NHS (Appointment of Consultants) Regulations, good practice guidelines, page 11, para. 5.3 http://www.dh.gov.uk/assetRoot/04/10/27/50/04102750.pdf	Destroy
L10	**CVs for non-executive directors**			
	successful	Review 5 years following term of office		Determined on review
	unsuccessful applicants	2 years following application		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L11	Decree absolutes	Return originals to provider, retain copy until Age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L12	Disciplinary Records– Papers relating to disciplinary action which has resulted in any change to terms and conditions of service, salary, performance pay or allowances	Until age 100		Destroy
L13	**Duty rosters clock cards, time sheets**			
	Duty rosters clock cards, time sheets.	2 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
	Organisation or departmental duty rosters, not the ones held on the individual's record.	4 years after the year to which they relate	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
	Time Sheets (relating to a group or Department e.g. Ward where the timesheets are kept as a tool to manage resources, staffing levels)	6 months	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
	Timesheets (for individual members of staff)	2 years after the year to which they relate NB Timesheets (for all individuals including locum doctors) held on the personnel record are minor records – retain for 2 years.	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L14	Employee Welfare Reports and Papers	6 years after last entry	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L15	Exposure monitoring records	5 years from the date the record was made	Control of Substances Hazardous to Health Regulations 2002 (reg.10(5))	Destroy
L16	Health declaration	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L17	Health referrals– including Medical Reports from doctors and consultants and any correspondence with the Occupational Health Service	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L18	History records of pay scales	Permanent		Retain permanently
L19	HRMS	Refer to individual record types in this section		Destroy
L20	Income Tax form P45	Until age 100		Destroy
L21	Industrial relations (not routine staff matters), including industrial tribunals	10 years - Normal Review Process		Determined on review

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L22	Interview documentation	1 year	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L23	Job advertisements	1 year		Destroy
L24	Job applications successful (following termination of employment)	3 years		Destroy
L25	**Job Applications – Unsuccessful**			
	Documents	1 year		Destroy
	Interview Documentation	3 years		Destroy
	Note confirming that an Access NI check was carried out and offer of appointment withdrawn	3 years		Destroy
	Equality Monitoring returns	3 years		Destroy
L26	Job descriptions (following termination of employment)	3 years		Destroy
L27	Leavers dossiers (provided a summary retained)	6 years after subject leaves the service		Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Leavers dossiers Summary (retained on file)	Age 100		Destroy Personal files of Chief Executive, Directors should be transferred to PRONI. All other files destroyed.
L28	Letter of appointment/contracts	Life of file – Age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L29	Marriage certificates	Return originals to provider Retain copy until age 100		Destroy
L30	Medical/Self certificates unrelated to Industrial Injury (see also GMGR Section L33)	4 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L31	Nurse training records (from hospital-based nurse training schools prior to the introduction of academic-based training)	30 years		Destroy
L32	Overpayment documentation	6 years after repayment or write-off		Destroy
	Performance Pay	7 years		Destroy
	Special Bonus Papers	7 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Third party client/advances in lieu of pay	6 years after repayment		Destroy
	Eyesight test documents	Retain currently only		Destroy
L33	Papers relating to any injury on duty	Until Age 100	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
L34	Part-time/Job sharer/Term time applications, decisions	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L35	**Personal Payroll History:** Records of pay Performance pay Overtime pay Allowances (incl deputising and substitution) Pay enhancements Taxable allowances Payment for untaken leave Reduced pay No pay Maternity leave Complete sickness absence record	Until Age 100	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
L36	**Pension Forms (all)**			
	Pension forms that relate to monies received, monies owed, payments made and administration of the HSC Pension Scheme	7 years	HMRC Technical Pension Notes for registered pension schemes under regulation 18 of SI2006/567 – 'RPSM12300020 – Scheme Administrator Information Requirements and Administration for General Retention of Records'	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Pensions estimates/awards	7 years	HMRC Technical Pension Notes for registered pension schemes under regulation 18 of SI2006/567 – 'RPSM12300020 – Scheme Administrator Information Requirements and Administration for General Retention of Records'	Destroy
L37	Qualifications and References	Until age 100		Destroy
L38	Resignation/termination/retirement letters	Until age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L39	Return to Work Interviews	4 years		Destroy
L40	Security Personnel Files	5 years after leaving (if at normal retirement age) or 10 years after leaving (if before normal retirement age)	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L41	**Special Leave**			
	Application for special leave/study leave – Paid	7 years	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Application for special leave/study leave – Unpaid	Age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
	Unpaid Leave periods (maternity leave etc.)	Age 100	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy Personal files of Chief Executives, Directors should be transferred to PRONI. All other files destroyed.
L42	Staff car parking permits	3 years		Destroy
L43	Staff photographs – held in personal file	Until age 100		Disposal method of Personal file
L44	Statutory maternity and statutory sick pay documents	6 years		Destroy
	Temporary variation forms	3 years after employment has ended		Destroy
	Trade Union Schedules	1 year after employment has ended		Destroy
	Salary requests from bank/building society pay details	1 year only		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L45	**Substances Hazardous to Health Records**			
	Monitoring exposure of employees to substances hazardous to health record	Where the record is representative of the personal exposures of identifiable employees for at 40 years or in any other case for at least 5 years from the date of the last entry made in it.	Control of Substances Hazardous to Health Regulations (NI) 2003 (reg.10(5))	Destroy
	Health surveillance records of employees who are, or are liable to be exposed to a substance hazardous to health	40 years from the date of the last entry made in it	Control of Substances Hazardous to Health Regulations (NI) 2003 (reg.10(5))	Destroy
	Health surveillance records of employees who are, exposed to asbestos	40 years from the date of the last entry made in it	Control of Asbestos Regulations (NI) 2007 (reg. 22)	Destroy
	Health surveillance records of employees who are, exposed to lead	40 years from the date of the last entry made in it	Control of Lead at Work Regulations (NI) 2003 (reg.10(5))	Destroy
	Records relating to doses of ionising radiation received by employees designated as classified persons	50 years from the date of the last entry or age 75 whichever is the longer	Ionising Radiations Regulations (NI) 2000 (reg. 21)	Destroy
	Health surveillance records of relevant employees engaged in work with ionising radiation	50 years from the date of the last entry or age 75 whichever is the longer	Ionising Radiations Regulations (NI) 2000 (reg. 21)	Destroy
	Record of assessment of any accident or occurrence likely to result in a person receiving an effective dose of ionising radiation	50 years from the date of the last entry or age 75 whichever is the longer	Ionising Radiations Regulations (NI) 2000 (reg. 21)	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L46	**Superannuation**			
	Accounts	10 years	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
	Added voluntary contributions	Age 100	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
	Added years	Age 100	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
	Registers	10 years	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
	Death benefit nomination and revocation forms	Until age 100 (Return originals to provider)	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
	Death certificates	Retain copy until Age 100 (Return originals to provider)	The National Archives – Employee and Personnel Records Good Practice Guidance (March 2006)	Destroy
L47	Tax forms – change of tax code	7 years		Destroy
L48	Training plans	see GMGR Section J67		Destroy
L49	Training records – all staff	Age 72 or 6 years after employment has ended whichever is the later. For independent contractors the minimum retention should be the duration of employment plus 3 years, although it is recommended the duration of employment plus 6 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
L50	Transport (staff pool car documentation)	3 years unless litigation ensues		Destroy
L51	**Wages/Salary records**			
	Bank details – current only	6 years after employment has ended		Destroy
	Category analysis print outs	2 years after employment has ended		Destroy
	Clock cards and time sheets	2 years after employment has ended		Destroy
	Computer payroll printout	7 years after employment has ended		Destroy
	Cumulative adjustment forms	2 years after employment has ended		Destroy
	Payment analysis print outs	2 years after employment has ended		Destroy
L52	Working Time Directive opt out forms	3 years after the opt out has been rescinded or has ceased to apply	The National Archives – Records Management Retention Scheduling Employee and Personnel Records Good Practice Guidance	Destroy
L53	Workforce Planning Records documenting the assessment, development, planning, management and analysis of workforce requirements, and the identification and evaluation of options for meeting these requirements	10 years		Destroy

M. Work Area - Pharmacy

Pharmacy records are categorised in three sections for your ease, Community, Hospital and All Pharmacy disciplines. However Pharmacists should be aware that guidance in any of these sections may be applicable to your practice.

Community Pharmacy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
M1	Accountable Officer Records	See GMGR Section J30		
M2	Extemporaneous worksheets	6 years		Destroy
M3	**Patient Records**			
	Patient Medication Record	Adults 6 years after the conclusion of treatment. Children and young people – Until the patient's 25th birthday or 26th if the young person was 17 at the conclusion of treatment or 8 years after death.		Destroy
	Minor Ailments Service	Adults - 8 years after the conclusion of treatment Children and young people – Until the patient's 25th birthday or 26th if the young person was 17 at the conclusion of treatment or 8 years after death.		Destroy
	Documented Clinical Interventions	2 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Sexual Health Record	10 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death	See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH). www.bashh-org/communities/aga/servicespec/guidance-retention-disposal-notes-0606pdf	Destroy
	Smoking cessation	8 years after the conclusion of treatment. Children and young people – Until the patient's 25th birthday or 26th if the young person was 17 at the conclusion of treatment or 8 years after death.		Destroy
M4	**Prescriptions**			
	Unlicensed Medicines / 'Specials' dispensing record	5 years	MHRA Guidance Note 14	Destroy
	Private Prescription Book	2 years after last entry (5 years after last entry for veterinary prescriptions)	Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980 Veterinary Medicines Regulations 2009(SI 2297) reg. 23	Destroy
M5	**Product Recalls**			
	Those holding a wholesale dealer licence	Records must be maintained in accordance with the terms of the licence		Destroy
	Pharmacies not holding a wholesale dealer licence	Records should be retained in accordance with professional guidance		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
M6	**Requisitions**			
	HS21S – copy of stock order	2 years	Regulation 6 (3)(c) Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980 This is a legal requirement in certain circumstances.	Destroy
	Stock requisitions (excluding controlled drugs and veterinary requisitions)	2 years	Regulation 6 (3)(c) Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980 This is a legal requirement in certain circumstances.	Destroy

Hospital Pharmacy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
M7	Accountable Officer Records	See GMGR Section J30		Destroy
M8	Clinical / Trials	See GMGR Section J57 and GMGR Section J58		
M9	External Orders and Delivery notes	2 years after the financial year to which they relate	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093028.pdf PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy

	Picking tickets / ward delivery notes	3 months (for a "reasonable" period for verification of order only)	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093028.pdf PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Ward / department requisition sheets & receipts	2 years	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093028.pdf PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Requests made by ward pharmacists	2 years		Destroy
	Ward / Department Medicine Transfer Forms	2 years		Destroy
	Returns Dockets (wholesaler and ward / department	2 years following the financial year to which they relate		Destroy
M10	**Medicines Information**			
	Provision of Information to another person e.g. drug information enquiry	8 years (enquiries relating to children, fertility, gynaecology and obstetrics should be kept for up to 25 years)	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Clinical Interventions	Record to be added to patient's notes / Patient Medication Record and retain for the period of time appropriate to the patient/speciality . Within the hospital setting the duplicate should be kept for 2 years. Clinically significant interventions should be recorded directly on the patient's notes.	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
M11	**Patients' Own Drugs**			

	Consent for and destruction of POD (excluding controlled drugs)	6 months	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Overdose / poisoning drug records	3 years where there is police involvement / coroners inquest 1 year for all others		Destroy
M12	**Prescriptions**			
	Chemotherapy / Cytotoxic	2 years after last chemotherapy treatment	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Discharge, outpatient, skin clinic and private prescriptions, Parenteral Nutrition. CIVAS and Specialist Medicines Prescriptions.	2 years	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Unlicensed Medicines / Dispensing record,	5 years	For supply of unlicensed medicines Requirement of MHRA Guidance Note No.14. MHRA Guidance Note 14 PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Consultant authorisation letter	5 years		Destroy
	Immunoglobulin / blood products	30 years	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
M13	**Product Defect Forms**			

	Product Recall– DHSSPS & Ward recall Records	5 years – No legal / statutory requirements		Destroy
M14	**Quality Assurance**			
	Equipment validation / calibration	See GMGR Section D1		Destroy
	Environmental monitoring results	1 year after the expiry dates of products	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Quality Control documentation, certificates of analysis	5 years or 1 year after expiry date of batch, whichever is longer.	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
	Medical gas testing	Records retained throughout the lifetime of the installation and 2 years after installation has been modified or retested or closure of the facility.		Destroy
M15	Records for Ambulance Bags and Resuscitation boxes	1 year after the expiry of the longest dated item	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
M16	**Security**			
	List of Users ID & Privileges	See GMGR Section H9		Destroy
	Departmental on-call records, duty rotas. (Records of community pharmacy rotas will be managed by HSCB)	See GMGR Section L13		Destroy
M17	Staff signature lists	Duration of Contract plus 1 year	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy

M18	Stock checks and stock adjustments	See GMGR Section J61		Destroy
M19	**Worksheets**			
	Chemotherapy/ aseptics, Parenteral Nutrition, PCA worksheets Production batch records Raw material request and control forms	5 years Where product liability exists this is extended up to 11 years after expiry. For paediatric worksheets product liability extends to up to 28 years	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy

All Pharmacy Disciplines

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
M20	**Controlled Drug (CD)**			
	Requisitions	2 year HSC Organisations Community Pharmacy HS21S – copy retained for 2 years. Private requisitions - forwarded to and retained by BSO	Misuse of Drugs Regulations (Northern Ireland) 2002	Destroy
	Bearer's note	2 years		Destroy
	Midwife's Supply Order	2 years	Misuse of Drugs Regulations (Northern Ireland) 2002	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
	Pharmacy Controlled Drugs Registers	2 years from the date of last entry although it is recommended that Community Pharmacies retain them for 5 years and Hospital Pharmacies retain them for 11 years.	Misuse of Drugs Regulations (Northern Ireland) 2002 Recommendation of 11 years based on NI response to 4th Report Shipman Inquiry	Destroy
	Ward / Department CD Record Books (ward registers)	11 years from last entry	Recommendation of 11 years based on NI response to 4th Report Shipman Inquiry	Destroy
	Destruction of patients' own Controlled Drugs	No Legal Requirement although it is recommended that Community Pharmacies retain them for 5 years and Hospital Pharmacies retain them for 7 years.		Destroy
M21	Competency / training records	See GMGR Section L49		Destroy
M22	Invoices	See GMGR Section F30		Destroy
M23	Medication Incidents	See GMGR Section A2 – A4 and GMGR Section A6		Destroy
	Records of internal pharmacy dispensing errors which are near misses and their associated statistics	One year plus current year (or longer if specified by professional guidance or organisational policy)	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy
M24	Patient Group Directions (PGDs)	See GMGR Section G87		Destroy
M25	Private Prescriptions	2 years (5 years for original or copy of veterinary prescriptions)		Destroy
M26	Refrigerator temperature records	5 years		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
M27	Record of Medicines posted / delivered to patients Record of patient consent for collection or delivery service	2 years from last entry	Supplementary Guidance for Pharmacists in Northern Ireland on the Provision of Prescription Collection and/or Delivery Services February 2011	Destroy
M28	Responsible Pharmacist Pharmacy record	5 years	Regulation 5(4) of the Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008 (SI 2008/2789)	Destroy
M29	Superseded standard operating procedures	15 years	PJ Online Advice: How to Keep Proper Pharmacy Records	Destroy

N. Work Area - Public Safety

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
N1	Audio tapes of calls requesting Fire Service Assistance e.g. 999 calls	See GMGR Section G7	The Limitation (Northern Ireland) Order 1989	Destroy
N2	Incident Recording System	See GMGR Section N1 Where litigation has commenced manage as per GMGR Section I1		Destroy
N3	Policy and standard operating procedures	See GMGR Section M29		Destroy

O. Work Area - Regulation

Early Years Services, e.g. child minding, play groups and support provided to Surestarts etc

Ref	Record Type	Minimum Retention Period	Relevant legislation / Derivation	Final Action
O1	Administrative records relating to the registration, inspection and running of the service.	8 years from the date of the last entry		Destroy
O2	Service provider's case records/notes (from referral to closure) related to each child/family receiving the service, e.g. care plan, reviews, consents, contact records, etc	8 years from the date of the last entry.		Destroy

Establishments and Agencies

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O3	Adult Placement Agencies - administrative records, e.g. statement of purpose; service user's guide; placement agreement and amendments; carer agreements; handbooks; reports on the conduct of the agency; quality reviews; and improvement plans.	8 years from the date of the last entry.		Determined on review after consultation with Trust social work and records management staff
O4	Adult Placement Carers - Approved /Not approved suitable/ Uncompleted or Withdrawn: Records, which include applications; case records/notes; assessments; support/counselling; specified health and health related information; information received from 3rd parties; reviews; case summaries; contact records, and Adult Placement Panel records, minutes and papers etc;	8 years from the date of the last entry. 3 years for records related to inquiries which do not proceed beyond initial information and counselling stages.		Determined on review after consultation with Trust social work and records management staff

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O5	Adult Placement Carers - information and documents specified in Schedule 3	8 years from the date of the last entry.	The Adult Placement Agencies Regulations (Northern Ireland) 2007 Reg. 21 & Schedule 3 The Adult Placement Agencies Regulations (Northern Ireland) 2007	Determined on review after consultation with Trust social work and records management staff
O6	Adult Placement Agencies - individual's service users records/notes related to activity within the placement, e.g. assessments, service user's plan and reviews; and the information, documents and other records specified in Schedule 4 relating to the service user.		The Adult Placement Agencies Regulations (Northern Ireland) 2007 Reg. 21 and Schedule 4 The Adult Placement Agencies Regulations (Northern Ireland) 2007	Determined on review after consultation with Trust social work and records management staff
O7	Children's Homes - administrative records relating to the running of the children's home, including a record in the form of a register of each child accommodated in the children's home and other records set out in Schedule 4.	retain for at least 15 years from date of last entry, except for records of menus which need be kept only for one year.	The Children's Homes Regulations (Northern Ireland) 2005 – Reg.28 and Schedule 4 The Children's Homes Regulations (Northern Ireland) 2005	Determined on review after consultation with Trust social work and records management staff
O8	Children's Homes - administrative records other e.g. the statement of purpose; children's guide; reports on the conduct of the home; reports on the assessment of quality of services including matters set out in Schedule 6 to the Children's Homes Regulations (NI) 2005; improvement plans; and RQIA reports etc	15 years from date of last entry,		Determined on review after consultation with Trust social work and records management staff

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O9	Children's Homes - case records (from referral to closure) maintained by the home in respect of each child accommodated in the children's home e.g. placement plan; care plans; reviews; and, in respect of each child, the information and other records set out in Schedule 3.	75 years from date of birth of the child to whom it relates or, if the child dies before attaining the age of 18, for a period of 15 years from the date of death of the child.	The Children's Homes Regulations (Northern Ireland) 2005 – Reg.27 and Schedule 3 The Children's Homes Regulations (Northern Ireland) 2005	Transfer to PRONI
O10	Day Care Settings e.g. day centres, adult centres, outreach schemes - administrative records relating to the running of the service e.g. statement of purpose; service user's guide; accounts; a copy of all inspection reports; employment records; duty roster; complaints and action taken; accidents/ incidents; food provided; and the other records specified in Schedule 5.	8 years from the date of the last entry.	The Day Care Setting Regulations (Northern Ireland) 2007 Reg. 19(2), Reg. 19(4) & Schedule 5	Destroy
O11	Day Care Settings - individual's case records/notes (from referral to closure) related to activity within the service, e.g. assessment of need and service user's plan; record of medicines; accidents/incidents; healthcare provision; correspondence, etc and the information, documents and other records specified in Schedule 4.	8 years from the date of the last entry.	The Day Care Setting Regulations (Northern Ireland) 2007 Reg. 19(1)(a), Reg. 19(4) & Schedule 4	Destroy
O12	Domiciliary Care Agencies, e.g. home help, domiciliary, sitting services, in-home respite, family aide, etc - administrative records relating to domiciliary care workers and service users; records relating to training and development of staff and other records specified in Schedule 4; and a record of each complaint, including details of the investigations made , the outcome, and any action taken in consequence.	8 years beginning on the date of the last entry	The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 Reg. 21 & Schedule 4 For records of complaints Reg. 22(8)	Destroy
O13	Domiciliary Care Agencies - administrative records, e.g. statement of purpose; service user's guide; reports on the assessment of quality of services; improvement plans; inspection reports, etc.	8 years beginning on the date of the last entry		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O14	Domiciliary Care Agencies – service provider's individual's case records/notes (from referral to closure) related to the individual/child/family receiving the service, e.g. care plan, detailed record of prescribed services (i.e. personal care and assessments of the need for such care), how services will be provided, contact records, records held by service users, etc.	8 years beginning on the date of the last entry		Destroy
O15	Independent Health Care Establishments and Agencies, i.e. independent hospitals; clinics and medical agencies - administrative records, e.g. register of patients; register of all surgical operations performed; register of all events which must be notified to the RQIA; a written record of suspected, alleged or actual incidents of abuse including details of the investigation, the outcome and action taken; all other records specified in Part II of Schedule 3 to the regulations; and a record of each complaint including details of the investigations made, the outcome and any action taken in consequence..	3 years beginning on the date of the last entry	The Independent Health Care Regulations (Northern Ireland) 2005 Regulation 21 Part II of Schedule 3 to the regulations	Determined on review
O16	Independent Health Care Establishments and Agencies, - a comprehensive medical record in relation to each patient, which includes: (i) a contemporaneous note of all treatment provided to him; (ii) his medical history and all other notes prepared by a health care professional about his case.	(a) For a patient who was under the age of 17 at the date on which the treatment to which the records refer was concluded - until the patient's 27th birthday. (b) For a patient who was aged 17 at the date on which the treatment to which the records refer was concluded - until the patient's 27th birthday. (c) For a patient who died before attaining the age of 18 - a period of 10 years beginning on the date of the patient's death.	The Independent Health Care Regulations (Northern Ireland) 2005 Regulation 21 Part I of Schedule 3 to the regulations as amended by Regulation 2 (12) of the Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspection) (Amendment) Regulations (Northern Ireland) 2011 (No. 17).	Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
		(d) For a patient who was treated for mental disorder during the period to which the records refer – a period of 20 years beginning on the date of the last entry in the record. (e) For a patient who was treated for mental disorder during the period to which the records refer and who died whilst receiving treatment – a period of 10 years beginning on the date of the patient's death (f) For a patient whose records relate to treatment by a general practitioner - a period of 10 years beginning on the date of the last entry. (g) All other cases - a period of 10 years beginning on the date of the last entry in the record.		
O17	Nursing Agencies – records relating to the supply of nurses, training and development of staff and other records as set out in Schedule 4	8 years from the date of the last entry	The Nursing Agencies Regulations (Northern Ireland) 2005 Reg 18 & Schedule 4	Destroy
O18	Nursing Homes - administrative records pertaining to the running of the home e.g. statement of purpose; patient's guide; accounts; employment records; duty roster; complaints and action taken; food provided; and other records as out in Schedule 4.	6 years from the date of the last entry	The Nursing Agencies Regulations (Northern Ireland) 2005 Reg. 19(2), Reg. 19(4) & Schedule 4	Determined on review after consultation with Trust social work and records management staff

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O19	Nursing Homes - individual's case records/notes (from referral to closure) related to activity within the home, e.g. assessments of need and patient's plan; medicines; accidents/incidents; contemporaneous note of all nursing provided; healthcare plan and provision; correspondence; and other records as out in Schedule 3.	6 years from the date of the last entry	The Nursing Agencies Regulations (Northern Ireland) 2005 Reg. 19(1)(a), Reg. 19(4) & Schedule 3	Determined on review after consultation with Trust social work and records management staff
O20	Residential Care Homes - administrative records pertaining to the running of the home e.g. statement of purpose; resident's guide; accounts; employment records; duty roster; complaints and action taken; food provided; and other records as out in Schedule 4.	6 years from the date of the last entry	The Residential Care Homes Regulations (Northern Ireland) 2005 Reg. 19(2), Reg. 19(4) & Schedule 4	Determined on review after consultation with Trust social work and records management staff
O21	Residential Care Homes - individual's case records/notes (from referral to closure) related to activity within the home, e.g. assessments of need and associated care plans; medicines; accidents/incidents; contemporaneous note of all care and services provided; healthcare plan and provision, correspondence; and other records as out in Schedule 3.	6 years from the date of the last entry	The Residential Care Homes Regulations (Northern Ireland) 2005 Reg. 19(1)(a), Reg. 19(4) & Schedule 3 Reg. 23(7)	Determined on review after consultation with Trust social work and records management staff
O22	Residential Family Centres – service provider's case records/notes (from referral to closure) related to each child/family receiving the service, including the information, documents and other records specified in Schedule 3	15 years from date of last entry.	The Residential Family Centres (Regulations (NI) 2007 Reg. 22(1)(a), Reg. 22(3)(d) & Schedule 3.	Determined on review after consultation with Trust social work and records management staff
O23	Residential Family Centres –administrative records pertaining to the operation of the establishment e.g. statement of purpose, residents guide, accounts, employment records, duty roster, complaints and action taken, food provided, inspection reports and other records as set out in Schedule 4.	15 years from date of last entry.	The Residential Family Centres (Regulations (NI) 2007 Reg. 22(2), Reg. 22(3)(d) & Schedule 4.	Determined on review after consultation with Trust social work and records management staff

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O24	Voluntary Adoption Agencies records with respect to staff i.e. records to be kept in relation to each person working for the purpose of the Agency as specified in Schedule 3.	15 years from the date of last entry	The Voluntary Adoption Agencies Regulations (NI) 2010 Reg.18 & Schedule 3	Destroy
O25	Voluntary Adoption Agencies other records i.e. related to applicants, birthparents, children, panels and post adoption work	see P1 – P6 inclusive		Determined on review after consultation with Trust social work and records management staff
O26	Voluntary Adoption Agencies – a written record of each complaint, including details of the investigation made the outcome and any actions taken in consequence.	10 years from the date the record is made	The Voluntary Adoption Agencies Regulations (NI) 2010 Reg.13(3)	Determined on review after consultation with Trust social work and records management staff

Northern Ireland Medical and Dental Training Agency

Ref	Record Type	Minimum Retention Period	Relevant legislation / Derivation	Final Action
O27	**Trainees** All records relating to: • medical and dental trainees: their postings, assessments, courses, study leave, Less Than Full Time Training • Doctors or Dentists In Difficulty / Careers Advice:	6 years after the completion of training. Unless involved in a complaint or fitness to practice issue in which case retain for 6 years after the last action on the case.	After the doctor has finished training they may be employed as a consultant in a trust and will be subject to appraisals and revalidation by the GMC.	Destroy

Ref	Record Type	Minimum Retention Period	Relevant legislation / Derivation	Final Action
O28	**Trainers** All records relating to: • Medical, dental and consultant trainers, courses, workshops • training posts and their approval	6 years after the completion of the training 6 years after recognition of the post for training has ended.		Destroy
O29	General Practice Retainer Scheme files	6 years after end of retainer scheme contact		Destroy
O30	GP Appraisal Appraisee / Appraiser Records:	See L2		
O31	**Continuing Professional Development** Information relating to courses offered by the Agency: • Course Details • Correspondence • Booking Records • Payment details • GP Appraisal 'Form 6A's' • Evaluation Feedback / Summaries	6 years after the course has ended	Takes into account revalidation and finance payment record retention timelines	Destroy

Ref	Record Type	Minimum Retention Period	Relevant legislation / Derivation	Final Action
O32	Information relating to: • Deanery Visits to HSC Trusts and General Medical/Dental Practices • GMC Visits to the Northern Ireland Deanery	See J30		Destroy
O33	**Survey Reports**			
	GMC	See J30 liaison between organisations relating to governance		Destroy
	Deanery	5 years		Destroy

Northern Ireland Social Care Council

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O34	Live register of all social care workers.	Updated as necessary to reflect currently available information.		Determined on review
O35	Records Relating to the Registration of Social Workers and Social Care Staff	Lifetime of registrant plus 10 years		Destroy
O36	Records in Relation to the Regulation/Conduct Of Social Workers and Social Care Staff, including: complaints; concerns; allegations (substantiated and un-substantiated); enforcement or decision; appeals; and appeals to Care Tribunal, etc	Lifetime of registrant or applicant plus 10 years		Determined on review
O37	Records related to: (i) information received about individuals eligible to register on the social care register but not yet registered and (ii) preliminary investigations into unregistered social care workers not leading to enforcement	30 years		Destroy
O38	Records in relation to the regulation of social work education and training, including regulation of the degree in social work and the provision of practice learning opportunities	Lifetime of the programme/learning opportunity provider plus 10 years		Determined on review
O39	Records in relation to the regulation of post qualifying education and training for social workers	15 years from date of approval		Determined on review

Regulation and Quality Improvement Authority

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
O40	All records/materials which form a fundamental part of the record for undertaking the function of registration and inspection for all regulated services as specified in the relevant regulations, including records related to enforcement action; appeals to Care Tribunal, etc.	General: 8 years from the date of the last entry. Children's Homes and Residential Family Centres: 15 years from the date of the last entry. Voluntary Adoption Agencies: records with respect to staff 15 years from the date of the last entry.		Determined on review
O41	All records/materials which form a fundamental part of the record for undertaking the function of inspection for schools which provide accommodation for children.	15 years from the date of the last entry.		Determined on review
O42	Duty of Quality Reviews with regard to services provided by HSC statutory bodies and their agents, including arrangements in which health and care services are provided, including records underpinning the review and supporting evidence.	8 years from the date of the last entry.		Destroy
O43	General Registration Enquiries – records, notes and correspondence related to straightforward inquiries/requests for information (Excluding FOI/DPA Requests – see J28) and associated contacts, if any, which do not result in an application for registration.	3 years after last contact		Destroy
O44	Live register of all regulated services	Updated as necessary to reflect currently available information.		Determined on review
O45	Preliminary investigations into unregistered services not leading to enforcement	3 years after last contact		Destroy

P. Work Area - Social Care - Children and Adults

Adoption

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P1	Applicant - Approved suitable/ Adoption order granted/ Not approved suitable/ Uncompleted or Withdrawn: Case Records, which include applications; case records/notes; records of contact; assessments; support/counselling; specified health and health related information; information received from 3rd parties; reviews; case summaries; any report, recommendation or decision; placement, post adoption work, etc.	75 years from date of decisions/granting order.	The Adoption Agencies Regulation (NI) 1989 Reg.14.	Determined on review after consultation with Trust social work and records management staff
P2	Applicant - Case files, which relate to inquiries which do not proceed beyond initial information and counselling stages.	40 years after last contact		Determined on review after consultation with Trust social work and records management staff
P3	Birth Parents - case records of birth parents and related support work pre and post adoption.	75 years from adoption.		Transfer to PRONI
P4	Children's case records, including relevant pre-adoption health, education and other 3rd party information, communications and reports requested for the purposes of adoption and indexes to case records; in-country tracing; inter-country tracing.	75 years from date the adoption order is made	The Adoption Agencies Regulations (Northern Ireland) 1989 Reg.14.	Transfer to PRONI
P5	Panel Records, minutes and papers.	75 years after creation.		Transfer to PRONI
P6	Post adoption counselling - case records for children/adults who have been adopted and other children/adults affected by adoption.	75 years after creation.		Transfer to PRONI

Adult case records – Fieldwork: all Programmes of Care

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P7	Carer's Assessments - individual case records (from referral through to closure) including referrals; assessments; care/case management records; social work contacts and other HSC professional services, case conferences and reviews; 3rd party communications and reports (e.g. medical reports, etc); records related to direct payments, self-directed support, etc; legal documentation; correspondence; case-specific supervision; and case summaries, including closure summaries, integrated care plans, etc.	8 years after closure or death of individual.		Determined on review after consultation with Trust social work and records management staff
P8	Client case files (not adult protection) - individual case records (from referral through to closure) including referrals; assessments (risk, core, complex, etc.); care/case management records; social work contacts and other HSC professional services, case conferences and reviews; 3rd party communications and reports (e.g. adult placements, day care, domiciliary care, residential, respite, medical reports and specialist assessments, etc.); records related to direct payments, self-directed support, etc; legal documentation; correspondence; case-specific supervision; and case summaries, including closure summaries, integrated care plans, etc.	8 years after closure or death of individual.		Determined on review after consultation with Trust social work and records management staff

Adult Protection/Safeguarding

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P9	Case files from referral through to closure, including referrals; screening; assessments (risk, core, complex, etc.); social work contacts; strategy/case conferences and reviews; care and protection plans; 3rd party communications and reports, including medical reports and specialist assessments; legal documentation; correspondence; case-specific supervision; and case summaries, including transfer summaries, etc.	30 years after closure or death.		Determined on review after consultation with Trust social work and records management staff
P10	Offenders/Individuals who may pose a risk to Vulnerable Adults **-** Notifications and records in relation to offenders and unadjudicated individuals; Public Protection Arrangements Northern Ireland; and Multi-Agency Risk Assessment Conferences.	100 years from date of notification or 30 years after death. 10 years situations where the referral is based on erroneous or false information.		Determined on review after consultation with Trust social work and records management staff
P11	Referrals resulting in no further action and no further support services required.	10 years after last action/entry.		Destroy
P12	Serious Case Reviews (SCR) - all records related to the SCR process from inception to publication and subsequent monitoring of action plans and learning.	50 years after the completion of the SCR Report or the decision not to proceed with the SCR.		Transfer to PRONI

Child Protection/Safeguarding Children

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P13	Case files from referral through to closure/transfer, including referrals; screening; initial assessment; pathway assessment; assessments; UNOCINI records; information relating to entry to and discharge from the child protection register; social work contacts; case conferences and reviews; core group meetings; 3rd party communications and reports (e.g. reports from other professionals/agencies/services); legal documentation; correspondence; case-specific supervision; and case summaries, including transfer/ closure summaries, etc.	75 years after closure or 15 years after death of child if child dies before attaining the age of 18.		Determined on review after consultation with Trust social work and records management staff
P14	Case Management Reviews (CMR) – all records related to the CMR process from inception to publication and subsequent monitoring of action plans and learning.	75 years after the completion of the CMR Report or the decision not to proceed with a CMR.		Determined on review after consultation with Trust social work and records management staff
P15	Offenders/Individuals who may pose a risk to Children **-** Notifications and records in relation to offenders and unadjudicated individuals; Public Protection Arrangements Northern Ireland; Multi-Agency Risk Assessment Conferences; Circular HSS CC: 3/96 (Revised): Sharing to Safeguard, (September 2008) as amended 14 May 2009.	100 years from date of notification or 30 years after death. 10 years for situations where the referral is based on erroneous or false information.		Determined on review after consultation with Trust social work and records management staff
P16	Referrals resulting in no further action and no further child or family support services required and/or do not progress to a UNOCINI pathway assessment.	up to child's 18th birthday		Destroy

Children in Need – Family Support

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P17	Case files from referral through to closure/transfer, including gateway and UNOCINI records; referrals; screening; records relating to family support; social work contacts; case conferences and reviews; 3rd party communications and reports (including relevant domiciliary support; early years; family centres; respite/short breaks records relating to individuals/ families); correspondence; case summaries, etc, including: (i) the support of disabled children and their families; and (ii) the support and supervision of children in need who are not looked after and who are not on the Child Protection Register and their families.	Transfer to Adult Social Care, where appropriate, otherwise 20 years after closure of case.		Determined on review after consultation with Trust social work and records management staff
P18	Family Centres – Non-residential: service provider's case records/notes (from referral to closure) related to each child/family receiving the service,	15 years from date of last entry.		Determined on review after consultation with Trust social work and records management staff
P19	Family Centres – Non-residential: administrative records pertaining to the operation of the establishment e.g. statement of purpose, service user's guide, quality reviews etc.	15 years from date of last entry.		Determined on review after consultation with Trust social work and records management staff

Children – Registers

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P20	Child Protection.	75 years after creation of the record.	Co-operating to Safeguard Children, Chapter 5, 5.83 - 5.91	Transfer to PRONI
P21	Disabled children.	Entry in the register to be retained until the child to whom it relates reaches the age of 18 years.		Transfer to PRONI
P22	Persons who act as child minders on domestic premises.	Entry in the register to be retained for at least 8 years from the date on which the person to whom it relates ceases to be registered.		Transfer to PRONI
P23	Persons, other than the Trust, who provide day care for children under the age of 12 on premises other than domestic premises.	Entry in the register to be retained for at least 8 years from the date on which the person to whom it relates ceases to be registered.		Transfer to PRONI
P24	Every child placed in an authority's area and every child placed by an authority outside its area.	Until the child to whom the entry relates attains the age of 23, or if the child dies before attaining 23, the period of 5 years beginning with the date of his death.	The Arrangements for Placement of Children (General) Regulations (NI) 1996 Reg. 10(5)	Transfer to PRONI
P25	Register of Foster parents and others with whom a child is placed as specified in Reg. 12.	10 years from the date on which his approval is terminated, or until his death, if earlier.	The Foster Placement (Children) Regulations (NI) 1996 Reg. 14(1)	Transfer to PRONI

Community Development/Health Improvement Initiatives & Partnerships

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P26	Community development promoting social inclusion; health improvement; health and well being capacity building; regeneration projects; and cross-border initiatives	8 years after closure of the project.		Determined on Review
	European partnerships,	See GMGR Section J42		

Court Proceedings – Children not looked after or on the Child Protection Register

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P27	Case records related to Children and Young People subject to public and private law applications and/or orders, e.g. Article 4/Article 56 reports to the court; Article 8 Orders, e.g. contact orders and residence orders; Article 50 supervision orders; and 'Wards of Court' (Article 173), etc.	20 years from closure or 15 years after the child's death.		Determined on Review

Foster Care Records

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P28	Applicant - Records related to inquiries which do not proceed beyond initial information and counselling stages.	40 years after last contact.		Destroy

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P29	Applicant - Approved suitable: Records, which include applications; case records/notes; assessments; support/counselling; specified health and health related information; information received from 3rd parties; reviews; case summaries; any report, recommendation or decision; placement and post placement work; contact records with foster families, e.g. “foster care diaries”, etc; and the matters set out in Regulation 13 of the Foster Placement (Children) Regulations (NI) 1996	For at least 10 years from the date on which his approval is terminated, or until his death, if earlier.	The Foster Placement (Children) Regulations (NI) 1996 Reg. 14(1)	Destroy
P30	Applicant - Not approved suitable/Uncompleted or Withdrawn: Records, which include applications; case records/notes; assessments; support/counselling; specified health and health related information; information received from 3rd parties; reviews; case summaries; contact records; any report, recommendation or decision, etc.	40 years from date of decision.		Destroy
P31	Records related to Private Foster Carers and children who are privately fostered.	10 years after closure of the case or until the death of the private foster carer, if earlier.		Determined on review after consultation with Trust social work and records management staff
P32	Panel records, minutes and papers.	40 years from the date the record is created.		Transfer to PRONI

Guardian Ad Litem Records

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P33	Records in specified proceedings under the Children (NI) Order 1995	75 years from date of birth or if the child dies before age 18 then retain for 15 years from his/her death.		Transfer to PRONI
P34	Records in proceedings under the Adoption (NI) Order 1989	75 years from date of final court decision (whether freeing/adoption order granted or not).		Transfer to PRONI

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P35	Case Trial Bundles	Records to be destroyed at the conclusion of the court case		Destroy

Looked after Children & Leaving and After Care

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P36	Children who are placed (e.g. in foster care, a children's home, with their own families or otherwise accommodated) - Case records (from referral through to closure), including referrals; assessments; social work contacts; case conferences and reviews; 3rd party communications and reports; legal documentation; correspondence; case-specific supervision; and case summaries, including closure summaries, etc; and those matters identified in Reg. 8 of the Arrangements for Placement of Children (General) Regulations) (NI) 1996.	75 years from date of birth of the child to whom it relates or, if the child dies before attaining the age of 18, for a period of 15 years beginning with the date of his/her death.	The Arrangements for Placement of Children (General) Regulations (NI) 1996 Reg. 9(1)	Transfer to PRONI
P37	Independent Visitors - Records related to the recruitment, selection, training and support and review and termination of Independent Visitors.	25 years after termination of role as an Independent Visitor.		Destroy
P38	Children and young people making the transition to independent living - records relating to assessments, pathway plans and their review.	Until the 75th anniversary of the date of birth of the child or young person to whom they relate, or if the child dies before the age of 18, for a period of 15 years beginning with and including the date of his death.	The Children (Leaving Care) Regulations (Northern Ireland) 2005 Reg. 9(1)	Transfer to PRONI

Miscellaneous

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P39	Notifications from other Trusts/Authorities about missing/found persons - person unknown to the Trust or Service.	3 years after notification received		Destroy
P40	“One-Off records”, e.g. straightforward requests for advice, initial information and contact, financial assistance, benefit enquiries, telephone calls, housing enquiries, inappropriate/re-directed referrals requiring no further action	3 years after closure/last contact		Destroy

Practice Learning- Students

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P41	Student Information and social work training - records related to student's practice learning opportunity, including non case-specific supervision, notes of meetings, mentoring, learning, tutoring, etc. Case specific supervision should be placed in the client’s case file.	10 years after completion of practice learning opportunity		Destroy

Staff Supervision Non Case-Specific

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
P42	Staff non case-specific supervision records, e.g. discussion and decision-making with regard to management (competent and accountable performance); professional development; support; and engagement of the individual with the organisation.	5 years in the location where the person works, thereafter transfer to Personnel file GMGR Section L2 It should be noted that Annual Assessments/Appraisals or Summary of Performance should continue to be dealt with as recommended in GMGR Section L2 for as long as the person remains with the organisation.		Destroy

Q. Work Area - Statistics

Ref	Record Type	Minimum Retention Period	Relevant Legislation / Derivation	Final Action
Q1	Statistics (including Korner returns) contract minimum data set, regional annual statistical returns required by the Department, payment activity data.	3 years from submission to Department. To be retained for 6 years by the Department		Destroy
	Data Input Forms (where the data/information has been input to a computer system).	2 years		Destroy
Q2	Laboratory records other than those in GMGR Section K.	8 years		Destroy

Addendum 1

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.