Document Title
Non Clinical Records Management Policy

Document Description	
Document Type	Policy
Service Application	Trust Wide
Version	5.0

Lead Author(s)	
Name	Job Title
	Corporate Governance Manager

Executive Director / Director / Manager			
If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date below:			
Name	Director of Governance	Date	
Signature		02.04.19	

Change History		
Version	Date	Comments
0.1	July 2011	Draft
0.2	Feb 2012	Updated following consultation
2.0	July 2013	Updated following minor review
3.0	July 2014	Full review
3.1	July 2015	Minor review
4.0	Dec 2017	Minor review
5.0	Feb 2019	Full review

Links with External Standards	
Department of Health: NHS Records Management Code of Practice	
National Data Guardian Standards	
Data Security & Protection Toolkit	

Key Dates	DATE
Ratification Date	20th February 2019 (Policy Approval Group)
Review Date	Feb 2021

Executive Summary Sheet		
Document Title:	**Non Clinical Records Management Policy**	
Please Tick (☑) as appropriate	This is a new document within the Trust	
	This is a revised Document within the Trust	☑
What is the purpose of this document?		
To ensure that the Trust has a robust approach to the use, storage and disposal of non-clinical records in accordance with current legislation and guidelines.		
What key Issues does this document explore?		
This policy identifies the obligations placed upon the Trust by the Department of Health's Records Management NHS Code of Practice, which covers all legal and statutory obligations with regards to the handling, storage and disposal of both Non Clinical and Clinical records. This policy focuses on Non Clinical Records. The policy includes a quick reference guide detailing the retention periods of non-clinical records.		
Who is this document aimed at?		
All staff working for Walsall Healthcare NHS Trust		
What other policies, guidance and directives should this document be read in conjunction with?		
Information Governance and Management Strategy Patient Records Policy Records Retention Policy General Data Protection Regulations Policy and Procedures		
How and when will this document be reviewed?		
At least every three years by the lead author or by an individual nominated by the lead Director.		

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation
	Corporate Governance Manager

Circulated to the following for consultation

Name/Committee/Group/	Designation
Intranet Forum	
Policies and Procedures Members	
Information Governance Steering Group	

Version Control Summary

Significant or Substantive Changes from Previous Version
A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

When a document is reviewed the changes should be recorded using the tracking tool below in order to clearly show areas of change for the consultation process.

Version	Date	Comments on Changes	Author
0.1	July 2011	Draft	Head of Governance – Compliance & Risk
0.2	Feb 2012	Updated following consultation	Head of Governance – Compliance & Risk
2.0	July 2013	Updated following minor review	Compliance and Risk Manager
3.0	July 2014	Full review	Compliance and Risk Manager
3.1	July 2015	Minor review	Acting Head of Compliance and Risk
4.0	Dec 2017	Minor review	Compliance and Risk Manager
5.0	Jan 2019	Full review following introduction of GDPR	Corporate Governance Manager

NON CLINICAL RECORDS MANAGEMENT POLICY

1.0 INTRODUCTION

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, all the way through to their lifecycle to their eventual disposal.

The Records Management: NHS Code of Practice has been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

This policy determines the standards which must be followed when handling any Trust non-clinical record.

2.0 Purpose of Policy

The purpose of this policy is to ensure non-clinical records are managed and controlled appropriately. This includes how a record is created and kept secure.

The aim of this policy is to ensure that a Trust wide system is in place in order to maintain the integrity of non-clinical records as well as to ensure that records are kept safely, securely and in accordance with the periods stated in the Department of Health's Records Management Code of Practice (appendix 1).

3.0 Statement of Intent

The Trust has an obligation to comply with the Department of Health's Records Management Code of Practice as detailed within this policy.

The General Data Protection Regulations/Data Protection act 2018, requires organisations to ensure all personal information is held, obtained, recorded, used and shared legally, fairly and securely.

4.0 Scope and limitations

Records can be created by anyone working within or on behalf of the Trust. This includes, but is not limited to, employees, agents, contractors and volunteers in any capacity.

This policy relates to all Trust non-clinical records, both manual and computerised, which become a formal record of the Trust.

It applies to information in paper or other physical forms, e.g. electronic, microfilm, negatives, photographs, audio or video records or other assets.

This document sets out a framework within which staff responsible for managing the Trust's non-clinical records can develop specific policies and procedures to ensure that

records are managed and controlled effectively and at best value, commensurate with legal, operational and information needs.

This policy applies to all staff who use non-clinical records at any level.

4.1 OBJECTIVES

To ensure that;

- **Records are available when needed**
  From which the Trust is able to form a reconstruction of activities or events that have taken place.
- **Records can be accessed**
  Records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;
- **Records can be interpreted**
  The context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;
- **Records can be trusted**
  The record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated;
- **Records can be maintained through time**
  The qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;
- **Records are secure**
  From unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required;
- **Records are retained and disposed of appropriately**
  Using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value;
- **Staff are trained**
  All staff are made aware of their responsibilities for record-keeping and record management.

5.0 ROLES AND RESPONSIBILTIES

5.1 Chief Executive (CE)

The Chief Executive has overall responsibility for records management in the Trust. As accountable officer, he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this as it will ensure appropriate, accurate information is

available as required.

The Trust has a particular responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

5.2 Caldicott Guardian

The Trust's Caldicott Guardian has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner. The Caldicott Guardian for Walsall Healthcare NHS Trust is the Medical Director.

5.3 The Data Protection Officer

The Data Protection Lead has responsibility for providing guidance on records management issues in relation to the legislation and for ensuring that related policies and procedures conform to the latest legislation and NHS guides on Data Protection, patient confidentiality, information security and rights of access to information.

5.4 Information Governance Steering Group

The Trust's Information Governance Steering Group is responsible for ensuring that this policy is implemented and that records management system and processes are developed, coordinated and monitored.

5.5 Information Asset Owners/Local Record or Senior Managers

The responsibility for local records management is devolved to the Information Asset Owners. General Managers and Heads of Departments within the Trust have overall responsibility for the management of all records generated by their activities and for ensuring that records controlled within their area are managed in a way which meets the aims of the Trust's record management policies.

General Managers and Heads of Service are responsible for ensuring that this policy is implemented in their individual departments.

All Managers (at all levels) are responsible for ensuring that Trust policies and procedures are implemented in their directorate/department, that all staff receive training appropriate to their needs and information is provided when requested to meet the requirements of legislation and NHS standards.

5.6 All Staff (with individual responsibilities under the policy)

All Trust staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. In particular all staff must ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy and with any guidance subsequently produced.

6.0 PROCEDURE

6.1 *Records Management*

Implementing and maintaining effective records management depends on the Trust's knowledge of what records it creates and are held, where they are stored, who manages them, in what format(s) they are made accessible, and their relationship to the Trust's functions.

The Trust will establish and maintain mechanisms through which departments and other units can register the records they are maintaining. The inventory of record collections will facilitate:

- The format of the record e.g. electronic, manual etc.

- The classification of records into series;

- The recording of the responsibility of individuals creating records;

- Retention periods of the record;

- Destruction cycle of the record.

The Trust is committed to ongoing improvement of its records management functions as it believes that it will gain a number of organisational benefits from so doing. These include:

- better use of physical and server space;
- better use of staff time;
- improved control of valuable information resources;
- compliance with legislation and standards;
- reduced costs.

The Trust also believes that its internal management processes will be improved by the greater availability of information that will accrue by the recognition of records management as a designated corporate function.

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

The storage of records on all types of media must be safe and secure from unauthorised access and meet health and safety and fire regulations. This must 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, the Trust may use the services of its third party storage provider until retention is achieved.

This document sets out a framework within which the staff responsible for managing the Trust's records can develop specific policies and procedures to ensure that records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.

6.2 Access and Disclosure of Records

Records should be stored in a secure location when not being used e.g. lockable filing cabinets, cupboards and rooms (locked and/or alarmed when unattended and outside of normal working hours).

Access controls have been implemented to prevent unauthorised access or alteration of records. Paper records will be kept in a locked filing cabinet or locked room; electronic files will be kept in individual's network folders or shared network folders with limited access to authorised individuals.

Access to NHS records and information will be in accordance with the General Data Protection Regulations/Data Protection Act 2018, Caldicott principles, Freedom of Information Act 2000 and in accordance with the relevant Trust policies.

The Trust will ensure it complies with the 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 are detailed in the Department of Health Records Management Code of Practice.

6.3 Closure and Transfer of Records

All Trust records must 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. Where possible, information on the intended disposal of electronic records should be included in the metadata when the record is created.

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

6.4 Non Clinical Records Management Audit

The Trust will conduct an annual non clinical records management audit to identify what records are held. If the records are duplicated and if the records are created, stored and disposed of in line with the guidance in this policy.

6.5 Retention and Destruction of Records

It is a fundamental requirement that all of the Trust's non clinical records are retained for a minimum period of time for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the Trust's business functions.

Regardless of type there is a requirement to keep all records for a minimum number of

years. This period of time is calculated from the end of the calendar or accounting year following the last entry in the record (e.g. manual file, computer record).

The Trust has adopted the retention periods set out in the Department of Health's Records Management: NHS Code of Practice (detailed in appendix 1).

Where a record is not listed the Trust's managers will consider how to manage the record type by carrying out a risk assessment of the pros and cons of destroying the record or maintaining it for a prolonged period in order to decide how best to manage the record. During this risk assessment attention will be paid to other retention periods for similar record types.

Once a retention period has been decided for a record type this will be approved by the Trust's Information Governance Steering Group and incorporated within the retention schedule detailed at appendix 1 of this policy.

The destruction of records is an irreversible act. Many Trust records contain sensitive and/or confidential information and their destruction will be undertaken in secure locations. Proof of secure destruction may be required. Destruction of all records, regardless of the media, will be conducted in a secure manner to ensure there are safeguards against accidental loss or disclosure.

The normal destruction method used by the Trust is shredding. This is undertaken on site by an individual member of staff or by the Trust's contractor or offsite storage provider. The contractor, or offsite storage provider, is required to provide proof of destruction in the form of a certificate.

A record of destruction of records, showing their reference, description and date of destruction, should be maintained and preserved by the Information Asset Owner or Department 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 might 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 2000 have been exhausted or the legal process completed.

Where a record is due for destruction and is the subject of a request for information under the Environmental Information Regulations (2004), the destruction process will be halted until the request for information has been completed, or, if the authority has decided not to disclose the information, until the complaint and appeal provisions of the Environmental Information Regulations (2004) have been exhausted.

6.6 Disposal/Archiving of Records

Disposal is wider than just destruction. It can also refer to the transfer of records from one media to another (e.g. paper to electronic or CD), or the transfer of records from one organisation to another (e.g. from the Trust to an authorised archive office).

The Trust will ensure detailed procedures are developed and certificates are held when a record has either been transferred to an archive or destroyed. This will enable the Trust to demonstrate the disposal of a record. Freedom of Information legislation requires that disposal (the point in a record's lifecycle when it is either transferred to an archive or destroyed) has been undertaken in line with Trust procedures/policies.

Records selected for archival preservation and no longer in regular use by the organisation should be transferred as soon as possible to an archival institution that has adequate storage and public access facilities.

Non-active records should be transferred no later than 30 years from creation of the record, as required by the Public Records Act 1958.

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.

7.0 EQUALITY IMPACT ASSESSMENT

The users of this policy will take into account their statutory duty to promote equality and human rights and to act lawfully within current equality legislation and guidance.

This policy has been equality impact assessed and has been shown to have no adverse impact on any equality group.

The Trust will continue to monitor its effect and will assess again if negative impact is identified or at the review date.

7.1 Financial implications

Any financial implications arising from the destruction and retention of records will be considered as part of the annual budget setting process across the Trust.

7.2 Risk Implications / Risk Assessment

There are no risk implications associated with this policy subject to successful implementation and compliance. The implementation of this policy mitigates risk around non-compliance with the Department of Health's Records Management: NHS Code of Practice and Standards within the Information Governance Toolkit.

8.0 MONITORING, CONTROL AND AUDIT

Monitoring Process	Requirements
Who	Compliance and Risk Team
Standards Monitored	• Duplicates of record held • Purpose of record • Where information is generated from • Does the record contain personal data • Is access to the record shared outside of the relevant department • Is there a register of the records held • Where is the data held • Is there a back up system • Is there a business continuity plan for the records • Has the retention period for the records been identified and what action is taken • Are records named in accordance with the Non Clinical Records Management Procedure
When	Annually
How	Audit
Presented to	Information Governance Steering Group
Monitored by	Information Governance Steering Group
Completion/Exception reported to	Quality and Safety Committee

Areas of non-conformance will be highlighted to the relevant departments and recommendations suggested to tighten controls or make adjustments to related procedures.

9.0 TRAINING

All Trust staff will be made aware of their responsibilities for non-clinical record keeping and non-clinical record management through published guidance and during Trust Induction with updates as required.

The training needs of staff in relation to records management will be identified so that training can be updated and reinforced as necessary.

Managers will be responsible for ensuring that their staff are aware of the Trust's standards and Non-Clinical Records Management Policy.

10.0 DEFINITIONS

The following terms are used within this policy:

Records Life Cycle	Describes the life of a record from its creation/receipt through the period of its 'active' use, then into a period of 'inactive' retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.
Records	Are defined as 'recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity'.
Information	Is a corporate asset. The Trust's records are important sources of administrative, evidential and historical information. They are vital to the Trust to support its current and future operations (including meeting the requirements of Freedom of Information legislation), for the purpose of accountability, and for an awareness and understanding of its history and procedures.

11.0 BEST PRACTICE, EVIDENCE AND REFERENCES

- Department of Health (2016) NHS Records Management Code of Practice
- The Public Records Act 1958
- The General Data Protection Regulations/ Data Protection Act 2018
- The Freedom of Information Act 2000

General Administration

Type of Information	Minimum Retention Period/ Retention Schedule	Notes	Final Action
Accident Records	10 years	Relating to the following: • Accident Forms, Accident Register, Incident Forms	Note 2
Administration Papers	2 years	after the settlement of the matter to which they relate and not covered elsewhere e.g. letters, Reminders, Drafts documents, duplicates of documents known to be preserved elsewhere, indices and registers compiled for temporary purposes, routine reports, other documents that have ceased to be of value on settlement of the matter involved	Note 2
Advance letters (e.g. DH guidance)	6 years		Destroy
Annual/corporate reports	3 years		Note 1
Assembly/Parliamentary questions, MP enquiries	10 years		Note 2
Audit Records	2 years	From the date of completion of the audit. Relating to the following internal and external in any format (papers, electronic etc): • Organisational Audits, Records Audits, Systems Audits	Note 2
Business Plans (including local delivery plans)	20 years		Destroy
Catering Forms	6 years		Note 2

Close Circuit TV Images (CCTV)	31 days	ICO's Code of Conduct	Erase permanently
Commissioning Decisions Appeal Documentation Decision Documentation	6 years	from date of decision or appeal decision	Note 2
Complaints	10 years	From completion of action. Files closed annually and kept for 10 years following closure. Relating to the following: • Correspondence, Investigation, Outcomes, Returns made to DH	Note 2
Copyright Declaration Forms	6 years	Library Service	Note 2
Data Input Forms	2 years	Where the data/information has been input into a computer system	Note 2
Diaries (office)	1 year	After the end of the calendar year to which they refer	Note 2
Exposure Monitoring Records	5 years	from the date the record was made	Note 2
Flexi Working Hours	6 months	Personal record of hours actually worked	Note 2
GMS1 Forms (registration with GP)	3 years		Note 2
Health and Safety Documentation	3 years		Note 2
History of Organisation	30 years	Relating to the following: • History of organisation or predecessors, its organisation and procedures eg establishment order)	Note 1

Hospital Trust Services	10 years		Destroy
Information requests – FOI, DPA, Subject Access Request, Police statements	6 years		Note 2
Laundry lists and receipts	2 years	from completion of audit	Note 2
Library registration forms	2 years	after registration	Destroy
Litigation	10 years	Where a legal action has commenced, keep as advised by legal representatives, relating to the following: • Complaints including accident/incident reports • Records/documents relating to any form of litigation	Note 2
Manuals	10 years	after life of the system (or superseded) to which the policies or procedures refer. Policy and procedures relating to the following: • Administrative, Clinical, Strategy	Note 1
Meetings Minutes, Papers & Agendas:			
- Executive committees	30 years	Master copies	Note 1
- Major committees	10 years	Master copies	Note 1
- Senior committees	5 years	Master copies	Note 1
- Operational committees	2 years	Master copies	Note 1

Nominal Rolls	6 years		Note 2
Patient Advice & Liaison Service	10 years	after closure of the case	Note 2
Patient Information Leaflets	6 years	after the leaflet has been superseded	Note 1
Patients property books/registers	Old copies in the property books retained for 6 months 6 years for slips contained in medical records	after the end of the financial year in which the property was disposed of, or 6 years after the register was closed. Property handed in for safekeeping	Note 2
Patient Surveys	2 years		Note 2
Phone Message Books	2 years		Note 2
Press Cuttings	1 year		Destroy
Press Releases	7 years		Note 1
Project files Over £100,000	6 years	Includes the following: • Termination, Abandoned projects, Deferred projects	Note 1
Project Files Less than £100,000	2 years	Termination	Note 2
Public Consultations	5 years		Note 2
Quality Assurance Records	12 years	Includes the following: • Healthcare Commission, Audit Commission, King's Fund Organisational Audit, Investors in People	Note 2

Receipts for registered and recorded mail	2 years	following end of financial year to which they relate	Note 2
Records management database	30 years	Documenting the transfer of trust records to public records archive or destruction of records	Note 1
Reports (major)	30 years		Note 1
Requisitions	18 months		Note 2
Research Ethics Committee Records	3 years	from date of decision	Note 1
Serious Incident Files	30 years		Note 1
Specifications	6 years	Equipment Services	Note 2
Statistics	3 years	from date of submission, can include the following: • Korner returns • Contract minimum data set • Statistical returns to DH • Patient activity	Destroy
Time sheets	6 months	Relating to a Group of Department eg on a ward where the timesheets are kept as a tool to manage resources/staffing levels	Note 2

Estates/Engineering			
Type of Information	**Minimum Retention Period/ Retention Schedule**	**Notes**	**Final Action**
Buildings and engineering works	30 years	Can include the following: • Major projects (abandoned or deferred) • Key records (final accounts, surveys, site plans, bills of quantities) • Town and country planning matters and all formal contract documents (executed agreements conditions of contract, specifications, documents on the appointment and conditions of engagement of private buildings and engineering consultants)	Note 1
Buildings	3 years	after occupation ceases. Papers relating to occupation of the building (but not health and safety information)	Note 2
Deeds of Title	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	Note 1
Drawings – plans and buildings (architect signed not copies)	Lifetime of the building to which they relate		Note 1
Engineering works – plans and building records	Lifetime of the building to which they relate		Note 1

Equipment – records of non-fixed equipment, including specification, test records, maintenance records and logs	11 years	If the records relate to vehicles (fleet vehicles) and where the vehicle no longer exists, providing there is a record that it was scrapped, the records can be destroyed	Note 2
Inspection Reports (boilers, lifts)	Lifetime of installation	If there is any measurable risk of a liability in respect of installations beyond their operational lives, the records should be retained indefinitely	Note 1
Inventories of furniture, medical and surgical equipment not held on store charge and with a minimum life of 5 years	Keep until next inventory		Note 1
Inventories of plant and permanent or fixed equipment	5 years	after date of inventory	Note 1
Land surveys/registers	30 years		Note 1
Leases – the grant of leases, licences and other rights over property	Period of the lease plus 12 years		Note 2
Maintenance contracts (routine)	6 years	from end of contract	Note 2
Manuals (operating)	Lifetime of equipment	Review if issues (eg HSE) are outstanding	Review
Medical device alerts	Retain until updated or withdrawn	(check MHRA website)	Note 2

Maps	Lifetime of the organisation		Note 1
Photographs of buildings	30 years		Note 1
Mortgage Documents	6 years after repayment	Relating to the following: • Acquisition, Transfer, Disposal	Note 1
Plans Building (as built) Building (detailed) Engineering	Lifetime of building	May have historical value	Note 1
Property acquisitions dossiers	30 years		Note 1
Property disposal dossiers	30 years		Note 1
Radioactive Waste	30 years		Note 1
Site files	Lifetime of site		Note 1
Structure Plans (organisation charts)	Lifetime of building		Note 1

Surveys – building and engineering works	Lifetime of building or installation		Note 1
Surgical Appliances Forms AP1,2,3,4	2 years	after completion of audit	Note 2

Financial

Type of Information	Minimum Retention Period/ Retention Schedule	Notes	Final Action
Accounts – annual (final – one set only)	30 years		Note 1
Accounts – minor records	2 years	from completion of audit. Pass books, paying-in slips, cheque counterfoils, cancelled/discharged cheques (for cheques bearing printed receipts, see Receipts), accounts of petty cash expenditure, travel and subsistence accounts, minor vouchers, duplicate receipt books, income records, laundry lists and receipts	Note 2
Accounts – working papers	3 years	from completion of audit	Note 2
Advice notes (payment)	1.5 years		Note 2
Audit records	2 years	from completion of audit Internal and external audit original documents	Note 2

Audit reports	2 years	after formal completion by statutory auditor external (including management letters, value for money reports and system/final accounts memoranda	Note 2
Bank statements	2 years	from completion of audit	Note 2
Banks Automated Clearing System (BACS) records	6 years	after year end	Note 2
Benefactions (records of)	5 years	after end of financial year in which the trust monies become finally spent or the gift in kind is accepted. In cases where the Benefaction Endowment Trust fund/capital/interest remains permanent, records should be permanently retained by the organisation	Note 2
Bills, receipts and cleared cheques	6 years		Note 2
Budgets (including working papers, reports, virements and journals)	2 years	from completion of audit	Note 2
Capital charges data	2 years	from completion of audit	Note 2
Cash sheets	6 years	after end of financial year to which they relate	Note 2
Contracts – financial	Approval files – 15 years Approved suppliers lists – 11 years		Note 2

Contracts - Non-sealed (property) on termination Non-sealed (other) on termination	6 years	after termination of contract	Note 2
Contracts – sealed (and associated records)	Minimum of 15 years,	after which they should be reviewed	Note 1
Contractual arrangements with hospitals or other bodies outside the NHS	6 years	after end of financial year to which they relate Including papers relating to financial settlements made under the contract (e.g. waiting list initiative, private finance initiative)	Note 2
Cost accounts	3 years	after end of financial year to which they relate	Note 2
Creditor payments	3 years	after end of financial year to which they relate	Note 2
Debtors' records – cleared	2 years	from completion of audit	Note 2
Debtors' records – uncleared	6 years	from completion of audit	Note 2
Demand notes	6 years	after end of financial year to which they relate	Note 2
Estimates, including supporting calculations and statistics	3 years	after end of financial year to which they relate	Note 2
Excess fares	2 years	after end of financial year to which they relate	Note 2

Expense claims, including travel and subsistence claims, and claims and authorisations	5 years	after end of financial year to which they relate	Note 2
Fraud case files/investigations	6 years		Note 2
Fraud national proactive exercises	3 years		Note 2
Funding data	6 years	after end of financial year to which they relate	Note 2
General Medical Services payments	6 years	after year end	Note 2
Invoices	6 years	after end of financial year to which they relate	Note 2
Ledgers	6 years	after end of financial year to which they relate Including cash books, ledgers, income and expenditure journals, nominal rolls, non-exchequer funds records (patient monies)	Note 2
Non-exchequer funds records	30 years	Although technically exempt under Public Records Act, it would be appropriate to treat these records as if they were not.	Review
Patient Monies (i.e. smaller sums of donated money)	6 years		Note 2

PAYE records	6 years	after termination of employment	Note 2
Payments	6 years	after year end	Note 2
Payroll (i.e., list of staff in the pay of the organisation)	6 years	after termination of employment	Note 2
Positive predictive value performance indicators	3 years		Note 2
Private Finance Initiative	30 years		Note 1
Receipts	6 years	after end of financial year to which they relate	Note 2
Salaries (see Wages)			Note 2
Superannuation accounts	10 years		Note 2
Superannuation forms SD55(ADP) and SD55J (NHS Pensions Scheme – copies)	10 years	(original to NHS Pensions Agency)	Note 2
Superannuation registers	10 years		Note 2

Tax forms	6 years		Note 2
Transport (staff pool car documentation)	3 years	unless litigation ensues	Note 2
Trust documents without permanent relevance/not otherwise mentioned	6 years		Note 2
Trusts administered by Strategic Health Authorities (terms of)	30 years		Note 1
VAT records	6 years	after end of financial year to which they relate	Note 2
Wages/salary records	10 years	after termination of employment	Note 2

Informatics

Type of Information	Minimum Retention Period/ Retention Schedule	Notes	Final Action
Documentation relating to computer programmes written in-house	Lifetime of software		Note 2
Software licences	Lifetime of software		Note 2

Human Resources			
Type of Information	**Minimum Retention Period/ Retention Schedule**	**Notes**	**Final Action**
Consultants (records relating to the recruitment of)	5 years		Note 2
CVs for non-executive directors (unsuccessful applicants)	2 years		Note 2
Duty rosters i.e. organisation or departmental rosters, not the ones held on the individual's records	4 years	after the year to which they relate	Note 2
Industrial relations (not routine staff matters), including industrial tribunals	10 years		Note 2
Job advertisements	1 year		Destroy
Job applications: Successful/Unsuccessful	3 years/1 year	following termination of employment	Note 2
Job descriptions	3 years		Note 2

Leavers' dossiers	6 years after individual has left	Summary to be retained until individual's 70th birthday, or until 6 years after cessation of employment if aged over 70 years at the time.	Note 2 Note 1
Letters of appointment	6 years	after employment has terminated or until 70th birthday, whichever is later	Note 2
Nurse training records (from hospital-based nurse training schools prior to introduction of academic based-training)	30 years		Note 1
Timesheets (for individual members of staff)	2 years after the year to which they relate	Note: timesheets (for all individuals including locum doctors) held on the personnel records are minor records – retain for 2 years Timesheets held elsewhere; i.e. on the ward retain for 6 months (as the master timesheet is held on the personnel file)	Note 2
Study leave applications	5 years		Note 2
Training plans	2 years		Note 2

Purchasing/Supplies			
Type of Information	**Minimum Retention Period/ Retention Schedule**	**Notes**	**Final Action**
Approval files (contracts)	6 years after end of the year the contract expired		Note 2
Approved suppliers lists	11 years		Note 2
Delivery notes	2 years after end of financial year to which they relate		Note 2
Products (liability)	11 years		Note 2
Stock control reports	18 months		Note 2
Stores records – major (e.g. stores ledgers)	6 years		Note 2
Stores records – minor (e.g. requisitions, issue notes, transfer vouchers, goods received books)	18 months		Note 2

Supplies records – minor (e.g. requisitions, issue notes, transfer vouchers, goods received books)	18 months		Note 2
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)	18 months		Note 2
Tenders (successful)	Tender period plus 6 year limitation period		Note 2
Tenders (unsuccessful)	6 years		Note 2

Schedule Key:

Note 1 - Where there is an existing relationship with an approved Place of Deposit, consult the provider in the first instance. If there is no existing relationship, consult the National Archive;
Note 2 - Destroy under confidential conditions
Destroy - Destroy under normal conditions
Review - Consider current guidance

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any procedural document that requires ratification

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		Non Clinical Records Management Policy
	Is the title clear and unambiguous? It should not start with the word policy.	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**	Yes	
	Are reasons for development of the document stated? This should be in the purpose section.	Yes	
3.	**Development Process**		
	Does the policy adhere to the Trust policy format?	Yes	
	Is the method described in brief? This should be in the introduction or purpose.	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
	Are all terms clearly explained/defined?	Yes	
5.	**Evidence Base**		
	Has a comprehensive literature search been conducted to identify best evidence to inform the policy?	Yes	
	Have the literature search results been evaluated and key documents identified?	Yes	
	Have the key documents been critically appraised?	Yes	
	Are key documents cited within the policy?	Yes	
	Are cited documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	

	Title of document being reviewed:	Yes/No	Comments
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	No	
	For Trust wide policies has the appropriate Executive lead approved the policy?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**	Yes	
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Yes	

Reviewer			
If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date			
Name		Date	January 2019
Signature		Approving Committee/s	IGSG/Policies and Procedures Group and Trust Executive Committee

Lead Manager (Local Policies) / Director (Trust Wide Policies)			
If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date it and forward to the Compliance and Risk Department for ratification.			
Name	Corporate Governance Manager	Date	
Signature		Approving Committee/s	IGSG/Policies and Procedures Group and Trust Executive Committee
Ratification Committee Approval			
Quality Board minute number: PPG minute number: **TMB minute number:**			

Service Overview & Improvement Action Plan: Equality Analysis Form

Title: Non Clinical Records Management Policy	What are the intended outcomes of this work? The purpose of this policy is to outline the principles relating to the management of non-clinical records and to support staff in applying these principles.
Who will be affected? All staff	Evidence: N/A

ANALYSIS SUMMARY: considering the above evidence, please summarise the impact of the work based on the Public Sector equality duty outcomes against the 9 Protected characteristics

Public Sector Duty / *Protected Characteristics* (highlight as appropriate)	**Eliminate discrimination, harassment and victimisation**	**Advance equality of opportunity**	**Promote good relations between groups**
AGE / DISABILITY/ RACE	*No Impact*	*No Impact*	*No Impact*
SEX (Gender)/ GENDER REASSIGNMENT	*No Impact*	*No Impact*	*No Impact*
RELIGION or BELIEF/ SEXUAL ORIENTATION	*No Impact*	*No Impact*	*No Impact*
PREGNANCY & MATERNITY	*No Impact*	*No Impact*	*No Impact*
MARRIAGE & CIVIL PARTNERSHIP	*No impact*	*Not applicable at present*	*Not applicable at present*

What is the overall impact? There are no negative implications associated with this policy. The implementation promotes positive opportunities and relationships between all groups and is in accordance with the new General Data Protection Regulations.

Any action required on the impact on equalities? *Impact of this policy has been assessed and it will not lead to any discrimination or other adverse events on any population groups, as described above.*

Name of person completing analysis	*Sharon Thomas*	**Date completed**	*January 2019*
Name of responsible Director			
Signature			