Broad descriptor	Record Type
Care Records with standard retention periods	Adult health records not covered by any other section in this schedule
Care Records with standard retention periods	Adult social care records
Care Records with standard retention periods	Children’s records including midwifery, health visiting and school nursing
Care Records with standard retention periods	Electronic Patient Records System
Care Records with standard retention periods	General Dental Services records

Care Records with standard retention periods	GP Patient records
Care Records with standard retention periods	Mental Health records
Care Records with standard retention periods	Obstetric records, maternity records and antenatal and post natal records
Care Records with Non-Standard Retention Periods	Cancer/Oncology - the oncology records of any patient

Care Records with Non-Standard Retention Periods	Contraception, sexual health, Family Planning and Genito-Urinary Medicine (GUM)
Care Records with Non-Standard Retention Periods	HFEA records of treatment provided in licenced treatment centres
Care Records with Non-Standard Retention Periods	Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)
Care Records with Non-Standard Retention Periods	Record of long term illness or an illness that may reoccur
Pharmacy	Information relating to controlled drugs

Pharmacy	Pharmacy prescription records *see also Controlled Drugs*
Pathology	Pathology Reports/Information about Specimens and samples
Event & Transaction Records	Blood bank register
Event & Transaction Records	Clinical Audit
Event & Transaction Records	Chaplaincy records

Event & Transaction Records	Clinical Diaries
Event & Transaction Records	Clinical Protocols
Event & Transaction Records	Datasets released by HSCIC under a data sharing agreement
Event & Transaction Records	Destruction Certificates or Electronic Metadata destruction stub or record of clinical information held on destroyed physical media
Event & Transaction Records	Equipment maintenance logs
Event & Transaction Records	General Ophthalmic Services patient records related to NHS financial transactions
Event & Transaction Records	GP temporary resident forms
Event & Transaction Records	Inspection of equipment records
Event & Transaction Records	Notifiable disease book

Event & Transaction Records	Operating theatre records
Event & Transaction Records	Patient Property Books
Event & Transaction Records	Referrals not accepted
Event & Transaction Records	Requests for funding for care not accepted
Event & Transaction Records	Screening, including cervical screening, information where no cancer/illness detected is detected
Event & Transaction Records	Smoking cessation
Event & Transaction Records	Transplantation Records
Event & Transaction Records	Ward handover sheet
Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).	Recorded conversation which may later be needed for clinical negligence purpose

Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).	Recorded conversation which forms part of the health record
Telephony Systems & Services (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).	The telephony systems record(not recorded conversations)
Births, Deaths & Adoption Records	Birth Notification to Child Health
Births, Deaths & Adoption Records	Birth Registers
Births, Deaths & Adoption Records	Body Release Forms
Births, Deaths & Adoption Records	Death - cause of death certificate counterfoil
Births, Deaths & Adoption Records	Death register information sent to General Registry Office on monthly basis

Births, Deaths & Adoption Records	Local Authority Adoption Record (normally held by the Local Authority children's services)
Births, Deaths & Adoption Records	Mortuary Records of deceased
Births, Deaths & Adoption Records	Mortuary register
Births, Deaths & Adoption Records	NHS Medicals for Adoption Records
Births, Deaths & Adoption Records	Post Mortem Records
Clinical Trials & Research	Advanced Medical Therapy Research Master File
Clinical Trials & Research	Clinical Trials Master File of a trial authorised under the European portal under Regulation (EU) No 536/2014

Clinical Trials & Research	European Commission Authorisation (certificate or letter) to enable marketing and sale within the EU member states area
Clinical Trials & Research	Research data sets
Clinical Trials & Research	Research Ethics Committee’s documentation for research proposal
Clinical Trials & Research	Research Ethics Committee’s minutes and papers
Corporate Governance	Board Meetings
Corporate Governance	Board Meetings (Closed Boards)

Corporate Governance	Chief Executive records
Corporate Governance	Committees Listed in the Scheme of Delegation or that report into the Board and major projects
Corporate Governance	Committees/ Groups / Sub-committees not listed in the scheme of delegation
Corporate Governance	Destruction Certificates or Electronic Metadata destruction stub or record of information held on destroyed physical media
Corporate Governance	Incidents (serious)
Corporate Governance	Incidents (not serious)
Corporate Governance	Non-Clinical Quality Assurance Records
Corporate Governance	Patient Advice and Liaison Service (PALS) records
Corporate Governance	Policies, strategies and operating procedures including business plans
Communications	Intranet site
Communications	Patient information leaflets

Communications	Press releases and important internal communications
Communications	Public consultations
Communications	Website
Staff Records & Occupational Health	Duty Roster
Staff Records & Occupational Health	Exposure Monitoring information
Staff Records & Occupational Health	Occupational Health Reports
Staff Records & Occupational Health	Occupational Health Report of Staff member under health surveillance
Staff Records & Occupational Health	Occupational Health Report of Staff member under health surveillance where they have been subject to radiation doses
Staff Records & Occupational Health	Staff Record

Staff Records & Occupational Health	Staff Record Summary
Staff Records & Occupational Health	Timesheets (original record)
Staff Records & Occupational Health	Staff Training records
Procurement	Contracts sealed or unsealed
Procurement	Contracts - financial approval files
Procurement	Contracts - financial approved suppliers documentation
Procurement	Tenders (successful)
Procurement	Tenders (unsuccessful)
Estates	Building plans and records of major building work

Estates	CCTV
Estates	Equipment monitoring and testing and maintenance work where asbestos is a factor
Estates	Equipment monitoring and testing and maintenance work
Estates	Inspection reports
Estates	Leases
Estates	Minor building works
Estates	Photographic collections of service locations and events and activities
Estates	Radioactive Waste

Estates	Sterilix Endoscopic Disinfector Daily Water Cycle Test, Purge Test, Nynhydrin Test
Estates	Surveys
Finance	Accounts
Finance	Benefactions
Finance	Debtor records cleared
Finance	Debtor records not cleared
Finance	Donations
Finance	Expenses
Finance	Final annual accounts report
Finance	Financial records of transactions
Finance	Petty cash
Finance	Private Finance initiative (PFI) files

Finance	Salaries paid to staff
Finance	Superannuation records
Legal, Complaints & information Rights	Complaints case file
Legal, Complaints & information Rights	Fraud case files
Legal, Complaints & information Rights	Freedom of Information (FOI) requests and responses and any associated correspondence
Legal, Complaints & information Rights	FOI requests where there has been a subsequent appeal
Legal, Complaints & information Rights	Industrial relations including tribunal case records
Legal, Complaints & information Rights	Litigation records
Legal, Complaints & information Rights	Patents / trademarks / copyright / intellectual property-

Legal, Complaints & information Rights	Software licences
Legal, Complaints & information Rights	Subject Access Requests (SAR) and disclosure correspondence
Legal, Complaints & information Rights	Subject access requests where there has been a subsequent appeal

Retention Start	Retention period	Action at end of retention period
Discharge or patient last seen	8 years	Review and if no longer needed destroy
End of care or client last seen	8 years	Review and if no longer needed destroy
Discharge or patient last seen	25th or 26th birthday (see Notes)	Review and if no longer needed destroy
See Notes	See Notes	Destroy
Discharge or patient last seen	10 Years	Review and if no longer needed destroy

Death of Patient	10 years after death see Notes for exceptions	Review and if no longer needed destroy
Discharge or patient last seen	20 years or 8 years after the patient has died	Review and if no longer needed destroy
Discharge or patient last seen	25 years	Review and if no longer needed destroy
Diagnosis of Cancer	30 Years or 8 years after the patient has died	Review and consider transfer to a Place of Deposit

Discharge or patient last seen	8 or 10 years (see Notes)	Review and if no longer needed destroy
	3, 10, 30, or 50 years	Review and if no longer needed destroy
Diagnosis	30 Years or 8 years after the patient has died	Review and consider transfer to a Place of Deposit
Discharge or patient last seen	30 Years or 8 years after the patient has died	Review and if no longer needed destroy
Creation	See Notes	Review and if no longer needed destroy

Discharge or patient last seen	2 Years	Review and if no longer needed destroy
Specimen or sample is destroyed	See Notes	Review and consider transfer to a Place of Deposit
Creation	30 Years minimum	Review and consider transfer to a Place of Deposit
Creation	5 years	Review and if no longer needed destroy
Creation	2 years	Review and consider transfer to a Place of Deposit

End of the year to which they relate	2 years	Review and if no longer needed destroy
Creation	25 years	Review and consider transfer to a Place of Deposit
Date specified in the data sharing agreement	Delete with immediate effect	Delete according to HSCIC instruction
Destruction of record or information	20 Years	Review and consider transfer to a Place of Deposit
Decommissioning of the equipment	11 years	Review and consider transfer to a Place of Deposit
Discharge or patient last seen	6 Years	Review and if no longer needed destroy
After treatment	2 years	Review and if no longer needed destroy
Decommissioning of equipment	11 Years	Review and if no longer needed destroy
Creation	6 years	Review and if no longer needed destroy

End of year to which they relate	10 Years	Review and consider transfer to a Place of Deposit
End of the year to which they relate	2 years	Review and if no longer needed destroy
Date of rejection.	2 years as an ephemeral record	Review and if no longer needed destroy
Date of rejection	2 years as an ephemeral record	Review and if no longer needed destroy
Creation	10 years	Review and if no longer needed destroy
Closure of 12 week quit period	2 years	Review and if no longer needed destroy
Creation	30 Years	Review and consider transfer to a Place of Deposit
Date of handover	2 years	Review and if no longer needed destroy
Creation	3 Years	Review and if no longer needed destroy

Creation	Store as a health record	Review and if no longer needed destroy
Creation	1 year	Review and if no longer needed destroy
Receipt by Child health department	25 years	Review and if no longer needed destroy
Creation	2 years	Review and actively consider transfer to a Place of Deposit
Creation	2 years	Review and consider transfer to a Place of Deposit
Creation	2 years	Review and consider transfer to a Place of Deposit
Creation	2 years	Review and consider transfer to a Place of Deposit

Creation	100 years from the date of the adoption order	Review and consider transfer to a Place of Deposit
End of year to which they relate	10 Years	Review and consider transfer to a Place of Deposit
Creation	10 Years	Review and consider transfer to a Place of Deposit
Creation	8 years or 25th birthday	Review and consider transfer to a Place of Deposit
Creation	10 years	Review and if no longer needed destroy
Closure of research	30 years	Review and consider transfer to a Place of Deposit
Closure of trial	25 years	Review and consider transfer to a Place of Deposit

Closure of trial	15 years	Review and consider transfer to a Place of Deposit
End of research	Not more than 20 years	Review and consider transfer to a Place of Deposit
End of research	5 years	Review and consider transfer to a Place of Deposit
Year to which they relate	Before 20 years	Review and consider transfer to a Place of Deposit
Creation	Before 20 years but as soon as practically possible	Transfer to a Place of Deposit
Creation	May retain for 20 years	Transfer to a Place of Deposit

Creation	May retain for 20 years	Transfer to a Place of Deposit
Creation	Before 20 years but as soon as practically possible	Transfer to a Place of Deposit
Creation	6 Years	Review and if no longer needed destroy
Destruction of record or information	20 Years	Consider Transfer to a Place of Deposit and if no longer needed to destroy
Date of Incident	20 Years	Review and consider transfer to a Place of Deposit
Date of Incident	10 Years	Review and if no longer needed destroy
End of year to which the assurance relates	12 years	Review and if no longer needed destroy
Close of financial year	10 years	Review and if no longer needed destroy
Creation	Life of organisation plus 6 years	Review and consider transfer to a Place of Deposit
Creation	6 years	Review and consider transfer to a Place of Deposit
End of use	6 years	Review and consider transfer to a Place of Deposit

Release Date	6 years	Review and consider transfer to a Place of Deposit
End of consultation	5 years	Review and consider transfer to a Place of Deposit
Creation	6 years	Review and consider transfer to a Place of Deposit
Close of financial year	6 years	Review and if no longer needed destroy
Monitoring ceases	40 years/5 years from the date of the last entry made in it	Review and if no longer needed destroy
Staff member leaves	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	Review and if no longer needed destroy
Staff member leaves	Keep until 75th birthday	Review and if no longer needed destroy
Staff member leaves	50 years from the date of the last entry or until 75th birthday, whichever is longer	Review and if no longer needed destroy
Staff member leaves	Keep until 75th birthday (see Notes)	Create Staff Record Summary then review or destroy the main file.

6 years after the staff member leaves	75th Birthday	Place of Deposit should be offered for continued retention or Destroy
Creation	2 years	Review and if no longer needed destroy
Creation	See Notes	Review and consider transfer to a Place of Deposit
End of contract	6 years	Review and if no longer needed destroy
End of contract	15 years	Review and if no longer needed destroy
When supplier finishes work	11 years	Review and if no longer needed destroy
End of contract	6 years	Review and if no longer needed destroy
Award of tender	6 years	Review and if no longer needed destroy
Completion of work	Lifetime of the building or disposal of asset plus six years	Review and consider transfer to a Place of Deposit

	See ICO Code of Practice	Review and if no longer needed destroy
Completion of monitoring or test	40 years	Review and if no longer needed destroy
Completion of monitoring or test	10 years	Review and if no longer needed destroy
End of lifetime of installation	Lifetime of installation	Review
Termination of lease	12 years	Review and if no longer needed destroy
Completion of work	retain for 6 years	Review and if no longer needed destroy
Close of collection	Retain for not more than 20 years	Consider transfer to a place of deposit
Creation	30 years	Review and if no longer needed destroy

Date of test	11 years	Review and if no longer needed destroy
End of lifetime of installation or building	Lifetime of installation or building	Review and consider transfer to Place of Deposit
Close of financial year	3 years	Review and if no longer needed destroy
End of financial year	8 years	Review and consider transfer to Place of Deposit
Close of financial year	2 years	Review and if no longer needed destroy
Close of financial year	6 years	Review and if no longer needed destroy
Close of financial year	6 years	Review and if no longer needed destroy
Close of financial year	6 years	Review and if no longer needed destroy
Creation	Before 20 years	Transfer to place of deposit if not transferred with the board papers
End of financial year	6 Years	Review and if no longer needed destroy
End of financial year	2 Years	Review and if no longer needed destroy
End of PFI	Lifetime of PFI	Review and consider transfer to Place of Deposit

Close of financial year	10 Years	Review and if no longer needed destroy
Close of financial year	10 Years	Review and if no longer needed destroy
Closure of incident (see Notes)	10 years	Review and if no longer needed destroy
Case closure	6 years	Review and if no longer needed destroy
Closure of FOI request	3 years	Review and if no longer needed destroy
Closure of appeal	6 years	Review and if no longer needed destroy
Close of financial year	10 Years	Review and consider transfer to a Place of Deposit
Closure of case	10 years	Review and consider transfer to a Place of Deposit
End of lifetime of patent or termination of licence/action	Lifetime of patent or 6 years from end of licence /action	Review and consider transfer to Place of Deposit

End of lifetime of software	Lifetime of software	Review and if no longer needed destroy
Closure of SAR	3 Years	Review and if no longer needed destroy
Closure of appeal	6 Years	Review and if no longer needed destroy

Notes
Basic health and social care retention period - check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday. Check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain demonstrating that a record has been destroyed, then the code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.

If a new provider requests the records, these are transferred to the new provider to continue care. If no request to transfer: 1. Where the patient does not come back to the practice and the records are not transferred to a new provider the record must be retained for 100 years unless it is known that they have emigrated 2. Where a patient is known to have emigrated, records may be reviewed and destroyed after 10 years 3. If the patient comes back within the 100 years, the retention reverts to 10 years after death.
Covers records made where the person has been cared for under the Mental Health Act 1983 as amended by the Mental Health Act 2007. This includes psychology records. Retention solely for any persons who have been sectioned under the Mental Health Act 1983 must be considerably longer than 20 years where the case may be ongoing. Very mild forms of adult mental health treated in a community setting where a full recovery is made may consider treating as an adult records and keep for 8 years after discharge. All must be reviewed prior to destruction taking into account any serious incident retentions.
For the purposes of record keeping these records are to be considered as much a record of the child as that of the mother.
For the purposes of clinical care the diagnosis records of any cancer must be retained in case of future reoccurrence. Where the oncology records are in a main patient file the entire file must be retained. Retention is applicable to primary acute patient record of the cancer diagnosis and treatment only. If this is part of a wider patient record then the entire record may be retained. Any oncology records must be reviewed prior to destruction taking into account any potential long term research value which may require consent or anonymisation of the record.

Basic retention requirement is 8 years unless there is an implant or device inserted, in which case it is 10 years. All must be reviewed prior to destruction taking into account any serious incident retentions. If this is a record of a child, treat as a child record as above.
Retention periods are set out in the HFEA guidance at:http://www.hfea.gov.uk/docs/General_directions_0012.pdf
For the purposes of clinical care the diagnosis records of CJD must be retained. Where the CJD records are in a main patient file the entire file must be retained. All must be reviewed prior to destruction taking into account any serious incident retentions.
Necessary for continuity of clinical care.The primary record of the illness and course of treatment must be kept of a patient where the illness may reoccur or is a life long illness.
NHS England and NHS BSA guidance for controlled drugs can be found at: http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx and https://www.england.nhs.uk/wp-content/uploads/2013/11/som-cont-drugs.pdf The Medicines, Ethics and Practice (MEP) guidance can be found at the link (subscription required) http://www.rpharms.com/support/mep.asp#new Guidance from NHS England is that locally held controlled drugs information should be retained for 7 years. NHS BSA will hold primary data for 20 years and then review.NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see:http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/

See also 'Controlled Drugs'. There will also be an entry in the patient record and a record held by the NHS Business Services Authority. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/
This Code is concerned with the information about a specimen or sample. The length of storage of the clinical material will drive the length of time the information about it is to be kept. For more details please see: https://www.rcpath.org/resourceLibrary/the-retention-and-storage-of-pathological-records-and-specimens--5th-edition-.html. Retention of samples for clinical purposes can be for as long as there is a clinical need to hold the specimen or sample. Reports should be stored on the patient file. It is common for pathologists to hold duplicate reports. For clinical purposes this is 8 years after the patient is discharged for an adult or until a child's 25th birthday whichever is the longer. . After 20 years for adult records there must be an appraisal as to the historical importance of the information and a decision made as to whether they should be destroyed of kept for archival value.
See also Corporate Retention

Diaries of clinical activity & visits must be written up and transferred to the main patient file. If the information is not transferred the diary must be kept for 8 years.
Clinical protocols may have archival value. They may also be routinely captured in clinical governance meetings which may form part of the permanent record (see Corporate Records).
http://www.hscic.gov.uk/media/15729/DARS-Data-Sharing-Agreement/pdf/Data_Sharing_Agreement_2015v2%28restricted_editing%29.pdf
Destruction certificates created by public bodies are not covered by an instrument of retention and if a Place of Deposit or the National Archives do not class them as a record of archival importance they are to be destroyed after 20 years.
Assumes a copy sent to responsible GP for inclusion in the primary care record

If transferred to a place of deposit the duty of confidence continues to apply and can only be used for research if the patient has consented or the record is anonymised.
The rejected referral to the service should also be kept on the originating service file.
Where cancer is detected see 2 Cancer / Oncology. For child screening treat as a child health record and retain until 25th birthday or 10 years after the child has been screened whichever is the longer.
See guidance at: https://www.hta.gov.uk/codes-practice
This retention relates to the ward. The individual sheets held by staff must be destroyed confidentially at the end of the shift.
The period of time cited by the NHS Litigation Authority is 3 years

It is advisable to transfer any relevant information into the main record through transcription or summarisation. Call handlers may perform this task as part of the call. Where it is not possible to transfer clinical information from the recording to the record the recording must be considered as part of the record and be retained accordingly.
This is the absolute minimum specified to meet the NHS contractual requirement.
Treat as a part of the child's health record if not already stored within health record such as the health visiting record.
Where registers of all the births that have taken place in a particular hospital/birth centre exist, these will have archival value and should be retained for 25 years and offered to a Place of Deposit at the end of this retention period. Information is also held in the NHS Number for Babies (NN4B) electronic system and by the Office for National Statistics. Other information about a birth must be recorded in the care record.
A full dataset is available from the Office for National Statistics.

The primary record of the adoption process is held by the local authority children's service responsible for the adoption service
The health reports will feed into the primary record held by Local Authority Children’s services. This means that the adoption records held in the NHS relate to reports that are already kept in another file which is kept for 100 years by the appropriate agency and local authority.
The primary post mortem file will be maintained by the coroner. The coroner will retain the post mortem file including the report. Local records of post mortem will not need to be kept for the same extended time.
See guidance at: https://www.gov.uk/guidance/advanced-therapy-medicinal-products-regulation-and-licensing For clinical trials record retention please see the MHRC guidance at https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials
For details see: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L_.2014.158.01.0001.01.ENG

http://ec.europa.eu/health/files/eudralex/vol-2/a/vol2a_chap1_2013-06_en.pdf
http://tools.jiscinfonet.ac.uk/downloads/bcs-rrs/managing-research-records.pdf
For details please see:http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/ Data must be held for sufficient time to allow any questions about the research to be answered. Depending on the type of research the data may not need to be kept once the purpose has expired. For example data used for passing an academic exam may be destroyed once the exam has been passed and there is no further academic need to hold the data. For more significant research a place of deposit may be interested in holding the research. It is best practice to consider this at the outset of research and orphaned personal data can inadvertently cause a data breach.
Committee papers must be transferred to a place of deposit as a public record: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/
Although they may contain confidential or sensitive material they are still a public record and must be transferred at 20 years with any FOI exemptions noted or duty of confidence indicated.

This may include emails and correspondence where they are not already included in the board papers and they are considered to be of archival interest.
Includes minor meetings/projects and departmental business meetings
The Public Records Act 1958 limits the holding of records to 20 years unless there is an instrument issued by the Minister with responsibility for administering the Public Records Act 1958. If records are not excluded by such an instrument they must either be transferred to a place of deposit as a public record or destroyed 20 years after the record has been closed.

Press releases may form a significant part of the public record of an organisation which may need to be retained
A) Where the record is representative of the personal exposures of identifiable employees, for at least 40 years or B) In any other case, for at least 5 years.
This includes (but is not limited to) evidence of right to work, security checks and recruitment documentation for the successful candidate including job adverts and application forms. May be destroyed 6 years after the staff member leaves or the 75th birthday, whichever is sooner, if a summary has been made.

Please see page 36 for an example of a Staff Record Summary used by an organisation.
Records of significant training must be kept until 75th birthday or 6 years after the staff member leaves. It can be difficult to categorise staff training records as significant as this can depend upon the staff member's role. The IGA recommends: 1 Clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer2 Statutory and mandatory training records - to be kept for ten years after training completed3Other training records - keep for six years after training completed.
Building plans and records of works are potentially of historical interest and where possible be kept and transferred to a place of deposit

ICO Code of Practice: https://ico.org.uk/media/for-organisations/documents/1542/cctv-code-of-practice.pdf The length of retention must be determined by the purpose for which the CCTV has been deployed. The recorded images will only be retained long enough for any incident to come to light (e.g. for a theft to be noticed) and the incident to be investigated.
The main reason for maintaining photographic collections is for historical legacy of the running and operation of an organisation. However, photographs may have subsidiary uses for legal enquiries.

Includes all associated documentation and records for the purpose of audit as agreed by auditors
These may already be in the financial accounts and may be captured in other records/reports or committee papers. Where benefactions endowment trust fund/legacies - permanent retention.
Should be transferred to a place of deposit as soon as practically possible

http://www.nationalarchives.gov.uk/documents/information-management/sched_complaints.pdf The incident is not closed until all subsequent processes have ceased including litigation. The file must not be kept on the patient file. A separate file must always be maintained.
Where redactions have been made it is important to keep a copy of the redacted disclosed documents or if not practical to keep a summary of the redactions.
Some organisations may record these as part of the staff record but in most cases they will form a distinct separate record either held by the staff member/manager or by the payroll team for processing.