Peninsula Medical Practice

Confidentiality, information sharing and the use of Internet, mobile phones and electronic equipment

Incorporating GDPR / DPA(2018)

The Health Centre
GRANGE OVER SANDS
LA11 7DJ

Fairfield Surgery
FLOOKBURGH
LA11 7JY

Practice Policy Document No. 1 v3.0
March 2019
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Confidentiality
All clinical staff are bound by their professional code of ethics issued by their relevant licensing body, such as the General Medical Council, The Nursing and Midwifery Council and the Royal Pharmaceutical Society.

All practice staff must respect the confidentiality of information acquired in the course of professional practice relating to a patient and the patient’s family. Such information must not be disclosed to anyone without the consent of the patient or appropriate guardian unless the interest of the patient or the public requires such a disclosure.

Information concerning particular patients can be shared within a health care team unless a patient objects. Specific consent for information to be shared to allow treatment is not required as patients have implied consent by joining the practice list. However, it is good practice to make sure that patients are aware that personal information about them will be shared within the health care team, unless they object, and the reasons for this.

The partners also require that all staff maintain the confidentiality of any information concerning the management or business dealings of the practice and any personal information concerning their work colleagues.

Legislation and Guidance
The extant legislation and guidance governing our work is:

- The Data Protection Act (2018); which applies the European Union General Data Protection Regulations (GDPR)
- The NHS Information governance resources
- The Caldicott Principles (2013 revision)

The legal basis under which we hold and process personal information are for those purposes justified under GDPR Articles 6 & 9.

Staff should note that the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 introduce new elements to the data protection regime, superseding the Data Protection Act 1998.

Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, The GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data; and all organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information.

Patient Information Systems
Patient identifiable information may only be stored and used on systems approved by the practice Information Governance Lead.

The only systems currently approved are:

- EMISWeb
- INRStar

Both of these systems may only be accessed by approved users, logged in under individual user names, with approved authentication systems that include regularly changed passwords and/or smartcard authentication.

Both of these systems are journaled and a record is created of every time that they are accessed.
A patient information leaflet is available setting out how we use clinical records, which organisations we work with that we may wish to share information with, and their rights, including the right to access any information that we hold on them.

**Responsible persons**
The responsible persons are named in the current Staff Quick Reference Handbook, and include:
- The Caldicott Guardian, who should be consulted when any member of staff has concerns about confidentiality and sharing of information concerning our patients
- The Information Governance Lead, who has responsibility for the safety and security of our information systems

**Use of Anonymised Data**
If information for the purposes of audit, research, public health purposes, teaching and training or to plan the delivery of healthcare is required, this information should be kept to the minimum necessary. It may only be passed to other organisations or agencies in anonymised form.

**Patient Identifiable Information**
You must adhere to the Caldicott principles which govern access to patient identifiable information. These are:

1. Justify the purpose(s) for using confidential information
2. Don’t use personal confidential data unless it is absolutely necessary
3. Use the minimum necessary personal confidential data
4. Access to personal confidential data should be on a strict need-to-know basis
5. Everyone with access to personal confidential data should be aware of their responsibilities
6. Comply with the law
7. The duty to share information can be as important as the duty to protect patient confidentiality

You are responsible for personal information about patients and must make sure it is effectively protected against improper disclosure at all times both within and outside the practice.

**Computer Systems**
Wherever possible work should be prepared and stored on the practice’s clinical system. Protection of this data will be covered by the practice’s security policy.

If you need to work on a portable computer system, for example a laptop, or take any patient identifiable material away from the practice on a portable computer or memory device to work on, then that computer or memory device must be encrypted to a standard approved by the practice’s Information Governance Lead.

If you need to take printouts of the patient record in order to visit patients away from the practice these must be returned promptly to the practice. They should be disposed of safely once they are no longer required.

**Disclosing Patient Identifiable Information in the Public Interest**
If you feel that you must disclose information in the public interest you must consult with the practice’s clinical partners.
Information Sharing Principles
Although principally designed for information sharing for safeguarding and promoting the welfare of children and young people; the ‘seven golden rules to sharing information’ published by the government are useful to inform best practice:

1) Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

2) Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3) Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4) Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.

5) Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6) Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

7) Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Conversations with and referrals to outside agencies should be recorded under an appropriate Read code.

Data Quality
Patient safety depends on accurate timely updating of clinical systems.

Where incorrect information has been recorded it must be amended as soon as possible with an attached note identifying the reason that the information has been changed.

Data Retention & Destruction of Confidential Material
Data may only be retained for a reasonable period of time.

The recommended retention schedules from the NHS ‘Records Management Code of Practice for Health and Social Care 2016’ are contained in an appendix to this policy.

Confidential / patient identifiable information must only be disposed of by being placed in the secure destruction bins / bags.
**Email**
The only email system that should be used for practice business is NHSmail. This is an accredited system meeting the Government’s ‘Official Sensitive’ security standard meaning that the whole NHSmail service, not just the link between systems, is fully secure.

Local Government email systems are not guaranteed to have similar levels of security and confidential patient sensitive information and must not be sent to Social Service or other Local Authority Departments unless subjected to additional encryption.

Referral forms and confidential information can be sent by FAX to a designated Safe Haven number within a Social Services or Local Authority Department.

**Use of electronic equipment and access to the internet**
You must always act responsibly with regard to internet, electronic and telecommunications equipment (including use of mobile phones), and use them in a professional, lawful and ethical manner.

**Inappropriate types of sites**
Accessing or downloading data from inappropriate websites, (e.g. pornographic websites or emails, racist, sexist or gambling websites or emails, sites promoting violence and illegal software) at any time is forbidden and may lead to disciplinary proceedings.

**Permitted personal use**
Reasonable personal use of the internet by the partners and employees of the Peninsula Medical Practice is permitted, as long as it does not interfere with the performance of normal duties, and remains in accordance with the stated IT policies, including those on acceptable use of equipment and use of email. Such limited, personal use of the internet should only be conducted when it doesn't interfere with the user's ability to carry out their normal duties, e.g. outside normal working hours.

You should bear in mind that when visiting an internet site, information identifying your PC may be logged. Therefore any activity you engage in via the internet may affect the Practice Team. Practice employees are strongly discouraged from using their Practice email address when using public web sites for non-practice purposes. This must be kept to a minimum as it results in you, and the Practice, receiving large amounts of unwanted email (spam).

**Information Governance Training**
Information governance training is an annual mandatory requirement for all staff using a practice approved training programme.

**Breaches of Practice Policy**
All breaches of practice policy will be considered on their merits and treated sympathetically if inadvertent. However, breaches of patient confidentiality will be taken very seriously, and if patient identifiable information is released deliberately or negligently then this will usually result in dismissal.

**Review**
This policy will be reviewed and amended whenever any significant changes in best practice are advised by the Department of Health, or significant changes in legislation are identified.
Declaration
This policy will be binding upon all employees of the Peninsula Medical Practice from the 1st October 2012.

We, the partners, have reviewed and accepted this policy.

Dr Diane Ruell
Dr Michael Bunter
Dr Nick Gent

1st October 2012

Reviewed and amended

1st March 2014

1st March 2019

NG
Appendix (1): confidentiality declaration

Peninsula Medical Practice

Confidentiality, information sharing and the use of internet, mobile phones and electronic equipment

I confirm that I have received a copy of Peninsula Medical Practice policy concerning confidentiality, information sharing and the use of internet, mobile phones and electronic equipment.

I confirm that I have read and understood this policy document.

I agree to abide by the terms of this policy during my period of employment by the Peninsula Medical Practice.

I agree that I will remain bound by the terms of this policy should I leave the employment of the Peninsula Medical Practice.

I agree that I will keep confidential all personal information concerning our current and past patients.

I agree that I will maintain the confidentiality of any information concerning the management or business dealings of the practice and any personal information concerning my work colleagues.

I understand that breaches of patient confidentiality will be taken very seriously, and if patient identifiable information is released deliberately or negligently then this will result in dismissal.

Name

________________________

Signature

________________________

Date

_____
Appendix (2): keyholder declaration

Peninsula Medical Practice

Keyholder declaration

As part of your duties with the Peninsula Medical Practice you are provided with a key to access the premises and codes to disable and enable the alarm systems.

I understand that the key and alarm codes are provided to me only for the purposes of accessing the premises of the Peninsula Medical Practice for those purposes agreed in my job description.

I agree to keep the key provided to me safe at all times and not to affix any label to that key that indicates that it gives access to the premises of Peninsula Medical Practice.

I agree not to allow any copies of the key to be made.

I agree not to make any record of the alarm codes provided to me, or to give these codes to any unauthorised persons.

I will report the loss of the key, or any disclosure of the alarm codes to a person who is not a member of the practice staff, to a senior member of the management team immediately I discover such a loss or disclosure.

I agree to return the key immediately should I leave the employment of Peninsula Medical Practice.

Name  

Signature  

Date  

_______
# Appendix (3): Record Retention Schedule

<table>
<thead>
<tr>
<th>Broad descriptor</th>
<th>Record Type</th>
<th>Retention Start</th>
<th>Retention Period</th>
<th>Action at end of retention period</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical records with standard retention periods</td>
<td>Medical records (including both electronica, paper charts, and clinical notes)</td>
<td>Discharge or patient last visit</td>
<td>5 years</td>
<td>Review and if no longer needed destroy</td>
<td>Black Health and HL Care Retention Policy - check for any other documents that could reflect the patient; all records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention. The medical record is maintained as a result of the patient and his/her family. Review for any other documents that could reflect the patient’s care and identify if any serious resident intervention. The medical record is maintained as a result of the patient and his/her family.</td>
</tr>
<tr>
<td>Clinical records with standard retention periods</td>
<td>Medical records (including both electronica, paper charts, and clinical notes)</td>
<td>Discharge or patient last visit</td>
<td>5 years</td>
<td>Review and if no longer needed destroy</td>
<td>Black Health and HL Care Retention Policy - check for any other documents that could reflect the patient; all records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention. The medical record is maintained as a result of the patient and his/her family. Review for any other documents that could reflect the patient’s care and identify if any serious resident intervention. The medical record is maintained as a result of the patient and his/her family.</td>
</tr>
<tr>
<td>Clinical records with standard retention periods</td>
<td>Medical records (including both electronica, paper charts, and clinical notes)</td>
<td>Discharge or patient last visit</td>
<td>26 years</td>
<td>Review and if no longer needed destroy</td>
<td>Black Health and HL Care Retention Policy - check for any other documents that could reflect the patient; all records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention. The medical record is maintained as a result of the patient and his/her family. Review for any other documents that could reflect the patient’s care and identify if any serious resident intervention. The medical record is maintained as a result of the patient and his/her family.</td>
</tr>
<tr>
<td>Clinical records with standard retention periods</td>
<td>Medical records (including both electronica, paper charts, and clinical notes)</td>
<td>Discharge or patient last visit</td>
<td>30 years</td>
<td>Review and if no longer needed destroy</td>
<td>Black Health and HL Care Retention Policy - check for any other documents that could reflect the patient; all records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention. The medical record is maintained as a result of the patient and his/her family. Review for any other documents that could reflect the patient’s care and identify if any serious resident intervention. The medical record is maintained as a result of the patient and his/her family.</td>
</tr>
<tr>
<td>Clinical records with standard retention periods</td>
<td>Medical records (including both electronica, paper charts, and clinical notes)</td>
<td>Diagnosis + 12 months</td>
<td>10 years</td>
<td>Review and if no longer needed destroy</td>
<td>Black Health and HL Care Retention Policy - check for any other documents that could reflect the patient; all records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention. The medical record is maintained as a result of the patient and his/her family. Review for any other documents that could reflect the patient’s care and identify if any serious resident intervention. The medical record is maintained as a result of the patient and his/her family.</td>
</tr>
<tr>
<td>Clinical records with standard retention periods</td>
<td>Medical records (including both electronica, paper charts, and clinical notes)</td>
<td>Diagnosis + 12 months</td>
<td>10 years</td>
<td>Review and if no longer needed destroy</td>
<td>Black Health and HL Care Retention Policy - check for any other documents that could reflect the patient; all records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention. The medical record is maintained as a result of the patient and his/her family. Review for any other documents that could reflect the patient’s care and identify if any serious resident intervention. The medical record is maintained as a result of the patient and his/her family.</td>
</tr>
</tbody>
</table>

*Note: All records should be reviewed for confidentiality and accuracy. All records should be reviewed for any necessary resident intervention.*
<table>
<thead>
<tr>
<th>Event 2: Transaction Events</th>
<th>Customer name</th>
<th>Location</th>
<th>Days to Process</th>
<th>Review and consider transfer to a Physical Bank</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event 3: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 4: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 5: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 6: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 7: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 8: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 9: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
<tr>
<td>Event 10: Transaction Events</td>
<td>Customer name</td>
<td>Location</td>
<td>Days to Process</td>
<td>Review and consider transfer to a Physical Bank</td>
<td>Notes</td>
</tr>
</tbody>
</table>

### Notes
- **Days to Process**: The number of business days it takes to process the event.
- **Review and consider transfer to a Physical Bank**: Indicates whether the event requires consideration for transferring to a physical bank.
- **Notes**: Additional information or notes related to the event.

**Example Notes**
- "Customer is eligible for a credit card.
- "Customer is eligible for a loan."
<table>
<thead>
<tr>
<th>Event</th>
<th>Transaction Records</th>
<th>Operating Theatre</th>
<th>Date of age to which the record is retained</th>
<th>Review and consider transfer to a Family Doctor</th>
<th>If transferred to a family doctor the date of retention rules apply and will only be used if the patient has consented to the record being retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event</td>
<td>Transaction Records</td>
<td>Patient Property Details</td>
<td>Date of the last to which they relate</td>
<td>2 years</td>
<td>Review and consider transfer to a Family Doctor</td>
</tr>
<tr>
<td>Event</td>
<td>Transaction Records</td>
<td>Medical Records and Preceding Events</td>
<td>Date of examination for conditions declared in any previous medical examination</td>
<td>2 years</td>
<td>Review and consider transfer to a Family Doctor</td>
</tr>
<tr>
<td>Event</td>
<td>Transaction Records</td>
<td>Full Blood Count and Blood Pressure</td>
<td>Date of examination for conditions declared in any previous medical examination</td>
<td>2 years</td>
<td>Review and consider transfer to a Family Doctor</td>
</tr>
<tr>
<td>Event</td>
<td>Transaction Records</td>
<td>Medical Records and Preceding Events</td>
<td>Date of examination for conditions declared in any previous medical examination</td>
<td>2 years</td>
<td>Review and consider transfer to a Family Doctor</td>
</tr>
<tr>
<td>Event</td>
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<td>Medical Records and Preceding Events</td>
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<td>Medical Records and Preceding Events</td>
<td>Date of examination for conditions declared in any previous medical examination</td>
<td>2 years</td>
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</tr>
<tr>
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<td>Transaction Records</td>
<td>Medical Records and Preceding Events</td>
<td>Date of examination for conditions declared in any previous medical examination</td>
<td>2 years</td>
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</tr>
<tr>
<td>Event</td>
<td>Transaction Records</td>
<td>Medical Records and Preceding Events</td>
<td>Date of examination for conditions declared in any previous medical examination</td>
<td>2 years</td>
<td>Review and consider transfer to a Family Doctor</td>
</tr>
</tbody>
</table>

To help patients understand the date of retention rules apply and will only be used if the patient has consented to the record being retained.
<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Length</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Records &amp; Occupational Health</td>
<td>Casual leave due to health conditions below entitlement level</td>
<td>5 years</td>
<td>Review and consider transfer to a different position</td>
</tr>
<tr>
<td>Staff Records &amp; Occupational Health</td>
<td>Casual leave due to health conditions above entitlement level</td>
<td>5 years</td>
<td>Review and consider transfer to a different position</td>
</tr>
<tr>
<td>Staff Records &amp; Occupational Health</td>
<td>Overtime paid in occurs and exceeds the normal length of leave</td>
<td>5 years</td>
<td>Review and consider transfer to a different position</td>
</tr>
<tr>
<td>Staff Records &amp; Occupational Health</td>
<td>Leaves of absence due to health conditions above entitlement level</td>
<td>5 years</td>
<td>Review and consider transfer to a different position</td>
</tr>
<tr>
<td>Staff Records &amp; Occupational Health</td>
<td>Leaves of absence due to health conditions below entitlement level</td>
<td>5 years</td>
<td>Review and consider transfer to a different position</td>
</tr>
</tbody>
</table>

Notes:
- For all records, review and consider transfer to a different position if no longer needed.
- All records are reviewed at the end of the financial year.
<table>
<thead>
<tr>
<th>Col2</th>
<th>Col3</th>
<th>Col4</th>
<th>Col5</th>
<th>Col6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compliance</strong></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Finance</strong></td>
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<td></td>
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<tr>
<td><strong>Legal, Compliance &amp; Information Rights</strong></td>
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<td></td>
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</tr>
</tbody>
</table>

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**Compliance**

- **Closer building name**: [Name of building]
- **Completion of works**: [Date of completion]
- **Review and if no longer needed destroy**: [Reason for review]

**Finance**

- **Settle insurance claims**: [Date of claim]
- **Review and if no longer needed destroy**: [Reason for review]

**Legal, Compliance & Information Rights**

- **Complaints or files**: [Date of complaint]
- **Review and if no longer needed destroy**: [Reason for review]

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**Compliance**

- **Closer building name**: [Name of building]
- **Completion of works**: [Date of completion]
- **Review and if no longer needed destroy**: [Reason for review]

**Finance**

- **Settle insurance claims**: [Date of claim]
- **Review and if no longer needed destroy**: [Reason for review]

**Legal, Compliance & Information Rights**

- **Complaints or files**: [Date of complaint]
- **Review and if no longer destroyed**: [Reason for review]

---

**Compliance**

- **Closer building name**: [Name of building]
- **Completion of works**: [Date of completion]
- **Review and if no longer needed destroy**: [Reason for review]

**Finance**

- **Settle insurance claims**: [Date of claim]
- **Review and if no longer needed destroy**: [Reason for review]

**Legal, Compliance & Information Rights**

- **Complaints or files**: [Date of complaint]
- **Review and if no longer destroyed**: [Reason for review]

---

**Compliance**

- **Closer building name**: [Name of building]
- **Completion of works**: [Date of completion]
- **Review and if no longer needed destroy**: [Reason for review]

**Finance**

- **Settle insurance claims**: [Date of claim]
- **Review and if no longer needed destroy**: [Reason for review]

**Legal, Compliance & Information Rights**

- **Complaints or files**: [Date of complaint]
- **Review and if no longer destroyed**: [Reason for review]
<table>
<thead>
<tr>
<th>Legal, Compliance &amp; Information Rights</th>
<th>Subject Access Requests</th>
<th>SVP and SubSVP Compensation</th>
<th>Notice of SAR</th>
<th>3 years</th>
<th>Review and if no longer needed destroy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal, Compliance &amp; Information Rights</td>
<td>Subject Access Requests</td>
<td>where there has been a subsequent appeal</td>
<td>Notice of appeal</td>
<td>6 months</td>
<td>Review and if no longer needed destroy</td>
</tr>
</tbody>
</table>