

RECORDS MANAGEMENT: NHS CODE OF PRACTICE

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Section 1 - Foreword

The Records Management: NHS Code of Practice has been published by the Department of Health. The guidance was drafted by a working group made up of representatives from the Department of Health, NHS Connecting for Health, the Health Archives Group and the NHS.

Section 2 - Introduction

1. This Code of Practice is a guide to required practice in the management of records for those who work within or under contract to NHS organisations. It replaces previous guidance:
 - HSC 1999/053 “For the Record”
 - HSC 1999/217 “Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients” (Replacement for FHSL (94) (30))
 - HSC 1998/153 “Using Electronic Patient Records in Hospitals: Legal Requirements & Good Practice”.

It provides a key component of information governance arrangements for the NHS. This is an evolving document because standards and practice covered by the code will continue to change.

2. The guidelines contained in this Code of Practice draw on advice and published guidance available from The Lord Chancellors Office (now the Department for Constitutional Affairs) and the National Archives, and also from best practices followed by a wide range of organisations in both the public and private sectors. The guidelines provide a framework for consistent and effective records management that is standards based and fully integrated with other key information governance work areas.
3. NHS managers need to be able to demonstrate active progress in enabling staff to conform to the standards, identifying resource requirements and any related areas where organisational or systems changes are required. Information Governance performance assessment and management arrangements need to facilitate and drive forward the required changes. Those responsible for monitoring NHS performance, e.g. strategic health authorities and the Healthcare Commission, should play a key role in ensuring that effective systems are in place.
4. The NHS is provided with support to deliver change through the:
 - Setting and Achieving the NHS Standard for Records Management: A Road Map. This can be accessed directly at [web reference to be incorporated later] or through the Information Governance Toolkit.
 - Information Governance Toolkit which will manage and maintain up-to-date records management policy and guidance and, more generally;
 - Information Governance policy and implementation teams within NHS Connecting for Health.

These are described in more detail at Annex A.

General Context

5. This Code of Practice, together with the supporting Annexes and in conjunction with the Records Management Resource Pack, identifies the specific actions, managerial responsibilities, and minimum retention periods for the effective management of records from creation, day-to-day use of the record, selection, storage, maintenance and ultimate disposal.

6. Records are a valuable resource because of the information they contain. High quality information underpins the delivery of high quality evidence-based health care, and many other key service deliverables. Information is of greatest value when it is accurate, up to date and accessible when it is needed. An effective records management service ensures that information is properly managed and is available when needed:
 - to support patient care and continuity of care;
 - to support day to day business which underpins the delivery of care;
 - to support evidence based clinical practice;
 - to support sound administrative and managerial decision making, as part of the knowledge base for NHS services;
 - to meet legal requirements, including requests from patients under subject access legislation;
 - to assist clinical and other audits;
 - to support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research;
 - whenever, and wherever there is a justified need for information, and in whatever media it is required.
7. The Secretary of State for Health and all NHS organisations have a duty under the Public Records Act 1958 to make arrangements for the safe-keeping and eventual disposal of all types of their records. This is carried out under the overall guidance and supervision of the Keeper of Public Records who is answerable to Parliament. In addition NHS organisations need robust records management procedures to meet the requirements set out under the Freedom of Information Act 2000.
8. All NHS records are public records under the terms of the Public Records Act 1958 S.3(1)-(2). Chief Executives and senior managers of all NHS organisations are personally accountable for records management within their organisation.
9. The National Archives is the body that is responsible for advising on the management of all types of public records, including NHS records. The National Archives are also responsible for the permanent preservation of records, including NHS records, where this is required. The National Archives' Records Management Standard requires:

"A systematic and planned approach to the management of records within an organisation, from the moment they are created to their ultimate disposal, ensures that the organisation can control both the quality and the quantity of the information that it generates; it can maintain that information in a manner that effectively serves its needs, those of government and of the citizen; and it can dispose of the information efficiently when it is no longer required".

(Public Record Office Records Management Standards, 1998)

Monitoring Records Management Performance

10. A number of bodies monitor NHS performance in respect of Records Management. The Healthcare Commission will be monitoring a core governance standard relating to broad records management as part of its annual assessment of performance. The Audit Commission regularly conducts studies into records management and related information quality issues. The Department of Health collects performance details as part of the annual information governance assessment and these will inform the work of both the Healthcare Standards Commission and the Audit Commission.
11. Other bodies are also likely to comment on records management performance, for example, the Information Commissioner when investigating alleged breaches of Data Protection or Freedom of Information legislation and the Health Service Commissioner when investigating a complaint.

Legal and Professional Obligations

12. There are a range of statutory provisions that limit, prohibit or set conditions in respect of the use and disclosure of information and, similarly, a range of statutory provisions that require information to be used or disclosed. The key statutory requirements covering personal and other information can be found in Annex C. Additionally, clinicians are obliged to meet records management standards set by their governing regulatory bodies.

NHS Connecting for Health

13. The impact of the Government's reform agenda will fundamentally affect the way the NHS approaches the management of all electronic records. The NHS Care Records Service (NHS CRS) is central to these reforms and will transform the way both health and social care information is managed. Annex B outlines the work programme.
14. In the mixed economy of paper and electronic records which will exist as the NHS Care Records Service is developed it is essential that paper and electronic records are consistently managed to ensure that a complete health record is available at the point of care. This transitional period will generate significant challenges e.g. before patient data is migrated to the national data spine to enable these processes it will need to be validated to ensure that duplicate registrations are eliminated and steps taken in the local feeder systems to the data spine to ensure that duplicate registrations do not occur in the future.

Social Care Records

15. Social Care Records Management is outside of the scope of this Code of Practice. The good practice outlined is, however, applicable to all organisations and colleagues from social care organisations are encouraged to adopt similar standards of practice. Relevant information for Social Care practitioners can be

found within the 'Custodian' database (the repository of standards and related learning for Local Government); see

<http://localegov.eibs.co.uk/custodian/social-care-blueprint>

Types of Record covered by this Code of Practice

The guidelines contained in this Code of Practice apply to NHS records of all types regardless of the media on which they are held, including:

- Patient health records (electronic or paper based; including those concerning all specialties, and GP medical records);
- Records of private patients seen on NHS premises;
- Accident & Emergency, Birth, and all other Registers;
- Theatre Registers & Minor Operations (and other related) Registers;
- Administrative records (including e.g. personnel, estates, financial and accounting records; notes associated with complaint-handling); X-Ray and Imaging reports, output and images (but see also HSG(95)3, "*Health Service Use of Ionising Radiations*", which gives specific advice on record keeping for procedures and treatments, such as X-Rays, which use ionising radiations);
- Photographs, slides, and other images;
- Microform (i.e. fiche / film);
- Audio and video tapes, cassettes, CD-ROM etc.
- E-mails
- Digital records
- Computerised records

Section 3 – NHS Records Management

16. The aims of the Code of Practice are:
- to establish an information governance framework for records management in relation to the creation, use, storage, management and disposal of records
 - to clarify the legal obligations that apply to NHS records
 - to explain the actions required by Chief Executives and other managers to fulfil these obligations
 - to explain the requirement to select records for permanent preservation
 - to set out *minimum* periods for retention of all types of NHS records, and
 - to indicate where further information on records management may be found.

Management and Organisational Responsibility

17. The records management function should be recognised as a specific corporate responsibility within every NHS organisation. It should provide a managerial focus for records of all types in all formats, including electronic records, throughout their life cycle, from planning and creation through to ultimate disposal. It should have clearly defined responsibilities and objectives, and adequate resources to achieve them.
18. A designated member of staff of appropriate seniority should have lead responsibility for records management within the organisation. This lead role should be formally acknowledged and made widely known throughout the organisation.
19. It is essential that the manager, or managers, responsible for the records management function should be directly accountable to, or work in close association with the manager or managers responsible for Freedom of Information, Data Protection and other information governance issues.
20. All staff, whether clinical or administrative, must be appropriately trained so that they are fully aware of their responsibilities in respect of record keeping and management. This should be done through both generic and specific training programmes, organisational policies and procedures and guidance documentation. For example, Health Records Managers who have lead responsibility for hospital patient case-notes and who manage the “records library” and other storage areas where records are kept, must have an up-to-date knowledge of, or access to expert advice on, the laws and guidelines concerning confidentiality, data protection (including subject access requests), and freedom of information.

Individual Responsibility

21. Under the Public Record Act all NHS employees have a degree of responsibility for any records that they create or use. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations. A description of these obligations can be found in Annex C.

Policy and Strategy

22. An organisation should have in place an overall policy statement, endorsed by the Board and made readily available to staff at all levels of the organisation, on how it manages all of its records, including electronic records.
23. The policy statement should provide a mandate for the performance of all records and information management functions. In particular, it should set out an organisation's commitment to create, keep and manage records and document its principal activities in this respect.
24. The policy should also:
 - outline the role of records management and its relationship to the organisation's overall strategy;
 - define roles and responsibilities including the responsibility of individuals to document their actions and decisions in the organisation's records, and to dispose of records appropriately;
 - provide a framework for supporting standards, procedures and guidelines; and
 - indicate the way in which compliance with the policy and its supporting standards, procedures and guidelines will be monitored.
25. The policy statement should be reviewed at regular intervals (at least once every twelve months) and, if appropriate, it should be amended to maintain its currency and relevance.

Active Records Management

26. The key issues for the management of electronic records are the same as those for the management of any record regardless of media. However, the means by which they are addressed needs to be tailored to the different environments.

Record Creation

27. Each operational/business unit of an NHS organisation should have in place an adequate system for documenting its activities. This system should take into account the legislative and regulatory environments in which the organisation works.
28. Records of a business activity should be complete and accurate enough to allow employees and their successors to undertake appropriate actions in the context of their responsibilities, to facilitate an audit or examination of the business by anyone so authorised, to protect the legal and other rights of the organisation, its patients, staff and any other people affected by its actions, and provide authenticity of the records so that the evidence derived from them is shown to be credible and authoritative.
29. Records created by the organisation should be arranged in a record-keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information.

Information Quality Assurance

30. Organisations need to ensure that their staff are fully trained in record creation and maintenance, including having an understanding of:
 - a) what they are recording;
 - b) why they are recording it;
 - c) how to **validate** information with the patient or against other records – so staff are recording the correct data;
 - d) the **correction** of errors – so staff know how to correct errors and how to report errors if they find them; and
 - e) the **use** of information – so staff understand what the records are used for (and therefore why accuracy is so important).

Record Keeping

31. Installing and maintaining an effective records management programme depends on knowledge of what records are held, in what form they are made accessible, and their relationship to organisational functions. An information survey or record audit will help to meet or is the first step to meeting this requirement, help to promote control over the records, and provide valuable data for developing records appraisal and disposal procedures.
32. Paper and electronic record keeping systems should contain descriptive and technical documentation to enable the system and the records to be understood and to be operated efficiently, and to provide an administrative context for effective management of the records.
33. The record-keeping system, whether paper or electronic, should include a documented set of rules for referencing, titling, indexing and, if appropriate, security marking of records. These should be easily understood to enable the efficient retrieval of information and to maintain security and confidentiality.

Record Maintenance

34. In order to comply with their statutory requirements, NHS organisations should be aware of what records they hold and where they are held.
35. The movement and location of records should be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions.
36. Storage accommodation for current records should be clean and tidy, should prevent damage to the records and provide a safe working environment for staff.
37. Equipment used to store current records should provide storage which is safe and secure from unauthorised access and which meets health and safety and fire regulations, but which allows maximum accessibility to the information commensurate with its frequency of use.

38. When records are no longer required for the conduct of current business, their placement in a designated records storage area rather than in offices may be a more economical and efficient way to store them. Procedures for handling records should take full account of the need to preserve important information.
39. A contingency or business continuity plan should be in place to provide protection for records which are vital to the continued functioning of the organisation. Key expertise in relation to environmental hazards, assessment of risk, business continuity and other considerations is likely to rest with information security staff and their advice should be sought.

Review of Records

40. The retention schedules in Annex D outline all types of NHS records and the required periods of retention. Some records have been identified in the "Final Action" column as requiring "Review". Where there are records which have been omitted from the retention schedules the Department of Health and/or the National archives should be consulted. The National Archives will provide advice about records requiring permanent preservation.
41. Procedures should be put in place in all NHS organisations to ensure that records are reviewed at the appropriate time. Chief Executives and the Senior Management Team or Trust Board are personally accountable for all aspects of Records Management within their organisation. The purpose of the review process is to ensure that the records are examined to determine whether or not they are worthy of permanent preservation, whether they need to be retained for a longer period or whether they should be destroyed. This is because their true value may not be able to be determined at an earlier stage.
42. The Records Manager in the NHS Organisation should determine the most appropriate person(s) to carry out the review in accordance with the retention schedule. This should be a Senior Manager with an understanding of the subject area to which the record relates.

Disclosure and Transfer of Records

43. There are a range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties, and similarly, a range of provisions that require disclosure. The key statutory requirements can be found in Annex C to this document. There are also a range of guidance documents that interpret statutory requirements and there may be staff within organisations who will lead on, or can advise on, particular types of disclosure.
44. Caldicott Guardians or their support staff should be involved in any proposed disclosure of confidential patient information, informed by the Department of Health publication 'Confidentiality: NHS Code of Practice'. Data Protection officers may be available to advise on Subject Access requests by members of the public, and guidance on dealing with such requests is available on the Department of Health website see:

[Data Protection Act 1998 subject access request handling guide](#)

45. These guidance documents and additional materials on Freedom of Information and other legislation can be found within the Information Governance toolkit.

For further information see:

<http://nww.nhsia.nhs.uk/infogov/igt/>

46. The mechanisms of transferring records should also be tailored to the sensitivity of the material contained within the records. Information Security staff should be able to advise on appropriate safeguards, but again guidance can be found within the Information Governance toolkit.'

Retention and Disposal Arrangements

47. Detailed guidance on retention periods for a full range of NHS personal health and administrative record types is provided in Annex D.
48. However, it is particularly important under Freedom of Information that the disposal of records - which is defined as the point in their lifecycle when they are either transferred to an archive or destroyed - is undertaken in accordance with clearly established policies which have been formally adopted by the organisation and which are enforced by properly authorised staff.

Record Closure

49. Records should be closed 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 should be shown on the record itself as well as noted in the index or database of the files/folders. Wherever possible, information on the intended disposal of electronic records should be included in the metadata when the record is created.
50. The storage of closed, or non-current, records awaiting disposal should follow accepted standards relating to environment, security and physical organisation of the files.

Appraisal of Records – Planning and Documentation

51. All NHS organisations must have systems in place for managing appraisal of records and for recording the disposal decisions made. An assessment of the volume and nature of records due for disposal, the time taken to appraise records, and the risks associated with destruction or delay in appraisal will provide information to support an organisation's resource planning and workflow arrangements.

Record Selection

52. Each organisation should maintain a selection policy which states in broad terms the functions from which records are likely to be selected for permanent preservation and the periods for which other records should be retained.
53. The policy should be supported by, or linked to disposal schedules, which should cover all records created, including electronic records. Schedules should be arranged based on series or collection of records and should indicate the appropriate disposal action for all records (e.g. review after 'x' years; destroy

after 'y' years).

54. Records selected for permanent preservation and no longer in regular use by the organisation should be transferred as soon as possible to an archival institution (Place of Deposit) that has adequate storage and public access facilities (see Annex C for arrangements for bodies subject to the Public Records Act).
55. Records not selected for permanent preservation and which have reached the end of their administrative life should be destroyed in as secure a manner as is necessary for the level of confidentiality or security markings they bear. A record of the destruction of records, showing their reference, description and date of destruction should be maintained and preserved by the Records Manager. Disposal schedules would constitute the basis of such a record.
56. If a record due for destruction is known to be the subject of a request for information, destruction should be delayed until disclosure has taken place or, if the authority has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted.

Annex A

Resources to Support Improvement

The role of the Information Governance Toolkit

- A1 Information Governance is defined as:-
- “A framework for handling personal information in a confidential and secure manner to appropriate ethical and quality standards in a modern health service”
- A2 It is the information component of Clinical Governance and it aims to support the provision of high quality care to patients and clients by promoting the effective and appropriate use of personal, sensitive information.
- A3 The Information Governance Framework enables National Health Service (NHS) organisations in England and individuals working within them to ensure that personal information is dealt with legally, securely, effectively and efficiently in order to deliver the best possible care to patients and clients. The focus is on setting standards and giving NHS organisations the tools to help them to achieve the defined requirements, make appropriate improvements to their service and ensure that improvement is maintained.
- A4 The Information Governance framework addresses a number of different aspects of NHS information handling over a number of key work areas i.e. the Caldicott recommendations on the use of personally identifiable information, the Confidentiality Code of Practice, the Data Protection Act 1998, the Freedom of Information Act 2000, Information Management and Technology Security (ISO 17799 Code of Practice for Information Security Management), Health Records Management, organisational Records Management and Information Quality Assurance. It provides a vehicle to develop clear standards, directly link the standards to support and guidance materials and exemplar documentation and also to assist in managing and monitoring change in the NHS.
- A5 The Information Governance framework also allows the NHS in England to manage change by educating staff, developing codes of practice, helping organisations and individuals to understand the requirements of law and ethics in respect of information handling and the consequent need for changes to systems and processes. Furthermore it enables the NHS to work in partnership with patients and clients by respecting their preferences and choices and addressing their concerns about the use of sensitive, personal information.
- A6 The Information Governance Toolkit provides the means by which NHS organisations can assess their compliance with current legislation, Government and national guidance. It has been approved by Health Ministers and ROCR.
- A7 The Healthcare Commission also use the toolkit as part of the standard to audit NHS organisations for their performance rating system.

“Setting and Achieving the NHS Standard for Records Management – A Roadmap.”

The Roadmap will contain a range of practical tools and guidance, including a knowledge base and templates that have been designed to support organisations in the implementation of the principles contained in the Records Management Code of Practice. These include:

- an outline records management strategy and implementation plan
- an outline archiving strategy and implementation plan including links to the work required to support the NHS Connection for Health agenda
- an appraisal of archiving options
- electronic document management including practical guidance on scanning.
- an overview of the revised requirements that will be incorporated in to subsequent versions of the IG Toolkit.

Version 1 of the Roadmap will be available later. Consultees are invited to comment on what they consider should be included in the Roadmap

Other Publications for Reference

1. ‘Good Practice Guidelines for General Practice Electronic Patient Records (version 3)’ – prepared by the Joint Computing Group of the General Practitioners Committee and the Royal College of General Practitioners, sponsored by the Department of Health. It can be found at:
<http://www.dh.gov.uk/assetRoot/04/06/97/65/04069765.pdf>
2. “NHS Health Record and Communication Practice Standards for Team-Based Care”. Launched by the NHS Information Standards Board this details best practice from the Nursing and Midwifery Council, General Medical Council and the Health Professions Council, to help ensure the recording and communication of patient information in a consistent way. It can be found at:
<http://www.isb.nhs.uk/pages/news010605.asp>
3. ‘Confidentiality: NHS Code of Practice’ (page 17) – details record keeping best practice. It can be found at:
<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>
4. The National Archives, as both a government department and an executive agency, plays a central role in the public records system, in particular, in the selection of records. Their review work is undertaken across government, in accordance with the Public Records Act 1958, and is carried out under the supervision, guidance and co-ordination of the Keeper of Public Records. This role was assigned to the Keeper in the light of the recommendations of the Grigg Committee on Departmental Records, which reported in 1954.

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

For further information see:

<http://www.nationalarchives.gov.uk/recordsmanagement/selection/acquisition.htm#5>

Annex B

NHS Connecting for Health

NHS Connecting for Health is responsible for delivering the National Programme for Information technology for the NHS in England.

The National Programme will revolutionise the way information is transferred and used across the NHS. It will also improve patient choice and the quality and convenience of care by ensuring that those who give and receive care have the right information at the right time.

The key areas of work are:

- **NHS Care Records Service**

The NHS Care Records Service will connect more than 30,000 GPs and 270 acute, community and mental health NHS trusts in a single, secure national system and provide all 50 million NHS patients with an individual electronic NHS Care Record detailing key treatments and care within either the health service or social care.

The information on the NHS Care Records will grow over time and eventually the public will be able to access their NHS Care Record themselves. This will mean that patients will have access to all their health information and can be more involved in making decisions about their own care and treatment.

The principle underlying the NHS Care Records Service was initially presented in the 1998 Department of Health strategy Information for Health, which committed the NHS to provide life-long electronic health records for everyone, with round-the-clock, on-line access to patient records and information about best clinical practice for all NHS clinicians.

- **Choose and Book**

Choose and Book will enable patients to select hospital appointments from a choice of those available at a time, date and place to suit them.

It will enable patients will be able to leave the GP's surgery with their appointment date and time or, if they prefer, make their appointment later, either online or using a telephone booking management service, after consulting with family, carers or colleagues.

- **Electronic Transmission of Prescriptions**

Electronic Transmission of Prescriptions will allow prescriptions generated by GPs and other prescribers to be transferred electronically to the dispenser and the reimbursement agency. For patients, it will improve safety and simplify the process of obtaining their medication (especially repeat prescriptions). For prescribers and dispensers, it will eliminate the re-keying of data and provide better information at the

point of prescribing. For the reimbursement agency it will increase capacity and reduce the unit cost of administering prescriptions.

- **The National Network – N3**

N3 is the name for the National Network, which replaces the private NHS communications network NHSnet. N3 provides fast, broadband networking services to the NHS offering reliability and value-for-money.

N3 is vital to the delivery of the National Programme for IT, providing the essential technical infrastructure through which the benefits to patients, clinicians and the NHS from NHS Connecting for Health can be realised.

- **Picture Archiving & Communications Systems**

Picture Archiving and Communications Systems capture, store, distribute and display static or moving digital images such as electronic x-rays or scans, for more efficient diagnosis and treatment. PACS takes away any need to print on film and to file or distribute images manually. The images can be sent and viewed at one, or across several NHS locations. This will enable clinicians and care teams working together to view common information and so will speed up diagnosis. The capacity of diagnostic services will increase with PACS as both test results and diagnoses will be available more quickly. Images will be available 24 hours a day, seven days a week and can be manipulated to enhance viewing and diagnosis.

For further information see:

http://www.connectingforhealth.nhs.uk/all_images_and_docs/NPfit%20brochure%20Apr%2005%20final.pdf