Overview of Records Management Code of Practice for Health and Social Care 2016

Laura Hynds, 14.03.2017

Revised standard for rm within the health sector

- Produced by the Information Governance Alliance (IGA)
- Involvement of ARA, IRMS, IHRIM and TNA in producing and approving the code
- ARA in particular played large role in revising the original draft of the records retention schedule
- Reflects changes since publication of 2006 code

What's changed?

- Document is much shorter and only has one part
- New code designed to support integration of health and social care provision
- Inclusion of digital continuity, business classification schemes and more detail on metadata and scanning requirements
- New section on how to deal with specific types of records
- Updated retention schedule

Extracts from Code of Practice

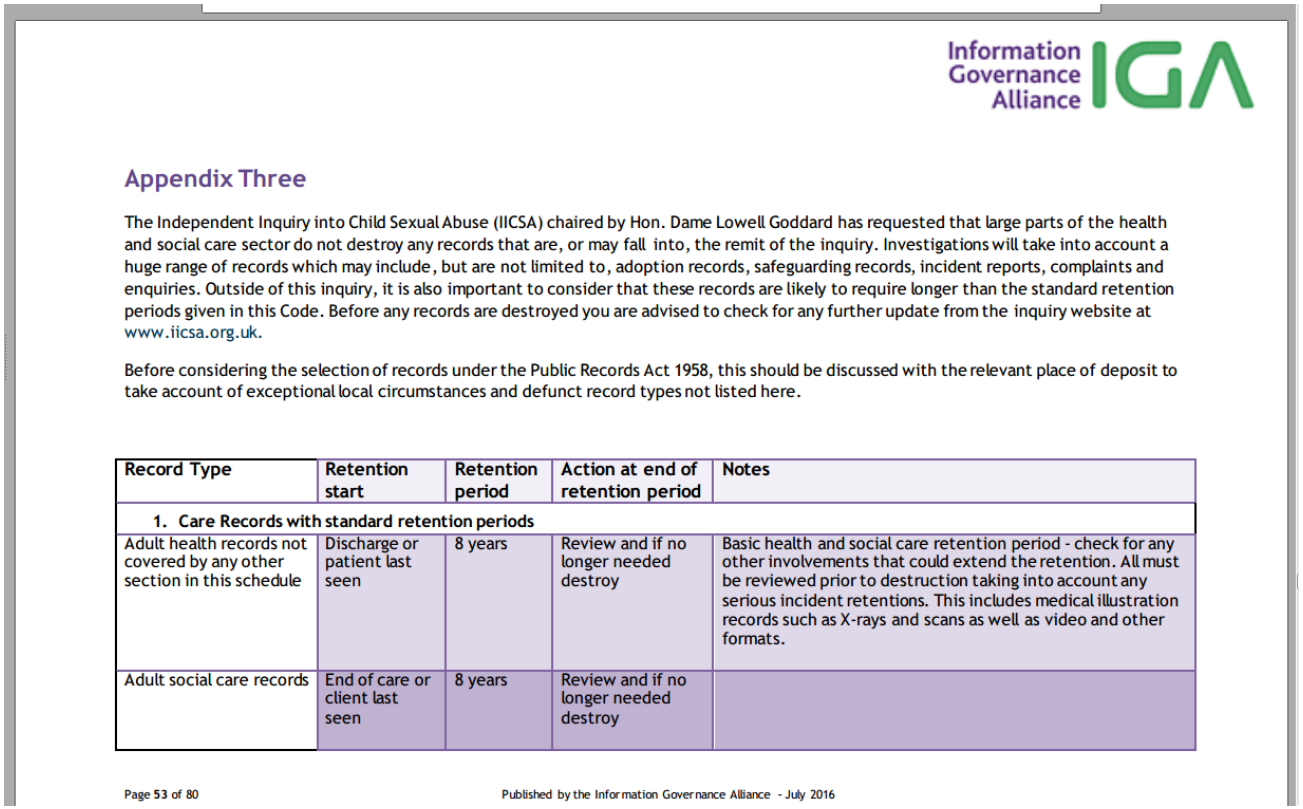
- Page 42, basis on which records should be selected for permanent preservation

The following factors should be taken into account when considering selection of patient records:

- The organisation has an unusually long or complete run of records of a given type
- The records relate to population or environmental factors peculiar to the locality
- The records are likely to support research into rare or long-term conditions
- The records relate to an event or issue of significant local or national importance (for example a public inquiry or a major incident)
- The records relate to the development of new or unusual treatments or approaches to care and/or the organisation is recognised as a national or international leader in the field of medicine concerned
- The records throw particular light on the functioning, or failure, of the organisation, or the NHS in general
- The records relate to a significant piece of published research

Extracts from Code of Practice

- Page 53, introduction to the retention schedule



Information Governance Alliance IGA

Appendix Three

The Independent Inquiry into Child Sexual Abuse (IICSA) chaired by Hon. Dame Lowell Goddard has requested that large parts of the health and social care sector do not destroy any records that are, or may fall into, the remit of the inquiry. Investigations will take into account a huge range of records which may include, but are not limited to, adoption records, safeguarding records, incident reports, complaints and enquiries. Outside of this inquiry, it is also important to consider that these records are likely to require longer than the standard retention periods given in this Code. Before any records are destroyed you are advised to check for any further update from the inquiry website at www.iicsa.org.uk.

Before considering the selection of records under the Public Records Act 1958, this should be discussed with the relevant place of deposit to take account of exceptional local circumstances and defunct record types not listed here.

Record Type	Retention start	Retention period	Action at end of retention period	Notes
1. Care Records with standard retention periods				
Adult health records not covered by any other section in this schedule	Discharge or patient last seen	8 years	Review and if no longer needed destroy	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.
Adult social care records	End of care or client last seen	8 years	Review and if no longer needed destroy	

Published by the Information Governance Alliance - July 2016

Annual Review

- New code will be undergoing annual review, feedback can be provided until 1st July

(https://nhs-digital.citizenspace.com/information-governance-alliance/records-management-code-of-practice-2016-feedback/)

- Unsure of involvement of royal colleges with revision of the Code
- Only small section on pharmacy records

Annual Review

- Further work required on management of retention of electronic patient record systems

Electronic Patient Records System (EPR) NB: The IGA is undertaking further work to refine the rules for record retention and to specify requirements for EPR systems	See Notes	See Notes	Destroy	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.
General Dental Services	Discharge or	10 Years	Review and if no	

Contact Details and Links

- Email: laura.hynds@googlemail.com

- New code available at:

https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care