RCR position statement on the Records Management Code of Practice for Health and Social Care 2016: application of the Code to radiology records retention protocols

Background

In 2016 the Information Governance Alliance (IGA) published the Records Management Code of Practice for Health and Social Care ('the Code').[1] According to NHS Digital, this document sets out what people working with or in NHS organisations in England need to do to manage records correctly. The Code is based on legal requirements and professional best practice including the Data Protection Principles as set out in the Data Protection Act 1998.[2] The key point that is relevant to this document is that 'Personal information must not be kept for longer than is necessary'.

Radiology/X-ray images and reports are classed as a 'general health record' in the Code. The purpose of this document is to interpret the Code from a radiology digital record perspective, providing guidance to radiology staff, information technology (IT) departments and system vendors on the implications of the Code on radiology record retention and how these might be addressed using digital solutions.

In the radiology world, the vendor neutral archive (VNA) is usually the system responsible for lifecycle management. However, other systems such as the electronic patient record (EPR), picture archiving and communication system (PACS) or an independent IT system can also be responsible for lifecycle management. This document references the VNA, but the principles are applicable across any IT system used for lifecycle management. To enable lifecycle management, the VNA must have inbuilt algorithms to enable data retention and also to move images offline to an archive as appropriate. They must conform to vendor neutral standards on image object change management (IOCM) for communicating to PACS and other systems that may also hold images.

Use of images

The Code deals with retention of records for all purposes. However, retention of records does not necessarily mean that they are being retained to support clinical management of patients. Sometimes record retention is related to medico-legal requirements. For this reason, it is recommended that local policies are developed detailing how long records need to be kept for instant online access to facilitate clinical management of patients and when can they be taken off-line and archived for future reference as appropriate.

Moving images offline
It is suggested that the film-packet rule of 'eight years since last visit to X-ray department for online retention' could be used as the appropriate time period to move records off-line, as this has been custom and practice for many years and no evidence of patient harm from this rule has been identified. However, these images should continue to be made available online if required.

Radiology record retention requirements

a) The Code requires:
    i. For imaging and report records of **adults,** that these should be retained for eight years since discharge or when the patient was last seen in the NHS organisation that stores the data.
    ii. For imaging and report data of **children**, that these should be retained until the child's 26th birthday or eight years since the child was last seen – whichever is later. (NB: 'Visit/last seen data item' – relates to the visit to the organisation that stores the data and is responsible for retention of it.)

b) The exceptions identified in the Code to the prevalent retention timescales are:
    i. Creutzfeldt-Jakob disease (CJD) diagnosis – eight years after the death of the patient
    ii. Cancer diagnosis – eight years after the death of the patient
    iii. Transplantation – 30 years after death of the patient
    iv. Continuity of care purpose (in some long-term diseases – for example, slow growing tumour, chance of recurrence and so on) – 30 years since last visit
    v. Screening mammography – ten years since study acquisition date
    vi. Obstetric ultrasound – 26 years since study acquisition date.

Data items to facilitate digital data retention algorithms

In order to have a robust algorithm for data retention within a VNA, it is important that the VNA receives and stores the following dates:

a) **Date of last visit** – data retention and destruction should be governed by the last visit to the organisation (ward, accident and emergency [A&E], outpatients or X-ray) and not just the X-ray department. It should be possible for NHS trusts to send visit information from their patient administration system (PAS) and emergency department information system (EDIS) to the VNA using standard HL7 messaging.
    i. X-ray department visit – study date from images
    ii. Inpatient visit (discharge from ward – HL7 ADT message from PAS)
    iii. Outpatient visit or (HL7 admit-discharge-transfer [ADT] or scheduling activity information [SCH] message from PAS)
    iv. A&E visit (HL7 message from EDIS)
b) **Date of birth** – via ADT messages and also from PACS
c) **Date of death** – should be communicated by PAS using HL7 ADT messaging
d) **Date of screening mammography** – study acquisition from PACS
e) **Date of obstetric ultrasound** – study acquisition from PACS
f) **Date of last visit to X-ray department** – study acquisition date on PACS.

Simplified rules of radiology records retention

For the purpose of clarity, some simple rules for record retention are described as per the IGA guidance. The simplied rules are mathematical calculations and hence would allow vendors to develop appropriate rules within their IT systems to support appropriate record retention. The most future date will be chosen by the VNA and imaging data should be retained until then.

a) For a regular patient (without exceptions) the VNA will have four dates from which to choose the most future date.
    1. Eight years from date of last visit

2. 26th birthday
3. Date of death – not applicable
4. Date of last screening mammography exam – not applicable

b) For a cancer, CJD or transplant patient the VNA will have four dates from which to choose the most future date.
   1. 30 years from date of last visit
   2. 26th birthday
   3. Eight years after date of death
   4. Date of last screening mammography exam – not applicable

c) For a patient with a long-term clinical condition with likelihood of recurrence, the VNA will have four dates from which to choose the most future date.
   1. 30 years from date of last visit
   2. 26th birthday
   3. Date of death – not applicable
   4. Date of last screening mammography exam – not applicable

d) For a patient who has had a **screening mammography** the VNA will have four dates from which to choose the most future date.
   1. Eight years from date of last visit
   2. 26th birthday
   3. Date of death – not applicable
   4. **Ten years after date of last screening mammography exam**

e) Obstetric ultrasound images are actually images of the child within a mother's folder, hence will need to be kept for 26 years – so will need to be treated very differently and will not influence or be influenced by the rules applied to a mother's folder.

Approval of record destruction

Prior to records being purged or deleted by the VNA, it is important that there is a human check of the records to ensure they meet the criteria for destruction.

Metadata retention after record destruction

After records are destroyed, the following metadata should be retained according to the Code:

a) Subject-patient ID-national ID (NHS number) and local PAS ID
b) Creator of the record – the specialty and organisation that created the document/report
c) Date of last visit
d) Date of destruction.

Reference:

1. Information Governance Alliance. *Records management code of practice for health and social care 2016.* London: Information Governance Alliance, 2016.
2. The UK Government. *Data protection act 1998.* London: The Stationery Office, 1998.

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December 2017