HANDLING AND RETENTION OF PATIENT RECORDS

Introduction

We still get numerous enquiries at the office about what should and should not be retained in the medical records and what information should be transferred to the new GP when a patient registers with a new practice. It is not possible to be absolutely prescriptive on these matters but the following information should give some basic guidance.

Medical Records

A reasonable working definition of medical records would be *'Any record which consists of information relating to the physical or mental health or condition of an individual, and has been made by or on behalf of a health professional in connection with the care of that individual.'*

Medical reports, letters and all clinical information would normally, therefore, be included in this category and this information should generally be forwarded to the new GP when transferring patients' records.

GMC Good Medical Practice

This requires that *'you keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment.'* It also stipulates that you '*make records at the same time as the events you are recording or as soon as possible afterward.'*

Retention of Medical Records

The Department of Health recommends the following periods during which medical records should be retained:

Maternity records:

- 25 years.

Records relating to children and young people (including paediatric, vaccination and community child health service records):

- Until the patient's 25th birthday or 26th if an entry was made when the young person was 17; or 10 years after death of a patient if sooner.

Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983:

- 20 years after no further treatment considered necessary; or 10 years after patient's death if sooner.

Records relating to those serving in HM Armed Forces:

- Must not to be destroyed.

Records relating to those serving a prison sentence:

- Must not to be destroyed.

All other personal health records:

- 10 years after conclusion of treatment, the patient's death or after the patient has permanently left the country.

Solicitors' Letters and Documentation of Complaints Procedures

These are not directly related to the medical care and should normally be stored separately from the medical records. They generally have no direct relevance to day to day medical care and management and by keeping them separate it is easier to omit third party and legally privileged data from copies of the medical records supplied under the Data Protection Act.

Solicitors' letters and documentation relating to a complaint or litigation against you should normally be retained if you believe this may be necessary for your own legal and professional protection. If the patient believes you have retained documentation they may seek access to copies under the Data Protection Act.

Documentation that you do not require may be sent on to the new practice if you believe that the patient and/or the new GP may require it to handle an ongoing situation

If you believe that the complaint or legal issue has been finally and satisfactorily resolved, with no chance of being revisited, then the documentation should probably be destroyed under the provisions of the Data Protection Act that limit holding data for longer than necessary. Unfortunately these decisions can only be made on an individual basis and the criteria and timescales cannot be precisely defined. A pragmatic decision must be made in each case. If in doubt - don't destroy it!

The BMA's Medico-Legal Committee has obtained advice from an external lawyer specialising in this area of law who has advised that GPs should keep all legal correspondence, reports and agreements secure for a minimum of 7 years. In the case of children, 7 years after they reach they reach 18 years of age. In cases concerning mental illness the records should be kept indefinitely as such claims would not be subject to a limitation period. Increasingly such records are being filed electronically for long-term storage.

The Good Practice Guidelines for General Practice Electronic Patient Records (version 3) gives the following advice on shredding original documents that have been scanned in unaltered and that are subject to an audit trail which cannot be altered.

'For the purposes of legal admissibility, GPs should obtain and keep written evidence (which may be incorporated into the EPR) of the destruction of the original document. This means:

- *identifying each file or document to be destroyed*
- *recording that the complete file or document has been stored electronically*
- *ensuring that the electronic version is a true and accurate copy of the original or stating how it is different.*

It is potentially dangerous for both paper and electronic records to co-exist and this raises issues about keeping both sets of records up to date. It is preferable to have a patient's record as either paper based or electronic. However the reality is that parallel records will remain for some time until practices can summarise their records onto their computer systems.'

Legally it is still not absolutely certain that you may safely shred scanned documents. Full compliance with the guidelines for electronic records would hopefully prove a good defence in the event of a legal challenge and we have been advised that both Customs and Excise and the legal profession have adopted a similar policy with regard to shredding scanned documents.

We would still advise the retention of hard copies of documents where you have reason to believe that litigation may be involved at some stage, or where you have particular doubts about shredding the original documentation. If in doubt you should retain the original or seek specific guidance from your medical defence organisation before destroying the original documentation.

There may be some argument for including a brief reference in the medical notes to a resolved complaint or legal issue as this may be pertinent to the medical care of the patient in the future. For example a patient who has complained about an intimate examination is likely to require especially sensitive clinical management for problems that may require further intimate examinations. A badly managed or misdiagnosed medical problem in the past may also create additional anxieties that would help inform future medical management. These decisions are a matter of professional judgement.

Child Protection Case Conference Reports

Wessex LMCs have in the past advised that Child Protection Case Conference Reports are best kept separately from the medical records. It is most important in these situations that the notes are carefully flagged to indicate the presence of such documentation and any potential child protection issues, such as inclusion on the Risk Register.

Some practices prefer to scan these reports into the medical records. This is also permissible, although it may present problems if data access is requested under the Data Protection Act when third party data must be excluded unless specific consent to disclosure is obtained. In addition data should not be stored for longer than necessary under the Data Protection Act and by inclusion of these reports in the medical records the data will be effectively maintained for posterity.

If the original hard copy is destroyed then it is wise to record in the medical records the specific agency that holds the original documentation.
It may not always be necessary to forward hard copies of reports which have not been scanned into the medical records to the new GP if the patient registers with a new practice, but the existence of such reports and the originating authority should always be flagged up in the notes. However, if there is any reason to believe that the reports are still relevant and that the child could be at risk or that the contained information may be required for the active and current management of the child, then it is essential that the documentation is sent to the new practice as soon as possible. When a family registers with a new doctor there may well be increased stresses as a result of moving or the breakdown of a relationship, often associated with loss of support from family and friends. This may well increase the risk to a vulnerable child and the new doctor should receive full information relating to any potential problems.

Police Information

In most cases this information should probably not be passed on to the practice as it will in general have no relevance to day to day medical management. Indeed there are issues regarding the sharing of sensitive personal data (as defined under the Data Protection Act) without the explicit and valid legal consent of the young person concerned. It could well constitute a breach of data protection, human rights legislation and/or the common law duty of confidentiality.

If a practice were to inadvertently disclose police information filed in the medical records, under a data access request for example, then the practice would potentially also be in breach of the law.

Very occasionally it may be essential to share the minimum data that will serve a legal purpose in order to draw attention to a serious danger to the patient or to family members or to practice staff in order to try to prevent serious harm. This data may be shared without consent if necessary.

It is not appropriate to include data about offences in the medical records, unless it is specifically required to inform the medical care of that patient or is essential to protect any other person. If the data is to be retained it should generally be filed separately and then destroyed as soon as it has served the valid legal purpose for which it was shared in the first place.

GPs would only be permitted to disclose such data without consent to someone who has a legitimate need to know and the authority to act upon such information and who shares the same duty of confidentiality.