



THE SCOTTISH OFFICE

National Health Service in Scotland
Management ExecutiveSt. Andrew's House
Edinburgh EH1 3DG

Dear Colleague

**GUIDANCE FOR THE RETENTION AND
DESTRUCTION OF HEALTH RECORDS****Summary**

1. This letter informs Health Boards and NHS Trusts of some changes in the minimum period for which certain categories of health records are retained as presently specified in Scottish Health Memorandum 60 of 1958 (SHM 58/60) and its accompanying schedule.

2. The guidance has been approved by the Secretary of State, the Keeper of the Records of Scotland and the Scottish Records Advisory Council.

Action

3. All Board General Managers and Chief Executives of NHS Trusts are asked to ensure that all appropriate staff are aware of and follow the guidance set out in Appendix A (as summarised in Appendix B) of this letter.

4. This letter should be copied to Unit General Managers, Chief Administrative Medical Officers and Medical Directors of NHS Trusts who should bring this guidance to the attention of all relevant clinical staff. Health Boards should make the necessary arrangements to inform GPs about the contents of this circular.

Background

5. Following a review of retention periods revised proposals were prepared and circulated for comment to Health Boards and a wide range of health professional bodies and other authorities with an interest in health records. After careful consideration of all responses, the Management Executive, in consultation with the Keeper of the Records, now sets out in Appendix A (as summarised in Appendix B) the revised minimum retention periods for health records.

6. Health records, for these purposes, are those records which relate to the physical or mental health of an identifiable individual which have been

1 December 1993

Addressees

For action:
General Managers,
Health Boards

General Manager,
State Hospital

Chief Executives and
Chief Executives
Designate,
NHS Trusts

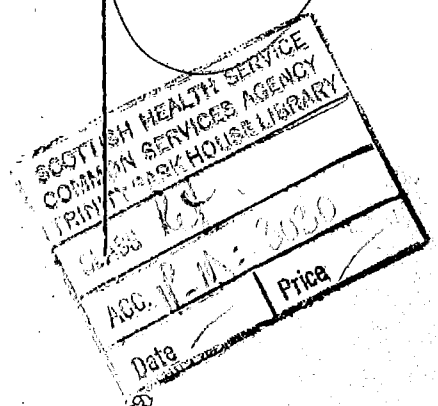
For information:
General Manager,
Common Services Agency

General Manager,
Health Education Board
for Scotland

Enquiries to:

Mr D Cowie
NHS Management
Executive
Room 151
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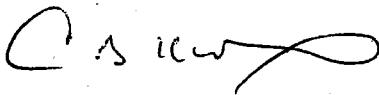
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made by or on the advice of a health professional in connection with the care and treatment of that person or in connection with the organisation of that care. They include records contained in "non-paper" media, including microfilm, computer files, slides and specimens.

7. As most addressees of this letter are aware, all Health Boards' records, which include records relating to NHS patients treated in private sector clinics, are owned by the Secretary of State on behalf of the Crown and are subject to the provisions of the Public Records (Scotland) Act 1937 and may only be destroyed in accordance with the Disposal of Records (Scotland) Regulations 1992. However, NHS Trusts become owners of health records which they have created or which they have inherited on gaining Trust status and such records are not subject to the 1937 Act or the 1992 Regulations. Nevertheless we wish to ensure a consistent approach throughout the NHS in Scotland and therefore all Chief Executives of NHS Trusts are asked to follow these minimum periods and ensure that staff are aware of and follow this guidance. An opportunity will be taken when convenient to seek to align the statutory position of health records held by NHS Trusts in Scotland with that in England where such records are public records.

Yours sincerely



C B KNOX
Director of Information Services

APPENDIX A

EXPLANATION OF RECOMMENDED MINIMUM RETENTION PERIODS

1. For the purposes of this guidance records contained on "non-paper" media (eg microfilm, computer files, slides and specimens) should be treated in the same way as paper records with the same minimum retention periods applying to them (but see paragraph 19).

2. At the conclusion of periods set out in this guidance the records may be destroyed but there is no obligation to do so. Destruction of health records should be based on appropriate health professional advice.

3. Health Boards, Trusts and GPs, as producers of products and equipment, are affected by the provisions of the Consumer Protection Act 1987 covering the liability of producers for defective products. They may also be liable in certain circumstances as suppliers and users of products. An obligation for liability lasts for 10 years and within this period the Prescription and Limitation (Scotland) Act 1973, as amended by the Consumer Protection Act 1987, provides that the pursuer must commence any action within 3 years' from the date on which the pursuer was aware of the defect and aware that the damage was caused by the defect. This means that if a defective product was likely to have affected the health of a patient, then the patient's record would have to be retained for at least 13 years'. It will be for Boards, Trusts and GPs to make their own judgement in such cases on whether any health records should be retained for this minimum period in order to defend any action brought under the Consumer Protection Act 1987.

4. It will be for Health Boards, Consultants, GPs, Dentists, Pharmacists, Opticians, Occupational Health Services, Cancer Registries, Nurses, Midwives, Health Visitors, Community Nurses, and as appropriate NHS Trusts, to decide which of their records should be retained for clinical or research purposes.

General Hospital and Community Health Service Health Records

5. There will be no change in the present minimum retention period of 6 years following the date of the last recorded entry or 3 years after death. All records must be kept in the original form for at least the first 3 years of the period but may be microfilmed or transferred to other media thereafter and held in that form for the remainder of the period.

Children's and Young Adults Health Records

6. Under the terms of sections 17 and 18 of the Prescription and Limitation (Scotland) Act 1973 it is normally the case that any action for damages in respect of personal injuries should be raised within 3 years from the date on which the injuries were sustained or, in the case of medical treatment, of the treatment to which the injuries relate. This period may be extended however if the pursuer, in the opinion of the court, could not have been in the position to know that the injury was sufficiently serious to justify the bringing of an action, that the injury was attributable in whole or in part to an act or omission on the defenders part or that the defender was a person to whom the injuries

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were attributable in whole or in part. In other words the period of 3 years may in fact start after the date of termination of the treatment. There is also to be left out of account any period during which the person who sustained the injuries was under legal disability either through non-age (ie under the age of 16) or unsoundness of mind (see paragraph 12) which does not mean insanity but an inability of the injured person by reason of their mental state, to manage their own affairs in relation to the relevant event and injury.

7. In the circumstances, to allow a sufficient period for any legal action to be initiated the general minimum retention period for children and young adults has been changed to require records to be retained until the individual reaches the age of 25 years or 3 years after death if this is earlier.

Obstetric Records

8. Associated with the records of children and young adults is the need to retain a mother's obstetric records. These should be retained for 25 years after the birth of the child (including stillbirth).

Psychiatric Records

9. The retention periods for psychiatric records will change and differentiate between those containing entries made on or before 31 December 1960 and those containing only entries made after that date. This date has been chosen on the grounds that new admission procedures under the Mental Health (Scotland) Act 1960 came into operation on 1 January 1961.

10. There will be no change in the retention of psychiatric records containing entries made on or before 31 December 1960 and these should continue to be retained indefinitely. However psychiatric records with the first entry made on or after 1 January 1961 should be retained for the lifetime of the patient and 3 years after death.

11. These proposals do not prevent retention for longer periods and because of the unique time series of psychiatric records held in Scotland there may be grounds for retaining certain records in perpetuity.

Health Records of Persons of Unsound Mind

12. Under the Prescription and Limitation (Scotland) Act 1973 a person who has been declared of unsound mind may sue for damages up to 3 years after being declared sound of mind. As explained earlier in this guidance, unsoundness of mind does not mean insanity but an inability of the injured person by reason of their mental state to manage their own affairs in relation to the relevant event and injury. The provisions of the Act will not necessarily apply to all psychiatric records but where an action is initiated it will affect not only the psychiatric records but all the health records of that patient. For example, a patient on being declared sound of mind has 3 years in which to sue for damages in

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relation to a hip operation performed while he was unsound of mind even if that operation had been performed 20 years earlier. It will be for Health Boards and NHS Trusts to make their own judgement in such cases in the light of local circumstances.

GP Records held by Health Boards

13. There will be no change in the retention period for GP records held by Health Boards where the patient has died. This will remain at 3 years after death. Where individuals leave the country temporarily and have expressed an intention to return, the records should be retained for 6 years or such reasonable longer period as may be agreed with the GP or Board and the person concerned. However, as explained in paragraph 7, records of children and young adults should be retained until the individual reaches the age of 25 or 3 years after death if this is earlier.

14. The Health Board should consult with the GP Sub-Committee of the Area Medical Committee regarding the arrangements for the disposal of such records (eg to agree any particular category of record which needs to be held for a longer period).

Records of Cancer Patients

15. There is a need to maintain on a long-term basis records which are kept on patients undergoing radiation therapy and chemotherapy. These records are required not only during the lifetime of the patient but also after death in order to allow an adequate and detailed audit of treatment to be undertaken. Accordingly, all records, including written records and radiographs of patients treated for cancer should be retained for the lifetime of the patient and 3 years after death. Even after this period, destruction of all such records may only be carried out after consultation with the consultant in charge.

Records of Patients with Genetic Disorders

16. In order that clinicians may provide accurate genetic advice it is essential that a definite, confirmed diagnosis is made of the condition that is suspected to be familial. This often requires not only confirming the diagnosis of the clinical condition in the affected individual but also determining the mode of transmission of the disorder within the family. Thus it requires confirmation of the diagnosis in any other members of the family who are thought to have been affected in the same or in previous generations and the medical records of family members are often required for confirming the disorder.

17. Accordingly, given the nature of this particular category of health record it would not be appropriate for the Management Executive to recommend a specific minimum retention period for such cases. In the circumstances it is for provider Units (including NHS Trusts), on the advice of the consultants in charge, to consider the retention of records (or parts of them), in respect of patients and their families with disorders which may be genetic, beyond the minimum period of 6 years as required for health records generally.

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X-Ray Films

18. The bulk of x-ray film gives rise to special storage problems. In 1990, the Royal College of Radiologists issued a resume of the issues relating to the retention of x-ray film. In this, it was pointed out that almost all records were in file within 3 years of being produced and it was recommended that the radiologists report rather than the x-ray film should be considered the primary record for retention. They therefore suggested that "the film envelope, and its content, save in special interest groups, may be discarded once 3 years has elapsed since the most recent previous examination." Special interest groups were identified as "paediatrics, maternity, research, teaching hospitals" and "radiotherapy". Ideally x-ray film should be retained for the same period as other health records in accordance with the recommendations in this guidance. However it is recognised that other considerations may make this impractical and unreasonable. It is therefore recommended that provider units, in consultation with their purchasers and relevant clinicians, and with reference to current professional guidance, should determine the duration for which x-ray film should be retained, taking into account clinical need, special interest groups, cost of storage and the availability of storage space. X-ray reports are an integral part of the main health record and are therefore covered by the appropriate minimum retention periods recommended in this guidance.

19. Pathological Specimens

19.1 Cervical Smears: The current professional guidance contained in the "Strong Report" on the Cervical Cytology Service in Scotland recommends that smears and records should be stored for 10 years in normal cases and indefinitely for abnormal cases. This guidance will continue to apply.

19.2 Histological Specimens: These are blocks of tissue removed at operation or biopsy for which slides are then made for microscopic examination and diagnosis. The current practice is that blocks are retained indefinitely, and slides made from these specimens are kept for a minimum of 10 to 15 years', depending on the storage space available. This practice should be maintained.

Retention of Records for Clinical Trials

20. The EC Directive on Good Clinical Practice for Investigators taking part in clinical trials, which was implemented in July 1991, recommends that patient files and other source data must be kept for the maximum period of time permitted by the hospital, institution or private practice, but not less than 15 years. The Directive rightly places the responsibility for retention of records for clinical trials on the investigator.

21. It is important that investigators should not assume that Health Boards or Trusts are required to retain the records beyond the minimum retention periods stated in this guidance and they must make sure suitable arrangements for retention and storage have been made with provider management before the trial starts. While all NHS Hospitals, Trusts and Practices should be encouraged to support ethical research,

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the Directive will place additional work on the institution which is likely to go far beyond routine requirements. In the circumstances investigators and sponsors of clinical trials must recognise that agreement can not be assumed and that special arrangements will be needed for each project. This may involve payment for the additional record handling and storage.

Historical Records

22. No surviving health record dated 1948 or earlier should be destroyed. After expiry of the minimum retention periods, post 1948 health records may be destroyed but there is no obligation to do so. It will be for Health Boards, NHS Trusts or GPs to decide which of their post 1948 health records should be retained for clinical or research purposes. Confidentiality of health records should be maintained for 75 years (100 years for minors) following the last recorded entry unless special permission is obtained from the relevant medical officer.

23. There is an obligation to preserve appropriate records for historical use by a wide range of readers in the future. The most appropriate method of retaining a selection for permanent preservation is by way of sampling. Specialist advice is available in the first instance from the Archivist of Greater Glasgow Health Board where a specialist sampling study has been undertaken. Every Board or Trust should have access to the services of a professional archivist. A number of Health Boards employ qualified Archivists to look after their non-current health records and make them available both to staff of the employing authority and members of the public in consultation with the Keeper of the Records of Scotland. Advice on the selection of health records for preservation or destruction is available from:

- The Archivist, Dumfries and Galloway Health Board, Crichton Royal Hospital, Dumfries, DG1 4TG (Tel: 0387 55301 Ext 2360)
- The Archivist, Grampian Health Board, Aberdeen Royal Infirmary Woolmanhill, Aberdeen AB9 1EF (Tel: 0224 663466)
- The Archivist, Greater Glasgow Health Board, Glasgow University Archives, Glasgow G12 8QQ (Tel: 041-330 5516)
- The Archivist, Lothian Health Board, Medical Archive Centre, Edinburgh University Library, Edinburgh EH8 9LJ (Tel: 031-650 3392)

24. In the case of areas which have no Health Board Archivist, the Keeper of the Records of Scotland, Scottish Record Office, Edinburgh EH1 3YY (Tel: 031-556 6585 Ext 131/132) will put enquirers in touch with the nearest Health Board Archivist, or an appropriate local Archive Office. Alternatively the Keeper's staff will offer advice on request.

APPENDIX B

SUMMARY OF MINIMUM RETENTION PERIODS FOR PERSONAL HEALTH RECORDS (At the conclusion of periods set out in this guidance the records may be destroyed but there is no obligation to do so.)

1. General Hospital and
Community Health Service
Health Records

a. Persons aged 16 or over on date
of admission

6 years following the date of the last recorded entry or 3 years after death.

b. Children's and Young Adults'
Records (persons aged less than 16
on date of admission)

Until the person reaches the age of 25 or 3 years after death if this is earlier.

c. Obstetric Records (meaning the obstetric records of the mother)

25 years after the birth of the child (including stillbirth)

2. Psychiatric Records

Records containing entries made on or before 31 December 1960 should be retained indefinitely.

Records with the first entry made on or after 1 January 1961 should be retained for the lifetime of the patient and 3 years after death.

3. GP Records

GP records should normally be sent to the appropriate Health Board on the death of a patient and retained for 3 years. Where individuals leave the country temporarily and have expressed an interest to return, the records should be retained for 6 years or such longer period as may be agreed with the GP or Board and the person concerned.

However records of children and young adults should be retained until the individual reaches the age of 25 or 3 years after death if this is

GP Records (cont'd)

earlier. Under certain circumstances GP records may require to be retained for a longer period (see paragraph 14 of Appendix A).

4. Records of Cancer Patients

Records of cancer patients should be retained for the lifetime of the patient and 3 years after death. After this period, destruction of all such records may only be carried out after consultation with the consultant in charge.

5. Records of Patients with Genetic Disorders

It is for provider Units (including NHS Trusts), on the advice of the consultants in charge, to consider the retention of records (or parts of them), in respect of patients and their families with disorders which may be genetic, beyond the minimum period of 6 years as required for health records generally.

6. X-Ray Films

Provider Units, in consultation with their purchasers and with relevant clinicians, should determine the duration for which x-ray film should be retained, taking into account clinical need, special interest groups, cost of storage and the availability of storage space. X-ray reports are an integral part of the main health record and are therefore covered by the appropriate minimum retention periods recommended in this guidance.

7. Cervical Smears

Smears and records should be stored for 10 years in normal cases and indefinitely for abnormal cases.

8. Histological Specimens

Blocks of tissue should be retained indefinitely and slides made from these specimens should be kept for 10 to 15 years depending on the storage space available.