Dr Mark Vanderpump - Retention Policy

In providing care I am required to keep clear, accurate and legible records which report the relevant clinical findings, the decisions made, the information given to patients, any drugs or other treatment prescribed and who is making the record and when.

These records are primarily intended to support patient care and authentically represent each and every consultation (including by telephone).

Types of Record

As an independent Consultant in Private Practice I am responsible for protecting your records these include:

- hand-written note
- computer-generated notes
- blood test results
- x-rays
- copies of correspondence
- photos or slides
- theatre records

These are securely stored and protected against accidental loss, including corruption, damage or destruction. All records are kept secure and confidential at all times based on legal requirements and best practice.

Record Retention

Records are kept in accordance with the Private and Voluntary Health Care (England) Regulations 2001. Schedule 3 lays down minimum periods for the retention of private record (see the table on the next page)

Type of Patient	Minimum period of Retention
Patient who was under the age of 17 at the date on which the treatment to which the records refer was concluded	Until the patient's 25th birthday.
Patient who was aged 17 at the date on which the treatment to which the records refer was concluded.	Until the patient's 26th birthday.
Patient who died before attaining the age of 18.	A period of 8 years beginning on the date of the patient's death.
Patient who was treated for mental disorder during the period to which the records refer.	A period of 20 years beginning on the date of the last entry in the record.
Patient who was treated for mental disorder during the period to which the records refer and who died whilst receiving that treatment.	A period of 8 years beginning on the date of the patient's death.
Patient whose records relate to treatment by general practitioner	A period of 10 years beginning on the date of the last entry.
Patient who has received an organ transplant.	A period of 11 years beginning on the date of the patient's death or discharge whichever is the earlier.
All other cases.	A period of 8 years beginning on the date of the last entry in the record.

The disposal of paper and electronic records is carried out in such a way that protects patient confidentiality.

22nd June 2018