Issues regarding sending attachments to GP records in electronic form

This is advice from the Joint GP IT Committee (JGPITC) of the General Practitioners Committee (GPC) of the BMA and the Royal College of General Practitioners (RCGP)

1. Scope

1.1 This document is not designed to be a definitive guide regarding the electronic transfer of documents relating to the GP held patient record, but merely to list the areas that need to be considered.

1.2 It is limited to the transfer of electronic documents (not the core record) between practices, or from practice to PCT, where the documents are not also being sent in hard copy.

2. Background

2.1 It is becoming clear that a small, but gradually increasing number of practices are sending scanned documents (where the original has been shredded) in electronic form when a patient leaves a practice.

2.2 Various issues regarding the transfer of electronic records and attachments are being raised due to the GP2GP project, and national definitive guidance is likely to result from these.

3. Areas to consider

3.1 A practice must keep records in a written form unless with the agreement of the PCT[1]

3.2 A practice must provide all a patient's records in 'written form' unless it has the agreement in writing from a PCT to do otherwise[2].

3.3 Guidance and support regarding approval can be sought from the appropriate LMC, who are an integral part of the accreditation process.

3.4 If a practice is scanning and then shredding the original documents, the file should be stored in an Industry Standard format as defined in the Good Practice Guidelines[3]

3.5 The documents should whereever possible be appropriately named with appropriate embedded metatags etc to enable the receiving practice to easily identify:

- The date of the original document

[1] The National Health Service (General Medical Services Contracts) Regulations 2004 Schedule 6 Part 5 Paragraph 73(2)
[2] The National Health Service (General Medical Services Contracts) Regulations 2004 Schedule 6 Part 5 Paragraph 73(7)
[3] The Good Practice Guidelines v3.1, June 2005, Section 6.4

- The patient
- The type of document
- The key content

3.6 Documents should be saved as individual files, or extractable to individual files.

3.7 The sending practice must consider what type of media is appropriate for sending the documents on – e.g. Floppy disc, CDRom, CDRom R/W, DVD. This consideration should include the likelihood of a receiving practice being able to access the contents, and the physical robustness.

3.8 The sending practice must ensure that the receiving practice can readily contact them in the event of any query (e.g. by clear labelling of contact name, telephone number and email address on outside of media)

3.9 The exterior of the media should include the patient's name, and other identifying information (Date of Birth, NHS Number), and indicate the range of dates that the documents cover (this will be important if the same media is sent to (a) subsequent practice(s).

3.10 The sending practice must ensure that they provide the receiving practice with a complete print out of all documents without delay in the event of any request for any reason by the receiving practice.

3.11 The sending practice should consider whether their processes are sufficiently robust to ensure that they have complied with their duty of care to both the patient and the receiving practice.

3.12 The sending practice should consider encryption of the disk. If encryption is used, the documents should be readily extractable (e.g. by easy access of password by email/telephone).

4. Summary

4.1 A practice should consider the above areas in detail before providing documents only in electronic form when a patient leaves their practice. They will need to seek advice and written consent from their PCT, and should consider seeking advice from a Medical Defence Organisation or independent legal advice.

Joint GP IT Committee
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