To consider

**Update on records retention review project**

**Issue**

1. In updating our retention policies, we will begin this year to remove information from our system on enquiries which were closed at the triage stage of the Fitness to Practise process. We will retain a skeleton record on each of these enquiries and need to agree the information that would be stored on these records.

**Recommendation**

2. The Strategy and Policy Board is asked to agree the information that should be retained on enquiry records.
Update on records retention review project

Issue

Background

3 At its meeting on 5 December 2012, and following a public consultation, Council agreed a comprehensive Records Retention and Disposal Policy which adopts a granular approach to the data we retain. The Policy ensures that material is retained for a proportionate amount of time in terms of balancing legislative requirements of the Data Protection Act, the Human Rights Act and the requirement to perform our statutory duties effectively.

4 A Project Board chaired by the Director of Resources and Quality Assurance, including the Director of Fitness to Practise and other key colleagues from the Fitness to Practise directorate, the Medical Practitioners Tribunal Service (MPTS), Information Services (IS) and Strategy and Communication has been established and meets on a monthly basis.

5 The first Project Board meeting was held on 24 February 2014 and the high level project approach for 2014 was agreed.

6 The Project Board agreed that, in 2014, we would focus specifically on Fitness to Practise Siebel records which are categorised as Enquiries closed at Triage with no further action. This is where a complaint has been raised but it did not meet the criteria to be promoted to a case and therefore no further action was taken.

7 The Project Board made this decision based on the view that this category of data would present the highest risk to the organisation in terms of legal challenge. The retention period for this material is four years if the concern is not about a doctor or could never lead to a finding of impaired fitness to practise; and five years if the matter was more than five years old and there was not a public interest in proceeding.

8 There are approximately 20,000 enquiries that were closed before January 2010 which fall into the scope of this work. Approximately 8,000 of these records were added to Siebel between 2006 and 2010, and have electronic information such as the complaint form and supplementary correspondence attached to them.

9 The other 12,000 records are pre-Siebel, closed enquiries imported to Siebel from Fitness to Practise databases dating back to the 1990s. Initial analysis shows that the electronic records contain limited information such as doctor name, complainant name and why the enquiry was closed. For each of these, we are likely to hold a paper record of the enquiry at our secure off-site storage facility.
In line with the agreed policy, we will create and retain a summary record for each enquiry closed at Triage. This paper sets out what this summary record will look like: a mixture of key structured data from Siebel and a brief description of the complaint.

The following, illustrative wording was used in our consultation document on the issue:

For a fitness to practise complaint closed at the assessment stage with no further action, the summary record would comprise the complainant’s name, the doctor’s name, the date of the complaint, a brief description of the issue and the reason for closure.

Structured data

The table below shows the information currently stored on an enquiry record which we intend to retain, and the reasoning for this.

<table>
<thead>
<tr>
<th>Information to retain</th>
<th>Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enquiry number</td>
<td>Needed as identifier (non-sensitive)</td>
</tr>
<tr>
<td>Doctor name and UID (linked to register record)</td>
<td>Basic requirement to maintain FtP history on a doctor. Link to register record will allow us to report on trends based on different doctor characteristics</td>
</tr>
<tr>
<td>Complainant name / referring organisation (linked to contact record)</td>
<td>Basic requirement if we ever needed to obtain further information</td>
</tr>
<tr>
<td>Date of complaint</td>
<td>Essential context (non-sensitive) - also for reporting trends</td>
</tr>
<tr>
<td>Date enquiry closed</td>
<td>Essential context (non-sensitive) - also for reporting trends</td>
</tr>
<tr>
<td>Closure and decision reason</td>
<td>Essential context (non-sensitive) - also for reporting trends</td>
</tr>
<tr>
<td>Incident location (Levels 1, 2 and 3)</td>
<td>Essential for monitoring patterns of complaints</td>
</tr>
<tr>
<td>Consent flag</td>
<td>Basic requirement if we ever needed to obtain further information</td>
</tr>
<tr>
<td>FtP owner</td>
<td>For internal reference</td>
</tr>
<tr>
<td>Incident date</td>
<td>Basic context (non-sensitive)</td>
</tr>
<tr>
<td>Enquiry type</td>
<td>Important context (non-sensitive) - also for reporting trends</td>
</tr>
<tr>
<td>Source type</td>
<td>Important context (non-sensitive) - also for reporting trends</td>
</tr>
</tbody>
</table>
13 All information held on an enquiry is shown in Annex A. Our proposal is that anything not shown in the list above would be removed. Key areas that would be removed and should be considered are:

- All activities (letters, emails, phone notes) including initial complaint.
- Any supporting documentation provided (records, reports etc).
- Patient and witness information (if not complainant).
- All service requests.

Summary of the complaint

14 For each summary record, we plan to create a brief description of the complaint. We propose that this description would comprise:

- The allegations against the doctor. This would be a brief summary of the complaint letter and any further information on the incident where this exists. It should be based on *Good medical practice* allegations where possible, and be similar in style to the existing ‘allegation descriptions’ on case files. For example: ‘Doctor accused of refusing to register patient with GP practice’, ‘Doctor alleged to have been a poor landlord to complainant’, ‘Doctor accused of diagnostic errors leading to serious side effects for patient’.

- The reasoning for closing the enquiry at the triage stage. This would show the decision reasoning as currently entered by triage staff – this is more than just the closure reason. For example: ‘Allegations incidental to the doctor's profession and not of a serious enough nature to bring the profession into disrepute’, ‘Allegations dealt with satisfactorily at a local level’, ‘CE advice shows that outcome was a known side effect of medication’.

15 Once agreed, we plan to develop detailed guidance for staff, working up a number of examples/scenarios based on the principles set out in paragraphs 11-13.

Other work

16 It should be noted that consideration of issues relating to the policy for publication of historical fitness to practise sanctions on the LRMP and disclosure of information about complaints to doctors is on-going, and will be brought to the Board (and Council as required) for consideration later this year.
Supporting information

How this issue relates to the corporate strategy and business plan

17 Strategic aim 5 of our Corporate Strategy: To work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions.

If you have any questions about this paper please contact:
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What is on an Enquiry?

An enquiry record is made up of a constantly visible applet of key information, plus a number of tabs below that can be selected and contain further detail.

**Overview applet**

<table>
<thead>
<tr>
<th>Enquiry number</th>
<th>Owner name</th>
<th>Enquiry type</th>
<th>Consent flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
<td>Status</td>
<td>Source type</td>
<td>Complainant</td>
</tr>
<tr>
<td>Referring organisation (and ODS code)</td>
<td>Reopen reason</td>
<td>Date received</td>
<td>Incident date</td>
</tr>
<tr>
<td>Completed date</td>
<td>Service date</td>
<td>Reopened date</td>
<td>Channel</td>
</tr>
<tr>
<td>SLA exception reason</td>
<td>SLA exception description</td>
<td>Complainant details button</td>
<td></td>
</tr>
</tbody>
</table>

**Summary**

Summary description box

**Online complaint details**

Information from the online complaint form is pulled through into this area:

Complaint details

This shows the incident date, and incident date reason, incident location, concern summary, witness information and consent/declaration flags. Doctor details, organisation details and any supporting documentation also shown.

Complainant details

Shows name, contact information, DOB, gender, reasonable adjustments required, relationship to patient, patient details (name and DOB)
Activities

All activities linked to enquiry (generally letters, emails, phone notes etc). Typical activities include letter of complaint, correspondence with complainant, maybe with employer, internal advice.

Notes

Any notes added to the case by the IO.

Complainants

Name and contact information for complainant (and link to contact record)

Service Requests

Split by triage outcome, Rule 12, complainant correspondence, further information requests.

For each Service Request, all activities/to-dos are shown, along with SR contacts, type and sub-type of SR, date created and closed, creator and status.

DO Service Requests

Service requests linked to correspondence with the Director’s Office - generally correspondence.

Doctor Identification

Shows doctor name, UID, registration status and contact info. Also holds the incident location (levels 1, 2 and 3), ELS area and ELA. List below shows identification steps and whether/when these were completed.

Doctor Triage

Shows doctor name and UID, then also shows triage outcome, closure reason, triage outcome notes (a summary of decision reasoning), who triaged and when and incident location info. Triage session date and triage script also shown.

Audit

Shows changes made to record.

Decision details

Shows doctor name and basic details, triage outcome, closure reason and outcome notes, incident location. Also has space for complainant history and doctor decision information.