retention period which they set in their policies and to destroy data for which they no longer have a legitimate use in accordance with the fifth data protection principle.

3.27 The physical storage of paper records can pose a significant problem for occupational health providers in terms of space and cost. These issues are less marked for electronic records, although the selective destruction of individual records may pose some difficulties. In providing advice on retention periods occupational health professionals should consider the delayed nature of many occupational diseases and the potential value of records to both the worker and the employer. Records can also provide valuable information for future epidemiological studies and the Data Protection Act provides that personal data which are processed only for research purposes may be kept indefinitely.

Destruction of records including electronic data

3.28 Paper records must be destroyed effectively (eg shredding or pulverisation) and not disposed of in normal waste. Occupational health professionals should ensure that appropriate standards for confidentiality are stipulated to any external provider undertaking the work. Similarly, when electronic data are destroyed expert advice should be sought to ensure destruction is effective and adequate safeguards with respect to confidentiality are applied. Simple deletion of files is inadequate and the occupational health service must seek expert IT advice to ensure that records are completely destroyed.

Ownership of records

3.29 For in-house providers of occupational health services, the employer owns the notes, paper and filing cabinet but the contents are the intellectual property of the occupational health authors. Similarly, for electronic records, the hardware and software programmes are the property of the employer, but the data held within them are the intellectual property of the professionals creating them. Therefore the contents cannot be accessed by the employer or their agents, other than the occupational health department, without the consent of the data subject.

3.30 Occupational health records generated and held by outsourced providers or contractors will normally remain the property of the occupational health service unless alternative contractual arrangements have been made.

Transfer of records

3.31 In general terms it is good practice and in the interests of the employer and worker for occupational health records to be transferred between providers when a service is handed over. There is however no specific legal requirement to transfer records and arrangements should be agreed between the parties concerned. The data controller for the outgoing service should ensure that records are only transferred to competent persons (normally occupational health professionals) or the subjects of the data.

3.32 ***Where a company changes its occupational health provider*** (either in-house or outsourced) it is generally in the best interests of all parties for records to be transferred to the incoming occupational health provider. Workers should be notified of the transfer to a new provider and be given the option to 'opt out' of the scheme but specific individual consent to transfer will generally be impractical unless the workforce is very

VIGNETTE 2 : Transfer of records between providers

Dr B learned that the electronics company for whom she worked had been successful in a recent take-over of another manufacturer. After discussions with her senior manager she approached her counterpart to investigate the nature of the other company's occupational health records. There were over nine hundred sets of paper records and duplicate statutory health records. Following detailed negotiations with the relevant officers in the other company an agreement was reached concerning the proper transfer of records.

Issues

The costs involved in records transfer can be significant and occupational health providers should factor these into contract negotiations.

Distinguish carefully between clinical and statutory health records – the treatment will be different.

Processes should be kept as simple as possible – provided adequate information is given to workers and the option to opt out offered, consent to transfer can otherwise be implied.

Points to consider

What should happen to the records of employees who were deceased or had left the company?

Where is the appropriate location for statutory health records which are not medical in confidence?

Can the outgoing provider refuse to transfer occupational health records – and if so is there any action needed?

small. Consultation with workers' representatives (eg trades unions) is a common method of communicating this activity. It is the responsibility of the existing occupational health provider to ensure that this duty is discharged. Some records, for example relating to hazard control, may have commercial secrecy considerations and outgoing providers must maintain confidentiality in this respect as well as in relation to personal records.

3.33 The practical aspects of transferring records between providers of off-site services is more challenging than transferring records held on the employer's premises. Records of which files have been transferred should be made as an audit trail and an appropriate secure method of transfer must be utilised. The outgoing provider may make a reasonable charge to cover the costs associated with the transfer of records.

3.34 If the worker declines transfer of his/her records, there are various options. If the records are not required for retention by statute:

- the records can be offered to the worker to retain;
- the records can be offered to the general practitioner (GP) to retain (with consent);
- the records may be destroyed according to the process outlined above. Alternatively, the records can be retained by the outgoing occupational health provider (but a storage charge may be applied).

3.35 ***Where an organisation (employer or occupational health provider) closes down***, records not required for retention by statute may be dealt with as above. If the employer is closing down, the occupational health provider may retain the records for an appropriate period of time but it is likely that this service would not be remunerated. If the occupational health provider ceases to trade the records could, with consent or opt out, be transferred to another occupational health organisation.

3.36 ***Where a worker changes job*** it is unusual for records to transfer. Even if the new occupational health provider is the same as the provider for his previous employment, it cannot be assumed that the worker will want records to transfer. In some circumstances (eg a move within the National Health Service (NHS)) it may be in the best interests of the worker and the employer to transfer notes but specific consent should be sought from the worker affected.

Consent

3.37 Consent is a process whereby an individual, having been provided with full information and understanding the consequences, agrees to a proposed action. Consent may be implied or express.

Implied consent may apply to situations where a worker's behaviour can clearly imply that consent is given, for example holding out their arm for venesection. However, implied consent should not be relied upon except in circumstances where it is obvious, routine and generally accepted.

Express consent may be given orally or in writing. Oral consent should be documented contemporaneously in the worker's record. When obtaining consent for the release of information to an employer, express consent in writing should be obtained. According to the GMC 2008 guidance on consent:

'You should get written consent if: There may be significant consequences for the patient's employment, social or personal life'.

It is prudent to record the key elements of the explanatory discussion you have with the worker on the consent form or in the medical record; this may be achieved by using standard text.

3.38 Consent:

- is a continuous process;
- is for the purpose for which it is given;
- can be withdrawn.

3.39 A widely drawn or blanket form of consent is ethically unacceptable; for example, seeking consent to allow an occupational health professional to write to any doctor about any matter cannot be 'informed' and is therefore unacceptable. Consent should be obtained for each significant step in the process of an occupational health assessment. For example, consent for an occupational health professional to obtain a report from a GP does not constitute valid consent for disclosure of information so obtained to management or others. When obtaining consent the worker's wishes to have another person involved in the discussion (eg relative or advocate) should be accommodated.

Capacity

3.40 Under the Mental Capacity Act 2005, a person is assumed to have capacity unless proved otherwise. The GMC advises that, when obtaining consent, consideration should be given to whether an individual has the capacity to give consent: are they able to retain, use and weigh up information needed in order to make a decision? In occupational health practice it is unusual that a worker would lack capacity but consideration should be given to vulnerable workers, such as those with neurological damage, learning difficulties or who are very young. In general it can be presumed that most young people of 16 and over have the capacity to make decisions and a person should not be treated as lacking capacity because he makes an unwise decision.[34]