



National Chlamydia Screening Programme: Lessons learnt report

The Incident

Background

Paper records relating to National Chlamydia Screening Programme (NCSP) screens and results relating to 2008-2017 had been archived with a council's external archive provider. Several boxes containing the records from the external storage facility had to be retrieved to ensure archived NCSP records and information on a locally held spreadsheet were fully synchronised.

What happened

Upon arrival in the sexual health office (SHO), two-thirds of 15 boxes were found to be unsealed and unsecured. Security cable ties were broken or missing, some boxes were damaged with the contents falling out, and many lids were damaged and removable. It was not clear at which stage from departure to arrival at the SHO this damage occurred, nor was it clear why this went unreported at any point in the process. It was of concern to public health staff as transporting records that contain person identifiable data (PID) on this occasion failed GDPR standards or NHS record-keeping practices.

Who was informed

The Director of Public Health (Chief Officer), Information Assurance Officer/IG compliance lead, internal property management staff, external storage provider and, later, council members and council archive auditors, and a full report was sent to the Information Commissioning Office (ICO) and Public Health England (PHE).

What was done

Meetings were held with all relevant parties, addressing the processes and trying to identify what went wrong, where, when and by whom. Further investigation focused on the following 3 areas: storage provider's archive facilities and systems, transportation, and internal processes to receive and deliver goods. All parties were asked to investigate individually and submit findings in writing. Sexual health staff visited the storage facility to inspect the archived NCSP records. At least two-thirds of the remaining 100-plus boxes were found damaged or unsealed. The team replaced damaged boxes or lids, and all boxes were sealed with appropriate security cable ties. Individual numbers on these cable ties were documented on the spread sheet to further increase confidence in security.

Immediate and Root Causes

Conclusions of further review found the following underlying causes:

1. Lack of accountability and ownership. Both the external archive provider and the receiving council claim that their agents had not noticed any damaged boxes, but immediate photographic evidence (taken on the day of arrival) belied this. While contract and local operating procedures specify what needs to be done in case of damaged/unsecure archive material, these were not followed.
2. Incorrect or flawed consumables. The cable ties were not the correct type, and the quality of the boxes was not good enough for storing this material. Neither cable ties nor the boxes were strong enough to withstand handling while in the depot or during transport.
3. Inefficient communication. There was miscommunication, ambiguity and inconsistency around the archiving procedures. The process was unclear to the agents of those providing and those who use the service. Even protocols and procedures in place were not being followed.

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4. Lack of understanding and awareness. There was a lack of understanding by outside agencies around the legal requirements in handling records with sensitive PID. The storage company had not been aware that council records may require a different level of security for archiving and that NCSP archiving would require a higher level of security (this is despite being marked clearly as 'High Security' on the box under 'Security Classification'). Sub-contracted staff were only required to sign a confidentiality clause but do not attend IG training. It was not entirely clear whether facilities staff had undertaken IG training.

What was done well

It was widely acknowledged that all the relevant participants judiciously and readily contributed to the investigation of this incident with the common aim of improving the archiving process that would make it more robust and meet confidentiality and GDPR requirements. Action was later supported by council members at a senior level.

Lessons to be learnt/what can you do to avoid this happening?

- Ensure appropriate 'Archiving Protocol & Procedure' guidance is in place and being adhered to, and that there is good awareness and knowledge about the archiving process at every level
- Accountability and documentation is needed at every point in the archiving process, with clear security levels identified (understood by all handlers)
- Ensure effective communication at every level especially when 'out sourced' or 'external organisation' are third parties
- Fit-for-purpose and appropriate consumables (such as security tags and quality of boxes) should be stipulated in the contract
- Commissioners could utilise 'Contract Management' tools and KPIs to improve standards in the archiving process and confidential requirements accordingly

Outcome

Commissioners of the storage facility have drafted and disseminated an improved 'Protocol and Procedure' to clearly guide the archiving process with sign-off requirements at each stage of the delivery and retrieval process. This has been fully supported by the storage company and will be put to the test later in the year by this office.

The sexual health archiving spread sheet, with comprehensive headings designed to fully record and able to trace every NCSP document and inclusive of specific destructions dates, is being adopted by the whole council as best practice.

Council auditors have commenced a comprehensive audit of all historical council records currently stored with the company, many without clear ownership or destruction dates that would meet GDPR legal requirements. Destruction dates will be appointed according to the type of record archived, and a more efficient, accountable and consistent archiving process is to be implemented from now on.