NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Information Governance Handbook

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1	Review and update to include GDPR/DPA18 changes and separate out some sections to the Staff Code of Conduct		IG Team	13/06/2018
2	Minor Amendments		IG Team	09/07/2018
3	Replace reference to LMS with ESR Removal of DPA1998 from Glossary Removal of gsi-family email domain names as no longer in use Removal of Safe haven fax procedures		IG Business Partner for Herefordshire and Worcestershire CCG	11/03/2020
3.1	Amended to ensure reference to one CCG and not the pre-merger CCGs, also some quick formatting changes	To ensure aligns to the current legal entity of the CCG	IG Business Partner for Herefordshire and Worcestershire CCG	14/05/2021

Glossary of Terms

Term	Acronym	Definition
Anonymisation		It is the process of either encrypting or removing personally identifiable information from data sets, so that the people whom the data describes remain anonymous.
Business Continuity Plans	BCP	Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable defined level.
Caldicott Guardian	CG	A senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing.
CareCERT		NHS Digital has developed a Care Computer Emergency Response Team (**CareCERT**). CareCERT will offer advice and guidance to support health and social care organisations to respond effectively and safely to cyber security threats.
Clinical Commissioning Group	CCG	They are responsible for commissioning healthcare services in both community and hospital settings.
Commissioning Support Unit	CSU	A Commissioning Support Unit (CSU) is an Organisation. Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners, for example by providing: Business intelligence services.
Code of Conduct		A set of rules to guide behaviour and decisions in a specified situation
Continuing Healthcare	CHC	CHC is health care provided over an extended period of time for people with long-term needs or disability / people's care needs after hospital treatment has finished
Common Law		The law derived from decisions of the courts, rather than Acts of Parliament or other legislation.
Care Quality Commission	CQC	This is an organisation funded by the Government to check all hospitals and Primary Care in England to make sure they are meeting government standards and to share their findings with the public.

Term	Acronym	Definition
Data Controller		The natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data.
Data Processor		A natural or legal person, public authority, agency or other body which processes personal data on behalf of the controller.
Data Protection Act 2018	DPA18	Act replaced DPA 1998 above
Data Protection Impact Assessment	DPIA	A method of identifying and addressing privacy risks in compliance with GDPR requirements.
Data Protection Officer	DPO	A role with responsible for enabling compliance with data protection legislation and playing a key role in fostering a data protection culture and helps implement essential elements of data protection legislation
Data Security and Protection Toolkit	DSP Toolkit	From April 2018, the DSP Toolkit replaced the Information Governance (IG) Toolkit as the standard for cyber and data security for healthcare organisations
Data Sharing Agreement		A legal contract outlining the information that parties agree to share and the terms under which the sharing will take place.
Freedom of Information Act 2000	FOI	The Freedom of Information Act 2000 provides public access to information held by public authorities
General Data Protection Regulation	GDPR	The General Data Protection Regulation (GDPR), agreed upon by the European Parliament and Council in April 2016, will replace the Data Protection Directive 95/46/etc in Spring 2018 as the primary law regulating how companies protect EU citizens' personal data.
Information Asset Owner	IAO	Information Asset Owners are directly accountable to the SIRO and must provide assurance that information risk is being managed effectively in respect of the information assets that they ‘own’.
Information Assets		Includes operating systems, infrastructure, business applications, off-the-shelf products, services, and user-developed applications
Information Commissioner’s Office	ICO	The Information Commissioner's Office (ICO) upholds information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

Term	Acronym	Definition
Individual Funding Requests	IFR	Application to fund treatment or service not routinely offered by NHS
Key Performance Indicators	KPI's	Targets which performance can be tracked against
Pseudonymisation		The processing of personal data in such a manner that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person.
Record Lifecycle		Records lifecycle in records management refers to the stages of a records "life span": from its creation to its preservation (in an archives) or disposal.
Senior Information Risk Owner	SIRO	Governing Body member with overall responsibility for: • The Information Governance policy • Providing independent senior governing body level accountability and assurance that information risks are addressed • Ensuring that information risks are treated as a priority for business outcomes • Playing a vital role in getting the institution to recognise the value of its information, enabling its optimal effective use.
Subject Access Request	SAR	A subject access request (SAR) is simply a written request made by or on behalf of an individual for the information which he or she is entitled to ask for under the Data Protection Act.

Contents

Information Governance – Top Do's and Do Not's

Do's

- Do familiarise yourself with information governance policies and the contents of this Handbook.
- Do seek advice and guidance if you are unsure at any time with regards confidentiality, privacy or security of personal information.
- Do report anything suspicious.
- Do safeguard the confidentiality of all person identifiable or confidential information.
- Do clear your desk of confidential information at the end of each day.
- Do lock your computer screen if you leave your desk for any length of time (Ctrl, Alt, Delete and Enter or Windows key and L)
- Do ensure that you cannot be overheard when discussing confidential matters.
- Do share only the minimum information necessary.
- Do transfer person identifiable or confidential information securely when necessary i.e. use an nhs.net email account to send confidential information to another nhs.net email account or to a secure government domain e.g. gov.uk or use the encryption facility on nhs.net
- Do use email 'cc' or 'bcc' with care
- Do report any actual or suspected breaches of confidentiality or loss of information/data. Use your organisation incident reporting process or via your line manager
- Do maintain your annual information governance training.
- Do ensure confidential information is disposed of correctly

Do Not

- Do not share login or passwords or leave them lying around for others to see.
- Do not share person identifiable information unless there are statutory grounds to do so.
- Do not use person identifiable information unless absolutely necessary.
- Do not collect, hold, or process more information than you need, and do not keep it for longer than necessary.
- Do not discuss sensitive information in public
- Do not download from doubtful sources
- Do not use illegal software
- Do not leave sensitive information lying around
- Do not plug in USB such as Data/Memory Sticks or other devices without permission from IT
- Do not open suspicious emails
- Do not open attachments in an e mail if you are unsure where they have been sent from. Forward the e mail to your IT helpdesk and ask them to open it
- Do not have white boards etc. with personal / corporate information in view by general public

Introduction

This handbook is intended to provide information to support and assist staff in meeting their obligations regarding good Information Governance and should be read in conjunction with the new Information Governance Code of Conduct and Information Governance & Data Security and Protection Policies.

Information Governance (IG) is the practice used by all organisations to ensure that information/data is efficiently managed and that appropriate policies, system processes and effective management accountability provides a robust governance framework for safeguarding information.

IG enables organisations to embed policies and processes to ensure that personal and sensitive information is:

- Held securely and confidentially.
- Obtained fairly and efficiently.
- Recorded accurately and reliably.
- Used effectively and ethically.
- Shared appropriately and lawfully.

NHS organisations hold large amounts of personal, personal confidential and sensitive information. All staff should be able to provide assurance that IG standards are incorporated within their working practices.

Personal and sensitive information can be contained within a variety of documents. For example:

- Health Records.
- Staff Information.
- Corporate Information.
- Commissioning Information.

Although this handbook provides overarching support to all staff working for the CCG, the CCG acknowledges that in some circumstances, there is a requirement for team specific Standard Operation Procedures (SOPs) to be developed to support the processes outlined in this handbook.

These will include, but not be limited to:

- Team retention periods for the records processed within that team
- Procedures to ensure data quality – the identification and management of data errors
- Individual rights – to ensure that where an individual exercises one of their rights, the request can be actioned

Legislation and Regulations

All staff should be aware of the legislation surrounding Information Governance that stipulate how organisations should safeguard information, what processes are in place to use, secure

and transfer information and also how patients and members of public have access to personal/business information.

Organisations must comply with the following:

- General Data Protection Regulations (GDPR) 2016
- Data Protection Act (DPA) 2018
- Freedom of Information Act 2000
- Privacy and Electronic Communications Regulations 2003-17
- Environmental Information Regulations 2004
- Health and Social Care Act 2012
- Common Law Duty of Confidentiality
- Access to Health Records Act 1990
- Human Rights Act 1998
- Public Records Act 1958
- Computer Misuse Act 1990

The Information Commissioners Office (ICO) is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

Principles of the new General Data Protection Regulation/Data Protection Act 2018:

- **Lawful, fair and transparent processing** – this principle emphasises transparency for all EU data subjects. When the data is collected, it must be clear as to why that data is being collected and how the data will be used.
- **Purpose limitation** – this principle means that organisations need to have a lawful and legitimate purpose for processing the information in the first place.
- **Data minimisation** – this principle instructs organisations to ensure the data they capture is adequate, relevant and limited.
- **Accurate and up-to-date processing** – this principle requires data controllers to make sure information remains accurate, valid and fit for purpose.
- **Limitation of storage in the form that permits identification** – this principle discourages unnecessary data redundancy and replication. It limits how the data is stored and moved, how long the data is stored, and requires the understanding of how the data subject would be identified if the data records were to be breached.

- **Integrity, Confidential and Secure** – this principle protects the integrity and privacy of data by making sure it is secure (which extends to IT systems, paper records and physical security).

GDPR also requires that:

- **Accountability and liability** – this principle ensures that organisations can demonstrate compliance.

Appointment of Data Protection Officer

Under GDPR/DPA18 the appointment of a Data Protection Officers (DPO's) is mandatory. It is especially important for health organisations which will be processing personal and sensitive information on a daily basis.

(More details about the GDPR/DPA18 principles can be found in the Information Governance Policy)

Caldicott Guardian Principles

All NHS employees must be aware of the seven Caldicott Principles which apply to both patient and staff data.

Previous Caldicott reviews have made recommendations aimed at improving the way the NHS uses and protects confidential information.

Principle 1: Justify the purpose - Why is the information needed

Principle 2: Don't use patient identifiable information unless absolutely necessary – Can the task be carried out without identifiable information?

Principle 3: Use the minimum necessary personal identifiable information – Can the task be carried out with less information?

Principle 4: Access to patient identifiable information should be restricted to required/relevant personnel.

Principle 5: Everyone with access to patient identifiable information should be aware of their responsibilities – *Lack of knowledge is not acceptable*

Principle 6: Understand and comply with the law.

Principle 7: The duty to share information can be as important as the duty to protect patient confidentiality

Confidentiality

Everyone working in or for the NHS has the responsibility to use personal data in a secure and confidential way. Staff who have access to information about individuals (whether patients, staff or others) need to use it effectively, whilst maintaining appropriate levels of confidentiality.

This handbook sets out the key principles and main 'do's and don'ts' that everyone should follow to achieve this for both electronic and paper records.

The common law of duty of confidentiality requires that information that has been provided in confidence may be disclosed only for the purposes that the subject has been informed about and has consented to, unless there is a statutory or court order requirement to do otherwise. Personal data is data which relates to a living individual who can be identified from that data or from data and other information which in in the possession of or is likely to come into the possession of the data controller (e.g. the CCG).

Such person-identifiable information may be manually held or automated and includes for example, the contents of filing cabinets, all patient information, including medical records, photographs, x-rays, and other images, computer disks, tapes, CD ROMs etc.

Personnel records include those held by line managers, as well as those held centrally by personnel departments.

The use of all such personal data is controlled by the new GDPR/DPA18 principles above.

Summary of key roles and responsibilities

Senior Information Risk Owner

The Senior Information Risk Owner is an executive Board member with allocated lead responsibility for the organisation's information risks and provides the focus for management of information risk at Board level. The CCG has nominated Mike Emery, Director of Digital Strategy and Infrastructure as the SIRO.

Information Asset Owners

The SIRO is supported by Information Asset Owners (IAOs) whose role is to understand what information is held, what is added and what is removed, who has access and why in their own area.

Caldicott Guardian

The Caldicott Guardian is the person with overall responsibility for protecting the confidentiality of personal confidential data (PCD) and for ensuring it is shared appropriately and in a secure manner. The CCG has nominated Mari Gay, Managing Director as the Caldicott Guardian.

Data Protection Officer

The Data Protection Officer is a role mandated by new Data Protection Act 2018 and is involved in all issues which relate to the protection of personal data. The CCG has nominated Hayley Gidman, MLCSU as the Data Protection Officer.

Information Governance Team

The Information Governance Team are responsible for ensuring that the Information Governance programme is implemented throughout the organisation. Please contact the team at the following email address: mlcsu.ig@nhs.net

The Information Governance Team is also responsible for:

- The completion and annual submission of the Data Security and Protection Toolkit requirements
- Support in investigating Serious Incidents Requiring Investigation (SIRIs),

- Offering advice and ensure the organisation complies with legislation, policies and protocols.
- Provide local IG training either face to face or by monitoring staff use of the IG Training Tool.

Premises Security

ID Badges

All staff should wear their ID badge at all times whilst on the organisations premises or when representing the organisation. ID badges are personal to the user and should not be passed to unauthorised personnel or loaned to other members of staff.

Managers should ensure that any member of staff, whether permanent or temporary, hand in their ID badge on their last day of employment.

The loss of an ID badge should be reported immediately to your line manager and an incident logged, although please note that this would not be an IG breach as it is not a breach of data protection or confidentiality.

Access Control

It is essential that access is tightly controlled throughout the organisation's premises. Where possible all access to work areas should be restricted.

Visitors should be asked to report to a reception where they will be asked to sign the visitors book recording their name, business, the person they are visiting, time of arrival and departure and then be met by the person who has invited them. Where at all possible, visitors should make appointments in advance and "cold calling" should be strongly discouraged. At the end of the meeting, the visitor will be escorted back to the reception area to sign out prior to departure.

Members of staff who require access through any door which is controlled via digital door locks or proximity access systems, will be issued with the appropriate code numbers or personal fobs/cards to ensure the security of the area is maintained at the highest level. Code numbers must be kept secure and must never be given to visitors. Such doors should never be latched or wedged open.

Staff should not release any door with controlled access without first checking the identity of the person seeking entry.

Where entry to a working area is by coded access, these codes must be changed on a regular basis or whenever it is felt that the code may have become compromised.

Staff should also be aware of other persons "tailgating", i.e. attempting to gain access to a controlled access area by closely following them as they enter. If the person is not recognised as a member of staff, or authorised visitor, he/she should be asked to:

- Wait at the door or in a designated waiting area;
- Give details of the person, with whom they have an appointment;
- Await the arrival of an identified member of staff to escort them into the controlled access area;

- At the end of the appointment / meeting the visitor should be escorted out of the controlled access area.

Staff are expected to challenge anyone found in non-public areas not displaying a name badge, firstly to ensure that they have a legitimate reason for being there and secondly to remind them of the organisations expectations with regard to use of identity badges.

Clear Screen & Clear Desk

Clear Screen

- Laptops, PCs and mobile devices should be locked when they are not in use regardless of how long they will be left unattended (i.e. to go to the toilet or to speak to a colleague at their desk, etc.). For Windows based systems, this can be completed by pressing **Ctrl** – **Alt** – **Delete** and then **ENTER** or holding the **Windows Key** and pressing **L**.

- On the occasions when there is a genuine mistake and screens are not locked, the password protected screensaver will launch after 7 minutes idle time. This should however only be used as a 'back up' for when the screen is not locked.

- You should always shut down your PC/laptop when leaving the office for the day. This enables any security and system updates to be rolled out and installed when the device is restarted.

- Computer and laptop screens should always be angled away from the view of unauthorised persons, being mindful of where they are positioned in relation to walkways and windows.

Clear Desk

- Where practically possible all confidential papers and removable media, including laptops etc. should be stored in suitable locked cabinets or other forms of security furniture when they are not in use, especially outside of working hours.

- Staff who are required to attend meetings or leave their desks unoccupied for any amount of time should remove any confidential information from their desks.

- Where lockable filing cabinets, drawers, cupboards etc. are not available, office/room doors must be locked if left unattended. At the end of each day all sensitive information should be removed from the workplace and stored in a locked area. This

  includes all person identifiable information, as well as business confidential information such as salaries and contracts.

- Staff should also be aware that information left on desks is more likely to be damaged or destroyed in a disaster such as fire, flood, etc.

Any visitor, appointment or message books should be stored in a locked area when they are not in use.

Information Governance Induction for New Starters

It is vitally important that all new staff are made aware of the CCG's Information Governance requirements at the earliest opportunity and clear guidance is given about their own individual responsibilities for compliance. Particular emphasis must be placed on how IG requirements affect their day to day work practices. It is equally imperative that IG remains embedded with each individual throughout their daily working practices.

To facilitate this, the IG team will provide an IG induction to all new starters within the 1st month of employment which can be arranged by contacting mlcsu.ig@nhs.net or 01782 872648

In addition to this, all staff are mandated to undertake the Data Security Awareness Induction e-learning module within their 1st year of employment. The Data Security Awareness Induction module is available on the Electronic Staff Record (ESR).

Annual Information Governance Training

All staff are mandated to complete annual IG training. The training is provided by the CSU IG team, either via face to face training sessions or through an equivalent e-learning module.

Dates for face to face sessions and the e-learning module are both available on the Electronic Staff Record (ESR). If you or your line manager feels that you require further IG training, e.g. for IAO or IAA roles, please contact the Information Governance team for advice.

Individual's Rights

Individuals legally have rights in relation to the data that is processed about them. The CCG must have processes in place should an individual choose to exercise any of their rights. It is vital that all staff can recognise such requests to allow them to be processed within the timescales set out in law.

The right to be informed

The CCG has a privacy notice which is available primarily through its public facing website. The purpose of the privacy notice is to inform the public about the collection and use of their personal data. All CCG staff need to be aware of this notice and be able to direct individuals both to the notice and to where they can contact if they have any queries or concerns, usually the Data Protection Officer.

In addition to the privacy notice, the CCG will also provide individuals with more specific information at the time personal data is collected from them, for example when an application of Continuing Healthcare is made, a complaint is made, or an individual signs up to be part of an engagement group. As it will vary as to when further information will need to be provided to individuals, the CSU IG team should always be consulted to determine what is required in each circumstance

Alongside this, the CCG also has an internal privacy notice which explains to CCG employees how the CCG processes their data. The notice is available on the staff intranet.

The right of access

Individuals, including staff, have the right to ask the CCG for confirmation of whether they process data about them, and if the CCG does, to have access to that data so the individual is aware and can verify the lawfulness of the processing.

This is called a Subject Access Request and the process around this is detailed further on in this handbook.

The right to rectification

If personal data that the CCG holds is found to be inaccurate or incomplete, individuals have the right to have it rectified. This includes any data that the CCG may have passed on to others, unless this proves impossible or involves disproportionate effort. If this is the case, the CCG will explain to the individual why this has not been possible.

The individual can make a request for rectification either verbally or in writing and the CCG has one calendar month to respond to such requests.

Should such a request be received, the CSU IG team should be contacted in the first instance. The CSU IG team will then ensure that the CCG's Data Protection Officer is made aware of the request, make sure that the request is recorded and support the CCG to acknowledge and then consider the request. If it is determined that rectification is required, the CCG must ensure that any recipients of the data that is to be rectified are informed that the data has been shared with them needs to be amended.

The right to rectification is not an absolute right. Requests deemed to be unfounded, excessive or repetitive in nature can be refused. Additionally, If the records in question need to be maintained for the purposes of evidence (such as information relating to a potential safeguarding concern) requests may also be refused.

The CCG does not have overarching processes for rectification of data as this will vary in each circumstance such a request is made and also depending on how the data to be rectified is held. Therefore, each request will be considered and acted upon on a case by case basis, with procedures in place within the teams holding data to which this right may apply.

The right to erasure

The right to erasure is also known as 'the right to be forgotten' and means that individuals have the right to have personal data that the CCG holds about them erased and to prevent processing in specific circumstances:

- Where the personal data is no longer necessary in relation to the purpose for which it was originally collected/processed.
- If the individual withdraws their consent for the CCG to process their data (if this was the basis on which it was collected).
- The personal data was unlawfully processed (i.e. a breach of UK data protection laws).
- The personal data has to be erased in order to comply with a legal obligation.

However, if the CCG have collected and are processing data about you to comply with a legal obligation for the performance of a public interest task or exercise of official authority,

i.e. because the CCG has a legal duty to do so in their functioning as a CCG, or because the processing is necessary for the provision of health or social care/ for the management of health or social care systems or services, then the right to erasure does not apply.

Requests for erasure can be made both verbally or in writing and the CCG has one calendar month to respond to such requests.

Should such a request be received, the CSU IG team should be contacted in the first instance. The CSU IG team will then ensure that the CCG's Data Protection Officer is made aware of the request, make sure that the request is recorded and support the CCG to acknowledge and then consider the request. If it is determined that data should be erased is required, as in some circumstances such a request can be refused, the CCG must ensure that any recipients of the data that is to be erased are informed that the data has been shared with them will also need to be erased.

The CCG does not have specific processes for erasure of data as this will vary in each circumstance such a request is made and depending on how the data to be erased is held. Therefore, each request will be considered and acted upon on a case by case basis, with procedures in place within the teams holding data to which this right may apply.

The right to restrict processing

This right means that individuals have the right to 'block' or suppress processing of their personal data which means that if they exercise this right, the CCG can still store their data but not to further process it and will retain just enough information about the individual to ensure that the restriction is respected in future.

Individuals can ask us the CCG to restrict the processing of their personal data in the following circumstances:

- If they contest the accuracy of the data the CCG hold about them, the CCG will restrict the processing until the accuracy of the data has been verified;
- If the CCG are processing the individual's data as it is necessary for the performance of a public interest task and the individual has objected to the processing, the CCG will restrict processing while they consider whether their legitimate grounds for processing are overriding.;
- If the processing of the individual's personal data is found to be unlawful but they oppose erasure and request restriction instead; or
- If the CCG no longer need the data held about the individual, but the individual requires the data to establish, exercise or defend a legal claim.

There are a number of different methods that could be used to restrict data, such as:

- temporarily moving the data to another processing system;
- making the data unavailable to users; or
- temporarily removing published data from a website.

Requests for restriction can be made both verbally or in writing and the CCG has one calendar month to respond to such requests.
As there are close links between this right and the right to rectification and the right to object, as a matter of good practice, the CCG should automatically restrict processing whilst requests to exercise those rights are considered.

Should such a request be received, the CSU IG team should be contacted in the first instance. The CSU IG team will then ensure that the CCG's Data Protection Officer is made aware of the request, make sure that the request is recorded and support the CCG to acknowledge and then consider the request.

If the CCG have disclosed the personal data in question to others, the CCG will contact each recipient and inform them of the restriction on the processing of the personal data - unless this proves impossible or involves disproportionate effort. If asked to, the CCG will also inform the individual about these recipients.

The CCG will inform the individual if it decides to lift a restriction on processing.

The CCG does not have specific processes for restriction of data as this will vary in each circumstance such a request is made and also depending on how the data to be restricted is held. Therefore, each request will be considered and acted upon on a case by case basis, with procedures in place within the teams holding data to which this right may apply.

The right to data portability

The right to data portability allows the individual to obtain and reuse personal data they have provided to the CCG for their own purposes across different services. It allows them to move, copy or transfer personal data easily from one IT environment to another in a safe and secure way, without hindrance to usability.

It does however only apply where the CCG are processing the personal data based on the individual's consent to do so, for the performance of a contract or where the processing is carried out by automated means. This means that currently, the CCG holds very limited data which would be subject to the right to data portability.

Requests for data portability can be made both verbally or in writing and the CCG has one calendar month to respond to such requests.

Should such a request be received, the CSU IG team should be contacted in the first instance. The CSU IG team will then ensure that the CCG's Data Protection Officer is made aware of the request, make sure that the request is recorded and support the CCG to acknowledge and then consider the request.

The CCG does not have specific processes for data portability as this will vary in each circumstance such a request is made and also depending on how the data is held. Therefore, each request will be considered and acted upon on a case by case basis, with procedures in place within the teams holding data to which this right may apply.

The right to object

Where the CCG necessarily processes personal data for the performance of a task in the public interest/exercise of official authority, the individual has a right to object to the processing. They must have an objection on grounds relating to their particular situation.

If an individual raises an objection, the CCG will no longer process the personal data unless it can demonstrate compelling legitimate grounds for the processing which override the individual's interests, rights and freedoms or the processing is for the establishment, exercise or defence of legal claims.

Objections can be made both verbally or in writing and the CCG has one calendar month to respond to such requests.

Should such a request be received, the CSU IG team should be contacted in the first instance. The CSU IG team will then ensure that the CCG's Data Protection Officer is made aware of the request, make sure that the request is recorded and support the CCG to acknowledge and then consider the request.

The CCG does not have specific processes for objections to processing as this will vary in each circumstance such a request is made and also depending on how the data is held. Therefore, each request will be considered and acted upon on a case by case basis, with procedures in place within the teams holding data to which this right may apply.

Rights in relation to automated decision making and profiling

Automated individual decision-making is a decision made by automated means without any human involvement.

Examples of this include:

- an online decision to award a loan; and
- a recruitment aptitude test which uses pre-programmed algorithms and criteria.

Automated individual decision-making does not have to involve profiling, although it often will do.

Profiling is:

"Any form of automated processing of personal data consisting of the use of personal data to evaluate certain personal aspects relating to a natural person, in particular to analyse or predict aspects concerning that natural person's performance at work, economic situation, health, personal preferences, interests, reliability, behaviour, location or movements."

[GDPR Article 4(4)]

As the CCG does not make any decisions based solely on automated processing, individuals' rights in relation to personal data processed in this way are not applicable.

The right to withdraw consent

Although not specified as an individual right in GDPR, individuals do have the right to withdraw their consent for their data to be processed for any specified purpose. They can withdraw their consent at any time.

Where possible, the CCG will make sure that the individual is able to withdraw their consent using the same method as when they gave it.

If an individual withdraws their consent, the CCG must stop the processing of their data as soon as possible.

Should such a request be received, the CSU IG team should be contacted in the first instance. The CSU IG team will then ensure that the CCG's Data Protection Officer is made aware of the request, make sure that the request is recorded and support the CCG to acknowledge and then consider the request.

The CCG does not have specific processes for requests to withdraw consent as this will vary in each circumstance such a request is made and also depending on how the data is held. Therefore, each request will be considered and acted upon on a case-by-case basis, with procedures in place within the teams holding data to which this right may apply.

Subject Access Requests

Access to Information (Subject Access Requests -SAR)

Every living person (or their authorised representative) has the right to access personal information/records held about them by an organisation. This type of request is known as a Subject Access Request – SAR.

The record can be in manual (paper files) or in computerised form and may include such documentation as handwritten notes, letters, reports, imaging records, photographs, DVD and sound recordings.

To note – Anything documented on a corporate means of communication (work email and Skype accounts, messages, e.g. WhatsApp on a work mobile) is subject to access to information legislation, i.e. SAR and FOI. If it is within scope of any request, it will be considered for release.

All Subject Access Requests must be made in writing. Within all applications for access to records the applicant will need to prove their identity.

Timescales to respond to a SAR

Under GDPR/DPA18 information requested must be provided without delay and at the latest within **one month** of receipt, all requests for access to records should be forwarded to the SAR Team **immediately** - see below.

Fees

Under GDPR/DPA18 all information is to be supplied free of charge (although "reasonable" fees can be charged for an excessive request or for further copies).

Failures to meet requests for information

Failure to comply and provide information requested under GDPR/DPA18 could result in a substantial fine.

The maximum fine that can be issued by the Information Commissioner Office (ICO) is 4% of an organisation's global turnover or 20 million euros, whichever is higher.

Individuals also retain the right to pursue a claim in court.

Recognising a SAR

A SAR must be made in writing; however, the requestor does not need to mention the GDPR or state that they are making a SAR for their request to be valid. They may even refer to other legislation, for example, the Freedom of Information Act 2000, but their request should still be treated according to this policy.

A SAR can be made via any of, but not exclusively, the following methods:

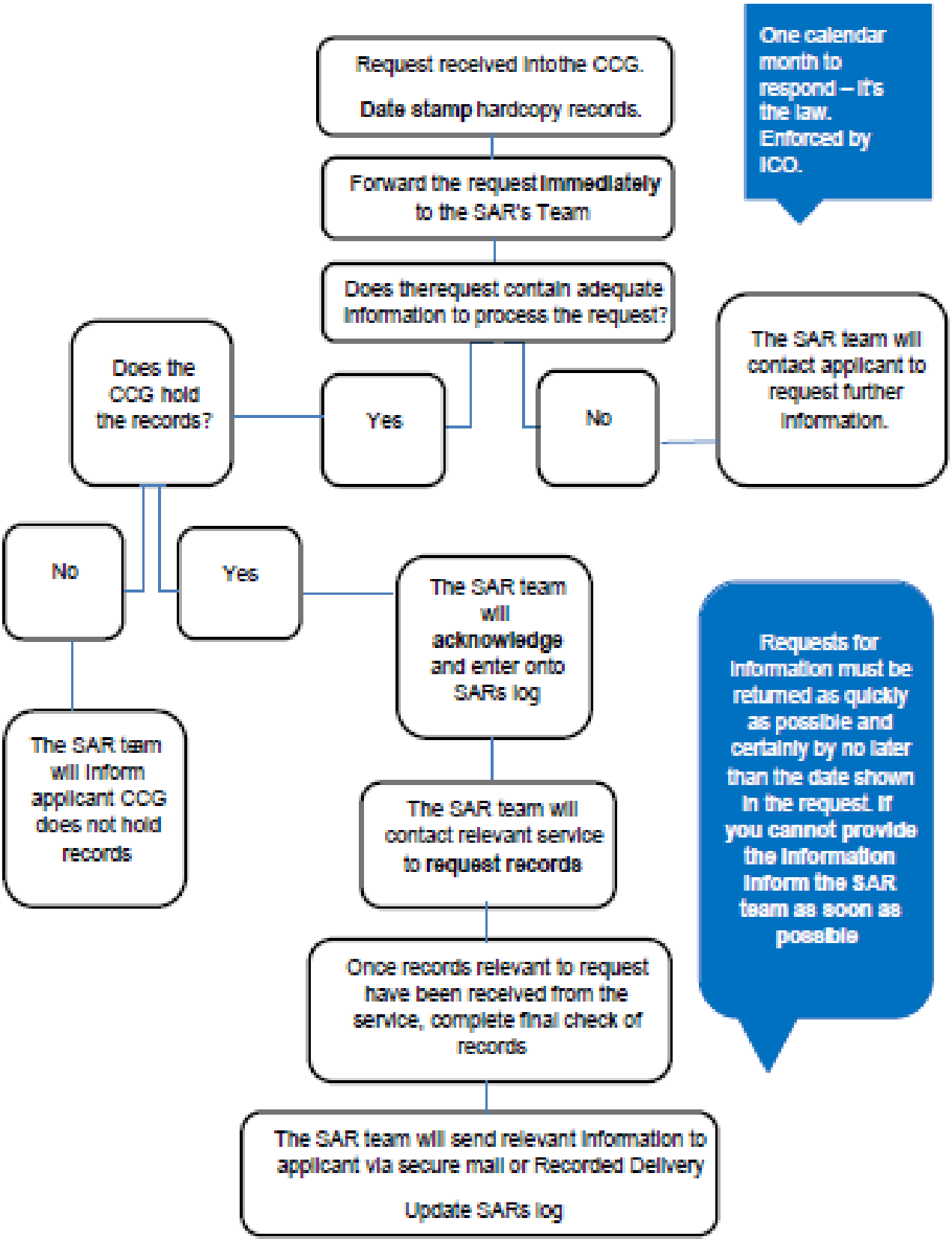
- Email
- Fax
- Post
- Social media
- CCG website

Requests for information held about an individual must be directed immediately to the Midlands and Lancashire CSU Subject Access Request Team:

Midlands and Lancashire CSU
Heron House
120 Grove Road
Stoke On Trent
ST4 4LX

Tel: 01782 872648
Email: mlcsusars@nhs.net

SAR Flowchart



Freedom of Information (FOI)

The Freedom of Information Act (2000) came into effect for all public authorities in January 2005. Since then, all requests for information have had to be answered in accordance with the Freedom of Information (FOI) Act 2000 or the Environmental Information Regulations 2004 (EIR).

The Freedom of Information Act gives a general right of access to all types of recorded information held by public authorities

Who can make a Request?

- Anyone can make a Freedom of Information request – they do not have to be UK citizens or resident in the UK.
- Freedom of Information requests can also be made by organisations, for example a newspaper, a campaign group or a company.
- Employees of a public authority can make requests to their own employer, although good internal communications and staff relations will normally avoid the need for this.

What information is covered by the Act?

- The Act covers all recorded information held by a public authority. It is not limited to official documents and it covers, for example, drafts, emails, notes, recordings of telephone conversations and CCTV recordings. Nor is it limited to information you create, so it also covers, for example, letters you receive from members of the public, although there may be a good reason not to release them.
- Requests are sometimes made for less obvious sources of recorded information, such as the author and date of drafting, found in the properties of a document (sometimes called meta-data). This information is recorded so is covered by the Act and you must consider it for release in the normal way.
- If a member of the public asks for information, you only have to provide information you already have in recorded form. You do not have to create new information or find the answer to a question from staff who may happen to know it (i.e. it's in their head)
- The Act covers information that is held on behalf of a public authority even if it is not held on the authority's premises. For example, you may keep certain records in offsite storage, or you may send out certain types of work to be processed by a contractor.
- Where you subcontract public services to a private company, that company may then hold information on your behalf, depending on the type of information and your contract with them. Some of the information held by the external company may be covered by the Act if you receive a freedom of information request.

What are the CCG's obligations under the Act?

As an organisation, there are two main obligations under the Act. The CCG must:

- publish certain information proactively.
- respond to requests for information where the information is not proactively published.

Making information available is only valuable to the public if they know they can access it, and what is available. The CCG should:

- publicise their commitment to proactive publication and the details of what is available.
- publicise the fact that people can make freedom of information requests to the CCG;
- provide contact details for making a request, including a named contact and phone number for any enquiries about the Act; and
- the CCG should communicate with the public in a range of ways. This is likely to include websites, noticeboards, leaflets, or posters in places where people access CCG's services.

Recognising a FOI request

A request for information under the general rights of access must be:

- received in writing
- state the name of the applicant and an address for correspondence
- clearly describe the information requested

A request can also be made electronically via email.

Timescale for responding

The deadline for a public authority to respond to requests made under the Act is **20 working days.**

The clock starts the next working day after receipt of the request it is therefore vital that all requests are forwarded to the FOI team immediately:
MLCSU.FOITeam@nhs.net

If you are unsure about a request for information, contact the FOI team in the first instance.

Information and Data Security

The contents below are issued for guidance to help staff carry out their roles in a secure and safe way when dealing with personal information.

Registration Authority/Smartcards

Smartcards are required to use and access IT systems essential to healthcare provision.

Primary Care Contractors need to use Smartcards in order to gain access to patient information i.e. those who provide the Choose and Book service and the Electronic Prescription Service.

Individuals are granted access to a Smartcard by the organisation's Registration Authority lead. It is up to the Registration Authority Team to verify the identity of all healthcare staff who need to have access to patient identifiable or sensitive data. Individuals are granted access based on their work and their level of involvement in patient care.

The use of Smartcards leaves an audit trail.

Staff should be aware that disciplinary action may be taken if Smartcards are shared or lost.

Line manager responsibilities

- To identify all roles within their area of responsibility which require access to the system and ensure that all employees, including temporary/agency/bank and locum employees, are provided with appropriate access.
- To ensure for all roles that involve access to the system that job descriptions and any recruitment materials make reference to the need to be registered and the role's responsibilities in relation to using the system.
- To ensure that all new starters within their area of responsibility, including agency/temporary employees, receive training in order to be able to access the system.
- To ensure that all employees are aware of Information Governance policies, associated documentation and their responsibilities in relation to use of and access to the system.
- To immediately inform the Registration Authority Team, of any leavers, starters and staff changes.

Staff smartcard code of practice

- Use your Smartcard responsibly and in line with your access rights.
- Inform the Registration Authority team or the IG team immediately should your Smartcard be lost, stolen or misplaced.
- Ensure that you report any misuse of the Smartcards
- Ensure that you keep your Smartcard and log-in details confidential. In particular you must not leave your PC logged in and you must not share or provide access to your Smartcards or passwords.
- Ensure that you accurately complete the necessary paperwork, provides suitable identification and attends any appropriate appointments in order to register on the system or have your Smartcard updated/re-issued.
- All members of staff using Smartcards should follow the organisation's suite of Information Governance policies and procedures; adhere to the GDPR and Caldicott Principles, and the Confidentiality Code of Practice and the Care Records Guarantee.

TO RAISE ANY SMARTCARD ISSUES PLEASE CONTACT
– worcester.smartcards@nhs.net

Data Security

Without effective security, NHS information assets may become unreliable, may not be accessible when needed, or may be compromised by unauthorised third parties.

Information, whether in paper or electronic form, is of high importance to the CCG, therefore the organisation must ensure that the information is properly protected and is reliably available.

- Access to all confidential or sensitive information whether held on paper or electronically must be restricted.
- Staff must ensure that doors and windows are closed properly, blinds drawn, and that any door entry codes are changed regularly, ideally when a member of staff leaves the team, or it is suspected that someone else knows the code.
- All employees should wear identification badges and where practical should challenge individuals not wearing identification in areas they know are not for public access (see premises security above). Visitors should be met at reception points and accompanied to appropriate member of staff or meeting and also should be asked to sign in and out of the building.
- Employees on termination of employment or contract must surrender door keys, Smartcards and all relevant equipment in compliance with the CCG's leavers' process.
- All computer assets including hardware and software must be recorded on an asset register that details the specification, user and location of the asset.

All staff are responsible for ensuring that no actual or potential security breaches occur as a result of their actions. The organisation will investigate all suspected and actual security breaches.

Remote working and portable devices

The developments with information technology have enabled staff to adapt to more flexible and effective working practices, by providing mobile computing and portable devices.

Although these working practices are advantageous, it is important for all staff to understand the associated risks to the information, and the responsibility to ensure that information accessed remotely or held on portable devices, is protected by adequate security.

It is important for staff to protect information which is processed remotely or is stored on portable devices and staff should read relevant policies to ensure good practice.

Staff are responsible for the security of any portable devices issued to them, and should take all necessary precautions to avoid loss, theft or damage. In the event of loss, damage or theft occurring, they must report this immediately to their line manager and ICT service desk.

Remote working and portable devices best practice guidance:

- Encryption is mandatory in all mobile devices used to store identifiable data.
- Any portable computing device must not be left unattended in a public place or left in vehicles either on view, unattended or overnight. When transporting it, ensure that it is safely stored out of sight.
- Staff should take extra vigilance if using any portable computing device during journeys on public transport to avoid the risk of theft of the device or unauthorised

disclosure of the organisation's stored information by a third party "overlooking". There are security measures which can be deployed to support this if such travel is common to the role, staff should enquire through their line managers.

- Staff should not leave the device unattended for any reason unless the session is "locked" and it is in a safe working place, devices should not be left in an unattended publicly accessible room for example. If possible, staff should take the device with them.
- Ensure that other 'non' authorised users are not given access to the device or the data it contains.

Passwords and PIN codes

- Passwords should be a combination of letters and digits of a pre-determined length and combination of characters, typically using the lower case of the keyboard.
- Passwords and/or PINs should not normally be written down, but if unavoidable, should be held on your secure drive in a passwords folder and never kept with the device or in an easily recognisable form.

Portable computing devices

- Sensitive corporate and PCD must not be stored or transferred using any unencrypted "USB Memory" device.
- Where it is not possible to encrypt sensitive/personal information, the advice of the IG team should be sought and, a one-off data transfer solution should be found using a secure method.
- Portable devices should only be used to transport confidential or sensitive information when other more secure methods are not available.
- Information should not be stored permanently on portable devices. Always transfer documents back to their normal storage area as soon as possible.
- Staff must ensure that any suspected or actual breaches of security are reported to their line manager.
- Staff must ensure that the mobile devices are used appropriately at all times.
- Staff should not under any circumstances use any mobile device whilst in control of a vehicle.
- All staff should be aware of their surroundings when using a mobile device, especially when discussing confidential information.

Network and Corporate Shared Drive Access

Obtaining a Network Account

It is NHS policy that all staff should have access to email. To use email, you require a network account. You also require an account to access the shared network drives.

Managers should contact the Corporate Services & Project Manager on 01527 482907 to request a new network account to be setup.

It is the user's responsibility to chase the IT Service to ensure that their network account is created in a timely manner. Please note that under no circumstances should another person's account be used in the interim if your account has not yet been set up.

Role Based Access

- Users will only be granted access to data and information that it is required as part of their job. Access is therefore granted on a 'need to know' basis.
- Access authorisation should be regularly reviewed, particularly when staff roles and responsibilities change. This is the responsibility of line managers.
- Staff must not access computer systems or data unless they have authority to do so. Access to files which are not in the course of the employee's duty will be considered a disciplinary offence. For example, accessing a friend or relative's manual or electronic file. This may also be deemed a breach of the Computer Misuse Act 1990 and GDPR/DPA18.
- Access should be requested via your line manager.

Third Party Access to Network

Third parties will not be given access to the organisations systems or networks unless they have formal authorisation to do so. All non-NHS companies will be required to sign security and confidentiality agreements with the organisation.

Where the third party has access to NHS patients and/or to their information; is providing support services directly to an NHS organisation; and/or has access to national systems and services, including HSCN, Choose and Book etc. they are required to provide IG assurances via the DS&P Toolkit as part of business/service support processes or contractual terms. That is, for these organisations annual SD&P Toolkit assessments are required for either or both of two purposes:

a. To provide IG assurances to the Department of Health or to NHS commissioners of services;

b. To provide IG assurances to NHS Digital as part of the terms and conditions of using national systems and services including HSCN, Choose and Book etc.

Third parties found accessing elements of the system to which they are not authorised will be deemed to have caused a data breach and will be denied access to the network immediately. An incident will be recorded following the organisation's incident reporting process and an investigation will take place to decide the outcome.

Prevention of Misuse

Any use of IT facilities for non-business or unauthorised uses without management approval will be regarded as inappropriate usage.

The Computer Misuse Act 1990 introduced three criminal offences. Staff must remember that the following offences can be enforced in a court of law:

- Unauthorised access
- Unauthorised access with intent to commit further serious offence
- Unauthorised modification of computer material

Software Licensing Procedure

New software, which has not been properly developed and/or properly tested, is a threat to the security of existing data and systems. All software and hardware procurements shall take account of the security requirements recommended by the IG team. Contravention of the recommendations may be considered a disciplinary offence.

Unauthorised Installation of Software

Unauthorised software poses a risk to your computer, other computers and the network as a whole from malicious code embedded within the software. The risk applies to all programs and games downloaded from the Internet, CD/DVD or any other storage media. Malicious code may be computer viruses and spyware, and the effects will vary depending on which has been downloaded.

A second and equally important reason why you should never use unauthorised software is because of licensing issues. The organisation is required to purchase licenses for the use of all software on its systems. If you install software without authorisation this process is bypassed, and you put the organisation at risk of legal action from the owner of the software. If you are installing so-called free software, it could be an illegal copy, or it could be trial software with an expiry date. Even if neither of these things apply, the software is likely to be for single personal use and require a license for corporate use.

It is a breach of security to download files which disable the network, or which have the purpose of compromising the integrity and security of the organisation's networks and/or file servers. To intentionally introduce files which cause damage to computers may result in prosecution under the Computer Misuse Act 1990.

Individual Responsibilities

Individuals must not install software onto an organisation provided desktop, laptop or other mobile device. Doing so constitutes a disciplinary offence. A request for installation should be made to the IT Service.

The IT Service audits all computer equipment including software. If unauthorised software is found on a system or if no license agreement has been purchased, IT Service staff are authorised to remove the software.

Should you suspect the presence of unauthorised software on your system you should report it to the IT Service, who can also advise on the procedure for purchasing software licenses.

It shall also be considered a disciplinary offence to connect any new hardware/equipment to the network without prior approval from your line manager and the IT Service.

Disposal of Equipment and Reuse of Surplus Equipment

Departments should follow a general policy of internal cascading of any surplus equipment within their own area.

Should it not be possible to reuse equipment internally within the organisation, once all information has been removed from any hardware and backed up where necessary, users must request that all hard disks within the hardware are destroyed by the IT service.

This is to ensure that the organisation:

- Complies with obligations under European Environmental Legislation;
- Fulfils its commitment to the Waste Reduction Policy 1996 and Sustainability Policy 2000;
- Meets software license obligations, and;
- Reduces the risk of sensitive data being made available to unauthorised persons.

Internet & Intranet

Permissible Access

Access to the internet is primarily for work or for professional development and training.

Reasonable personal use is permitted during your own time (for example, during your lunch break), provided that this does not interfere with the performance of your duties. Personal access to the internet can be limited or denied by your manager. Staff must act in accordance with their manager's local guidelines. The organisation has the final decision on deciding what constitutes excessive use.

The internet must never be assumed to be secure. Confidential information or data must never be transmitted over the internet unless the data or information is encrypted. Information obtained through the internet may not be accurate, and users must check the accuracy, adequacy or completeness of any such information.

Non-Permissible Access

No member of staff is permitted to access, display or download from internet sites that hold offensive material. To do so may constitute a serious breach of the organisations security and could result in disciplinary action, dismissal and/or criminal prosecution. Offensive material includes hostile text or images relating to gender, ethnicity, race, sex, sexual orientation, religious or political convictions and disability. Users must not create, store or distribute any material that is libellous, blasphemous or defamatory. This list is not exhaustive. Other than instances which demand criminal prosecution, the organisation is the final arbiter on what is or is not offensive material, or what is or is not permissible access to the Internet.

If a web page cannot be accessed, it is possible that the site has been banned and access to the website has been blocked. Sites that are added to this list include ones which contain offensive content i.e. pornographic, terrorist, racist etc. If you require access to a blocked site permission must be gained from your line manager and IT.

Monitoring

You should be aware that a range of monitoring is conducted on internet usage. This indicates time spent on the internet and list of visited websites. Logs of internet usage are used to investigate allegations of misuse.

Unintentional Breaches of Security

If you unintentionally find yourself connected to a site that contains offensive material, you must disconnect from the site immediately and inform your line manager and the IT Service Desk.

Acceptable Use of Social Media & Social Networks

NHS organisations of all types are now making increased use of social media and social networks to engage with their patients, other stakeholders, and to deliver key messages for good healthcare and patient services generally. These online digital interactions are encouraged and their use is likely to be further extended as new communications channels become available. Social media has great potential to help the NHS reach patients and service users that do not engage using traditional communications and engagement channels.

However, the inappropriate or ill-considered use of social media also has the potential to damage both individual's and the NHS' reputation. It is therefore important that staff are aware that there are a number of legal implications associated with the inappropriate use of social media. Liability can arise under the laws of defamation, copyright, discrimination, contract, human rights, protection from harassment, criminal justice act etc. This list is however non-exhaustive.

Social media describes the online tools, websites and services that people use to share content, profiles, opinions, insights, experiences, perspectives and media itself. These tools include social networks, blogs, message boards, podcasts, microblogs, image sharing, social bookmarking, wikis, and vlog's. Internal SharePoint sites also provide social networking capabilities and are included in this procedure. The feature that all these tools, websites and services have in common is that they facilitate conversations and online interactions between groups of people.

It is important that all staff and contractors have a general awareness of the information risks and good practices associated with the protection of sensitive information in social media and other social interaction scenarios.

External social media sites must not be used to exchange any work-related information between colleagues or organisations, for example in place of using email.

The organisation has the right to manage its reputation on all levels, including any employee interaction on social networking sites that could possibly reflect an opinion upon the organisation.

Personal use of social media at the workplace and at home

This section of the procedure provides guidance on the use of social media tools by NHS employees in a personal capacity. For example, this includes a personal profile on Facebook or use of Twitter in a personal capacity by NHS employees.

It is important to remember that adherence to the expectations set out in this handbook applies equally whilst not at work when any inference is made to work, either specifically or indirectly.

All policies apply equally inside and outside of work hours when work related.

Staff or contractors must be aware of their association with the organisation when using social media. If they identify themselves as an employee of a specific NHS organisation, they should ensure that their profile and any related content is consistent with how they would wish to present themselves with colleagues, patients and service users.

Staff or contractors who may not directly identify themselves as an NHS employee when using social media for personal purposes at home, should be aware that content they post on social media websites could still be construed as relevant to their employment at the organisation. For example, employees should not write or report on conversations, meetings or matters that are meant to be private or internal to the organisation.

Unauthorised disclosure of confidential information would constitute misconduct/gross misconduct in accordance with the organisations disciplinary policy. **Employees must not cite or reference patients, service users, partners or providers without their written approval**.

The organisation will not accept liability for any consequences arising out of employee's personal use of social networking sites.

Using social media for professional purposes

This relates to the use of social media tools by NHS employees in the course of carrying out their normal duties in delivering NHS services. For example, this would include using a Facebook page to promote NHS activities and initiatives.

Setting up a unique social media presence for specific service / campaign

This can be used to:

- Enhance engagement with a target audience. This is likely to work best for specific campaigns or issues (e.g. Quit smoking – through privileged access to content and information for 'Facebook friends'; information re: prize draw winners; uploading event photos, etc.)
- Allow service users to share experiences
- Promote specific events via invites and newsfeeds
- Drive traffic to the official website where more information is available
- Send information/support directly to service users mobiles (e.g. via Twitter)

Interacting with existing external social media sites

This can be used to:

- Engage with other service providers – creating a virtual network of relevant professionals to share and disseminate information and good practice and to act as a hub on relevant topics
- Monitor what's being said online about the organisation and its services, and give an authorised user the right-to-reply
- Drive traffic to the organisation's website and social media pages

Departments considering using Social Media

Certain considerations must be made when scoping the use of Social Media.

- Moderating the site must be done on a 365 day basis, in order that any malicious or malevolent comments are removed as soon as possible. This must be undertaken within the department.
- Disclaimers on social media sites do not remove the organisation's obligations to accuracy and implications.
- Comments made to a social network site belonging to the organisation can be disclosed under the Freedom of Information Act 2000.
- When the organisation (or department within the organisation) creates an account on a social networking site such as Twitter or Facebook, the Information Commissioner has dictated that the organisation must be in a position to receive a Freedom of Information/Environmental Information Request via that medium.
- If an FOI or EIR request is received via this medium, you must notify and forward it to the FOI team immediately.

Approval Process for access to Social Media

Any staff member wishing to set up a social media presence OR interact with existing external sites where they are identified as an organisation employee MUST follow the following procedure:

- Obtain approval from relevant Line Manager and Director
- For communications on behalf of the organisation, any other NHS services, or a partnership of which the organisation is a member, a business case should be made which will be considered and referred to directors with recommendations. The Information Governance, Human Resources and Communications team should be consulted during this process.
- For staff or contractors wishing to use an NHS or other professional website or social media tool during working hours to share best practice or seek advice and feedback from other colleagues as part of their role, they should gain the appropriate authorisation from their line manager before proceeding. Line managers unsure of which sites, forums or tools are acceptable for use should speak to the Information Governance team for advice.

General usage guidance

When using social media, employees should respect their audience. As a general rule, employees should be mindful of any detrimental comments made about colleagues whilst using social media. Any conduct which breaches the employee code of conduct such as failing to show dignity at work (harassment), discriminatory language, personal insults, obscenity, and disclosure of confidential information will be considered a disciplinary matter. These examples are not exhaustive.

Staff and contractors should also show proper consideration for others' privacy and for topics that may be considered sensitive or controversial.

Staff and contractors are encouraged not to divulge who their employers are within their personal profile page (e.g. in accordance with RCN guidelines, "RCN Legal Advice on using the internet"). However, those that do divulge their employer should state that they are tweeting/blogging etc. in a personal capacity.

Staff and contractors must not share details of the organisation's implemented security or risk management arrangements. These details are confidential, may be misused and could lead to a serious breach of security.

Staff and contractors are ultimately responsible for their own online behaviour. They must take care to avoid online content or actions that are inaccurate, libellous, defamatory, harassment, threatening or may otherwise be illegal. It is possible for staff or contractors to be subject to civil proceedings or criminal prosecution. Remember; once something is put on a social networking site even if you delete it, there may be a record of it kept indefinitely.

Note: These guidelines apply to all methods of accessing social networks. This includes organisation-owned or personal computers, any mobile devices, etc.

Safe Haven Procedures - Sending Person Confidential Data or Commercially Sensitive data

Safe Haven is a term used to describe either a secure physical location or the agreed set of administrative arrangements that are in place within the organisation to ensure person confidential data (PCD) or commercially sensitive information is communicated safely and securely. It is a safeguard for confidential information which enters or leaves the organisation whether this is by post, fax or other means.

If such information needs to be sent inside or outside of the organisation by post or fax, the Safe Haven procedures outlined in this document must be followed.

The principles can equally be applied to ensure the secure transfer of business confidential information.

Any members of staff handling confidential information, whether paper based or electronic, must adhere to the safe haven principles.
Before sending any PCD or commercially sensitive information, it should be considered whether it would be sufficient to send anonymised or pseudonymised information instead.

Information that is 'lost' or 'missing in transit' in any format should be reported as an incident as detailed in the "Information Governance Incidents" section of this handbook.

Safe Haven Email Procedures

When sending emails containing PCD or commercially sensitive information, the email **must** be sent to and from an nhs.net account, or other nhs.net compatible domain accounts such as:

- Nhs.net
- Gov.uk
- Secure.nhs.uk
- Gov.uk
- Cjsm.net
- Pnn.police.uk
- Mod.uk
- Parliament.uk

Check with your IG Support Officer if you are unsure whether an account is secure if not covered above.

NHS Mail Encryption Facility

NHS.net users can securely share sensitive information with non-accredited or non-secure email services, for example those ending in nhs.uk, Hotmail, Gmail and Yahoo.

The NHS.net encryption feature means that health and social care staff now benefit from a secure service which allows them to communicate across organisation boundaries and industry sectors.

NOTE: It is not possible for anyone other than an NHS.net user to initiate an encrypted email exchange using the NHS mail encryption feature, however by replying to an encrypted email received from an NHS.net email address, the encryption is maintained.

If you have a contact that uses a non-accredited or non-secure email service (e.g. ending .nhs.uk) with whom you need to exchange sensitive information, you will need to send the initial encrypted email that they can then open, read and reply to securely. Guidance on how to do so has been published by NHSmail and can be found at https://portal.nhs.net/Help/policyandguidance

Safe Haven Post Procedures

Important points to note when sending PCD or commercially sensitive information by post:

- **Never** use internal envelopes or previously used envelopes.
- Whether being sent internally or externally, the information must always be tracked.

  When sending externally, it is advised that the information be sent by a tracked delivery method (e.g. recorded delivery or special delivery)

This can be done by using either a tracking system or post book. The following information must be included as a minimum:

- Date the information is being sent
- Method of sending, i.e. internal, signed for, 1st class, etc.
- What information is being sent
- Where the information is being sent to
- Initials of the person responsible for sending the information.
- Request that the recipient confirms receipt.

Internal Post Procedures

When sending PCD or commercially sensitive information in the internal post system the following procedures must be followed at all times:

Secure Bag**:

- Log all items which are being sent, stating where it is going to, date sent; secure bag number and the signature of the person packaging the information.
- Ensure that the secure bag is numbered and the information is placed inside along with a compliment slip or memo, requesting that the recipient calls to confirm receipt.
- Ensure that the contents of the bag are correct before sealing.
- Seal the bag, using an appropriate seal.
- Address the bag to a named individual only (specific job title where not possible), including full postal address. Also include a return address.
- Place into the internal mail ready for sending.
- Request that the recipient confirms receipt.

**Secure bags are the recommended way to send PCD in the internal mail. The secure bags are far more cost effective than standard envelopes and every effort should be made to use this method.

Standard Envelope:

- Log all items which are being sent, stating where it is going to, date sent, and the signature of the person packaging the information.
- Place in a **new** envelope and mark clearly **"Private and Confidential"**.
- Address the envelope to a named individual only (specific job title where not possible) including full postal address. Also include a return address.
- Ensure that the contents of the envelope are correct before sealing.
- Seal the envelope and place Sellotape over the seal. Sign or initial diagonally over the Sellotape so that the writing can be seen either side of the tape was it to be removed.
- Request that the recipient confirms receipt of the letter, either by enclosing a compliment slip or covering note.

External Post Procedures

When sending PCD or commercially sensitive information in the external post, the above "Standard Envelope" procedures must be followed at all times. However, it is strongly advised that **Tamperproof Envelopes** be used rather than a standard envelope.

Safe Haven Telephone Procedures

When sharing PCD or commercially sensitive information over the telephone, the following procedures must be adhered to at all times:

When receiving calls requesting personal information in particular:

- Verify the identity of the caller
- Ask the reason for the request
- Ensure that the caller is entitled to the information that they are requesting – if in doubt, take advice from your manager or the Information Governance Team.
- If speaking to a service user, ask questions that require them to provide information, rather than giving them details which they need to confirm, e.g. ask them for their address, rather than telling them what is on their record and asking if it is correct.
- If you need to pause the call for any reason, remember to use "hold" to ensure the caller can't overhear other confidential conversations that may be going on in the background.
- When calling back, call the main switchboard and ask to be put through. Do not call back to direct numbers or mobile phones.
- Ensure that you cannot be overheard when providing personal information.
- Ensure that you do not leave any person identifiable information on answer machines/voicemail.

Safe Haven Room Requirements

If confidential information is to be received in a specific location:

- It should be to a room/area that is lockable or accessible via a coded key pad known only to authorised staff. The code should be changed regularly or in the case of a suspected or actual breach.
- The room/area should be sited in such a way that only authorised staff can enter that location i.e. it is not an area which is readily accessible to all members of staff working in the same building or office, or to visitors.
- If the room/area is on the ground floor, any windows should have locks on them.
- The room/area should conform to health and safety requirements in terms of fire, flood, theft or environmental damage.
- Manual paper records containing personal information should be stored in locked cabinets when not in use.
- Computers should not be left on view or accessible to unauthorised staff and should have a secure screen saver function and be switched off when not in use.

- Equipment such as fax machines should have a code password and be turned off out of office hours (if possible).

Please contact the Information Governance team for advice on whether a room can be designated as a Safe Haven.

Safe Haven Room Procedures

- A list of staff authorised to enter the Safe Haven room must be maintained. Those staff listed will need to be authorised by the Caldicott Guardian for the organisation.
- Only staff named on the above list should be provided with either the key code, swipe card or key to the Safe Haven room.
- No-one who is not listed should be provided with access to the Safe Haven room, under any circumstances.
- Should anyone be required to have access to the room for either data quality or audit purposes etc., those people should also be approved and included on the list of authorised staff.
- The door to the Safe Haven room should be kept locked at all times, even when the room is in use.
- No person identifiable information should be left in trays or on desks when not in use and should be locked away in suitable storage.
- Any computers within the Safe Haven room should be positioned facing away from the door or any windows. Computer screens should be locked immediately and not wait until the screensaver appears.

Email

Email Retention

There is occasionally a misconception that email messages constitute a short-lived form of communication. All email messages are subject to Data Protection and Freedom of Information legislation and can form part of the corporate record. Emails should be retained in line with the retention schedule set out in the Records Management Code of Practice for Health and Social Care with the retention period being determined by the content/subject of the email.

https://digital.nhs.uk/data-and-information/looking-after-information/data-security-andinformation-governance/codes-of-practice-for-handling-information-in-health-andcare/records-management-code-of-practice-for-health-and-social-care-2016

Emails should not routinely be saved to shared drives or other shared storage areas unless there is a genuine need for the content to be accessible to others, for example if the email contains guidance or instructions that are applicable to a whole team.

Dos and Don'ts of Email

Users may not use the organisations email systems:

- To breach copyright or intellectual property rights of a third party.
- To view, store, download, send, forward or copy inappropriate material. Examples include but are not limited to; obscene or pornographic material, discriminatory material or anything of a criminal nature.
- To send defamatory or libellous messages.
- To breach the GDPR/DPA18
- To forward chain or junk email.

In addition, the use of a non-NHS email account (personal or web mail) is not permitted for the purpose of the organisations business under any circumstances.

Personal use of the organisations email system is not permitted where it substitutes for a webmail system such as Gmail.

The organisation considers email as an important means of communication and recognises the importance of appropriate email content and prompt replies in conveying a professional image and delivering good customer service.

The organisation requires all users to adhere to the following guidelines:

- Write well-structured e-mails;
- Use short, descriptive subjects;
- Signatures must adhere to the corporate standard,
- Do not send unnecessary attachments;
- Before opening email attachments, ensure that you are satisfied of the validity of the sender and the attachment;
- Ensure that the purpose and content of the e-mail message is clearly explained;
- Do not write emails in capitals. This can be considered rude and aggressive;
- Use a spell checker before emails are sent;
- If you require a response by a particular date, make the recipient aware of this deadline;
- Only mark emails as important or high priority if there is a genuine need to;
- Ensure emails are only sent to people who need to see them and only use the reply to all button when absolutely necessary;
- Email should be treated like any other correspondence and should be answered as quickly as possible;
- When on annual leave or away from the office for over one day, the Out of Office facility should be used;
- Ensure that the content is verifiable, evidence based and capable of being subjected to public scrutiny, including applications made under the Freedom of Information Act 2000 and the Data Protection Act 2018;

- Be responsible about your use of email; be aware that the email you send may be forwarded without your prior knowledge or consent, or you may be sending to a recipient who has shared access to their inbox with another member of staff, for example their PA;
- Make a clear distinction between opinion and fact;
- Always check the recipients email address is correct before sending.

Sending emails to mailing/distribution lists

If an email is to be sent to a number of people or to the members of a mailing/distribution list, it may be that the recipients do not (or should not) know who else the email has been sent to, particularly if the recipients include members of the public. Therefore the "BCC" field should be used rather than the "To" or "CC" field to allows the email addresses of the other recipients to be concealed.

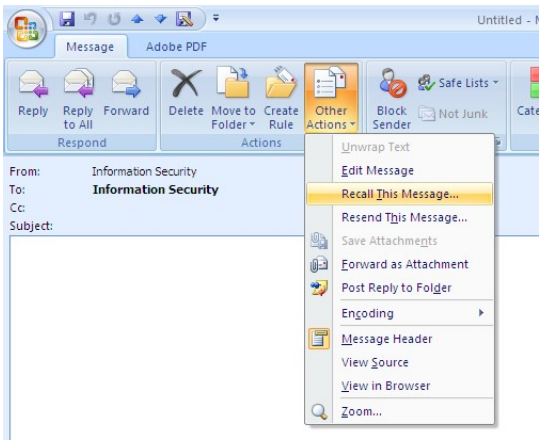
This means that the recipient list of the email cannot be reused, and it reduces the chances that the recipients will receive spam or viruses as a result of having shared their email address with many others.

Alternatively, it may be advisable to set up a distribution list and use the alias rather than including individual names or email addresses in the headers.

Recalling emails

If an email has been sent in error, for example to an incorrect recipient or an attachment has been missed off, it may be possible to recall the email. However, please note that messages must be recalled as soon as possible because this function will not work if the recipient has already read the email. Also, the recipient of the email that you want to recall must also be using an Exchange account, not a webmail account such as Gmail or the recall won't work.

To do this, open the sent email that is to be recalled and select "Recall This Message" from the "Actions" menu. You will then have the option to either delete the message or replace it with a new one.



Monitoring

At the request of the Accountable Officer the IT service may carry out investigations into email usage.

All external emails are routinely virus scanned and where viruses are detected the email is quarantined until clean. If this is impossible then the email administrator will contact the recipient.

Formal complaints about the misuse of email will be investigated and managed according to the organisations existing grievance and disciplinary policies. Inappropriate emails will be automatically blocked for the protection of the organisation and individuals (e.g. spam and adult content).

Section 6 of the Regulation of Interception of Communications & Provision of Communication-Related Information Act of 2002 (RICA) allows companies to monitor and intercept email provided that it takes place “in the course of the carrying on of any business” at the company.

The CCG may therefore open e-mails in an absent employee’s inbox if this is necessary to see whether there are business communications that need to be dealt with in the employee’s absence. However, the company must not open e-mails that in their unopened state appear not to relate to the business (for example e-mails that are marked “personal” in the header) unless there are convincing grounds on which to believe they are in fact business related. This does not prevent an interception which is carried out only to gain access to the contents of business communications, but which may incidentally and unavoidably involve some access to other personal communications on the system.

Due to this Act, should there be a necessity for an employee to use their work email for personal emails, it is recommended that they put 'PERSONAL' in the subject line of the email, for example, or create rules in Outlook that moves all incoming personal messages to a separate folder, therefore meaning that should their emails need to be accessed, for example while they are on leave or off sick, then work emails can be distinguished from personal without actually opening the message.

If work email accounts are used for personal emails, then once the email is on the organisations network, it becomes the responsibility of the organisation to protect it under the GDPR/DPA18.

For this reason, a process has been put in place to ensure that access to staff emails is suitably protected so that the messages can be accessed only with a valid reason. A request for access to another user’s emails should be made through the Information Governance team.

Long Term Absence

If a staff member is on long term absence (more than four weeks), their line manager should, with the help of the IT Service, redirect their email account to someone else within the department to manage the account. The justification of redirecting the messages should be clearly established prior to redirection. The duty of confidentiality should be impressed upon the member of staff who receives the redirected mail.

It must also be ensured that an out of office message is added to the account at the earliest opportunity. It is recommended that it is set up so that an automated response is sent to every email, rather than just the initial email received from a sender.

Shared Email Access

There may be circumstances where there is a requirement, for example, for a PA to access a Director's email account.

Under no circumstances should this be facilitated by the Director sharing their network account password with their PA. Doing so is a breach of policy and must be reported as an incident via the incident reporting process.

Microsoft Outlook provides the facility for a user to share their inbox with other users in the same way as a calendar can be shared. Other items such as contacts or tasks can also be shared in this way.

It should be noted that where access is granted to another user, that user may have access to any private, confidential or sensitive materials associated with the respective user account. As a result, access should ONLY be authorised where this is absolutely necessary for operational purposes (and preferably with the individual's consent). Access can be "tailored" by applying rules within your inbox. For example, a rule could be set up which moves any items received which are marked as confidential to a subfolder rather than leaving them in your main inbox. Please refer to the above section "Monitoring".

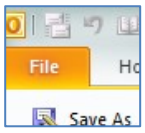
Any person, who is granted access to another user's inbox to fulfil the requirements of their role, should only view the information required to allow them to do so. Users accessing inboxes of other staff are required to treat all material viewed as confidential and not to act upon it or disclose it to any other person except those directly associated with the operational requirement for which the access was granted. They must preserve the confidentiality of any private or personal data that they may view inadvertently whilst undertaking operational matters.

If you need to share your complete inbox, including any sub folders, with another user then this needs to be facilitated by the IT Service and so a call must be logged with your IT Helpdesk. When doing so, please be mindful that this will mean that ALL emails will therefore be accessible to the user with whom you share your inbox.

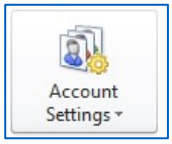
How to share your inbox (Based on Microsoft Outlook 2016):

If you just wish to share your main inbox (and not sub folders) then you can facilitate this yourself by following these steps:

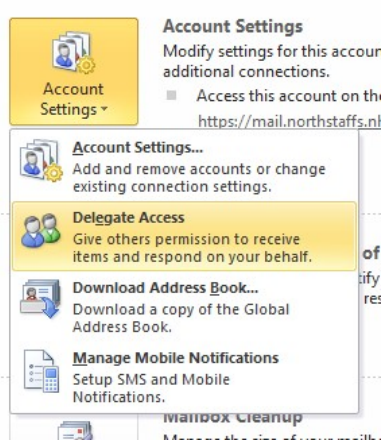
From the File menu in Outlook:



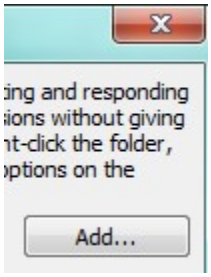
Click on Account Settings:



and then Delegate Access:

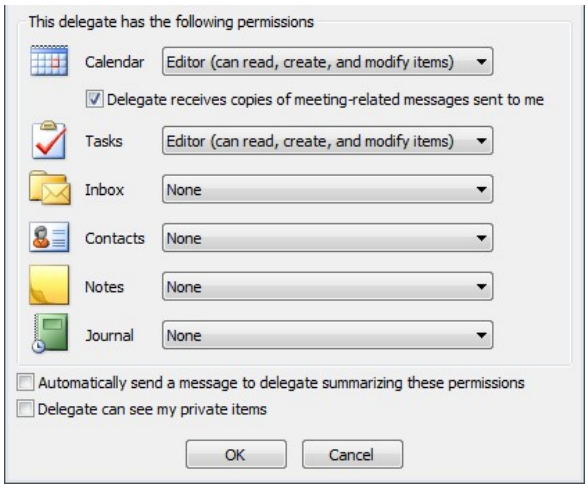


Click on add:



Find the person with whom you wish to share your inbox in the global address list that appears then double click on their name.

The following pop up will then appear

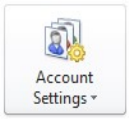


Use the drop down lists and check boxes to set the access permissions you require and then click on OK.

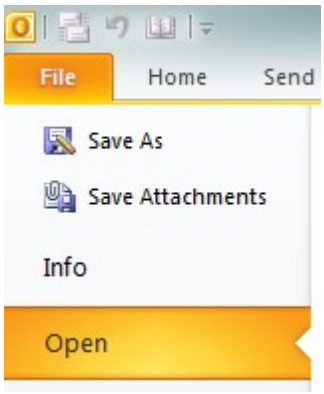
You will then be able to see the person you have just added in your list of delegates.

How to access an inbox which has been shared with you (Based on Microsoft Outlook 2016):

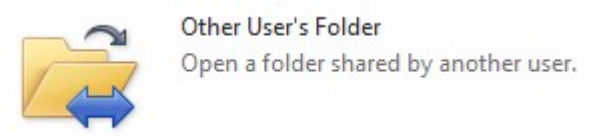
From the File menu in Outlook:



Click on “Open” on the left hand side of the screen:



Click on “Other User’s Folder”:



In the pop up that appears, click on “Name”. This will open the global address list. Find the name of the person who has shared their inbox with you and double click on it.

Click on OK.

The other user’s inbox will then be opened.

If IT have facilitated your access to another user’s full inbox (including subfolders) then the inbox should be displayed as a folder in the left-hand side of your Outlook.

Accessing another user's inbox via the IT Service

If it is not possible or appropriate to request a user share their inbox with you, for example because they are absent from work, have left the organisation or the access is required for a HR investigation, then a request must be made to the IT Service, via the Information Governance team.

Video and Teleconferencing

Video and teleconferencing is becoming a powerful way for colleagues to communicate and collaborate but can be open to abuse both deliberate and accidental as systems are designed to be easy to use with the ensuing security relying more and more on end users than on restrictions built into the software/hardware.

The use of such equipment will also contribute to the organisation's ability to reduce the need for travel.

As this form of communication is two-way technology, equipment should be located and used where there is the least risk of private activities being accidently seen or overheard.

When arranging the meeting, and sending out invites, this guidance should be included to ensure that all participants are aware of and signed up to the following:

- All participants must identify themselves at the beginning of the meeting and when speaking, to ensure that the other participants are aware of the speaker.
- No recording outside of that organised by the Chair shall be made.
- No participants shall be expected to invite others to take part in the meeting/session without the express consent of the Chair.
- Headsets should be worn for all meetings/sessions where participants may be overheard by others, and webcams should be used where they cannot be overseen by others outside of the invited participants.
- Where a participant enters/leaves the session, whilst it is in progress, the Chair must ensure that all participants are aware of the fact, with participants announcing their arrival/leaving with their name and job role etc.
- At the end of the session the Chair must make sure that all participants are aware that the session has concluded, and if a recording is being made that the recording is stopped at this time.

Responsibilities

Chair of Meeting/Session

The Chair is responsible for the overall running of the meeting/session. They must ensure that all participants are introduced at the beginning of the meeting/session, and that they are all able to see and hear each other. The Chair will be responsible for ensuring that reasonable adjustments are put in place where a participant has an access need.

They will be responsible for the facility itself for the duration of the meeting/session, from ensuring all is in order before the meeting, coordinating with IT Technical Staff if required, and ensuring all is in order at the end of the meeting. They are also required to ensure that all participants have signed a “Compliance” statement form before each meeting/session begins.

All participants invited to the meeting/session should be aware as to whether the meeting/session is being recorded or not. They should also ensure that no additional recordings are made by participants themselves.
If the session is recorded, the Chair is responsible for ensuring that all participants have given their consent and that there is a verbatim copy available for all participants if requested.

Meeting/Session Participants

All participants are expected to adhere to this guidance and return the signed Code of Conduct declaration forms that they are given, either at a training session or before their first video or teleconferencing meeting/session.

No additional recordings are to be made without the express permission of the Chair before the meeting/session commences.

They must wear headsets to ensure that other staff may not overhear the conversations, and any webcams used should not be overseen by others where possible.

Training & Implementation

Training on the use of the software/equipment will be provided. Contact can be made via the local IT Service.

All users will need to familiarise themselves with this guidance before access to the systems.

Data Security and Protection Incidents

It is important that information remains safe, secure and confidential at all times.

All staff are encouraged to report all incidents via the Incident Reporting Form as soon as is possible following the identification of the incident.

In addition to the internal reporting of incidents, it is a legal obligation under GDPR/DPA18 to notify personal data breaches to the ICO within 72 hours, unless it is unlikely to result in a risk to the rights and freedoms of an individual.

All health and social care organisations are to use the reporting tool accessed via the new Data Security and Protection Toolkit to report data breaches. This reporting will be undertaken by the Information Governance Team.

What is a data breach?

A **data breach,** as defined under GDPR/DPA18, means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, access to, personal data transmitted, stored or otherwise processed.

(Personal data is defined as: 'any information relating to an identified or identifiable individual)'

What are the types of breaches?

GDPR/DPA18 defines three types of breaches: Confidentiality, Integrity or Availability.

- Confidentiality breach – unauthorised or accidental disclosure of, or access to personal data
- Availability breach – unauthorised or accidental loss of access to, or destruction of, personal data
- Integrity breach – unauthorised or accidental alteration of personal data

When is an incident reportable under GDPR/DPA18

Grading the personal data breach

Any incident must be graded according to the significance of the breach and the likelihood of those serious consequences occurring. The incident must be graded according to the impact on the individual or groups of individuals and not the organisation.

The **significance** is further graded rating the incident of a scale of 1-5. 1 being the lowest and 5 the highest.

The **likelihood** of the consequences occurring are graded on a scale of 1-5, 1 being a non-occurrence and 5 indicating that it has occurred.

Grade the potential significance of the adverse effect on individuals:

No.	Effect	Description
1	No adverse effect	There is absolute certainty that no adverse effect can arise from the breach
2	Potentially some minor adverse effect or any incident involving vulnerable groups even if no adverse effect occurred	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be the cancellation of a procedure but does not involve any additional suffering. It may also include possible inconvenience to those who need the data to do their job.
3	Potentially Some adverse effect	An adverse effect may be release of confidential information into the public domain leading to embarrassment or it prevents someone from doing their job such as a cancelled procedure that has the potential of prolonging

		suffering but does not lead to a decline in health.
4	Potentially Pain and suffering/ financial loss	There has been reported suffering and decline in health arising from the breach or there has been some financial detriment occurred. Loss of bank details leading to loss of funds. There is a loss of employment.
5	Death/ catastrophic event.	A person dies or suffers a catastrophic occurrence

Establish the likelihood that adverse effect has occurred:

No.	Likelihood	Description
1	Not occurred	There is absolute certainty that there can be no adverse effect. This may involve a reputable audit trail or forensic evidence
2	Not likely or any incident involving vulnerable groups even if no adverse effect occurred	In cases where there is no evidence that can prove that no adverse effect has occurred this must be selected.
3	Likely	It is likely that there will be an occurrence of an adverse effect arising from the breach.
4	Highly likely	There is almost certainty that at some point in the future an adverse effect will happen.
5	Occurred	There is a reported occurrence of an adverse effect arising from the breach.

Both the adverse effect and likelihood values form part of the breach assessment grid.

There are a limited number of circumstances where even when an organisation is aware of a breach of personal data there may be containment actions that will remove the need for notification to the ICO but may still need to be recorded as a near miss as it may still constitute a reportable occurrence under the NIS directive.

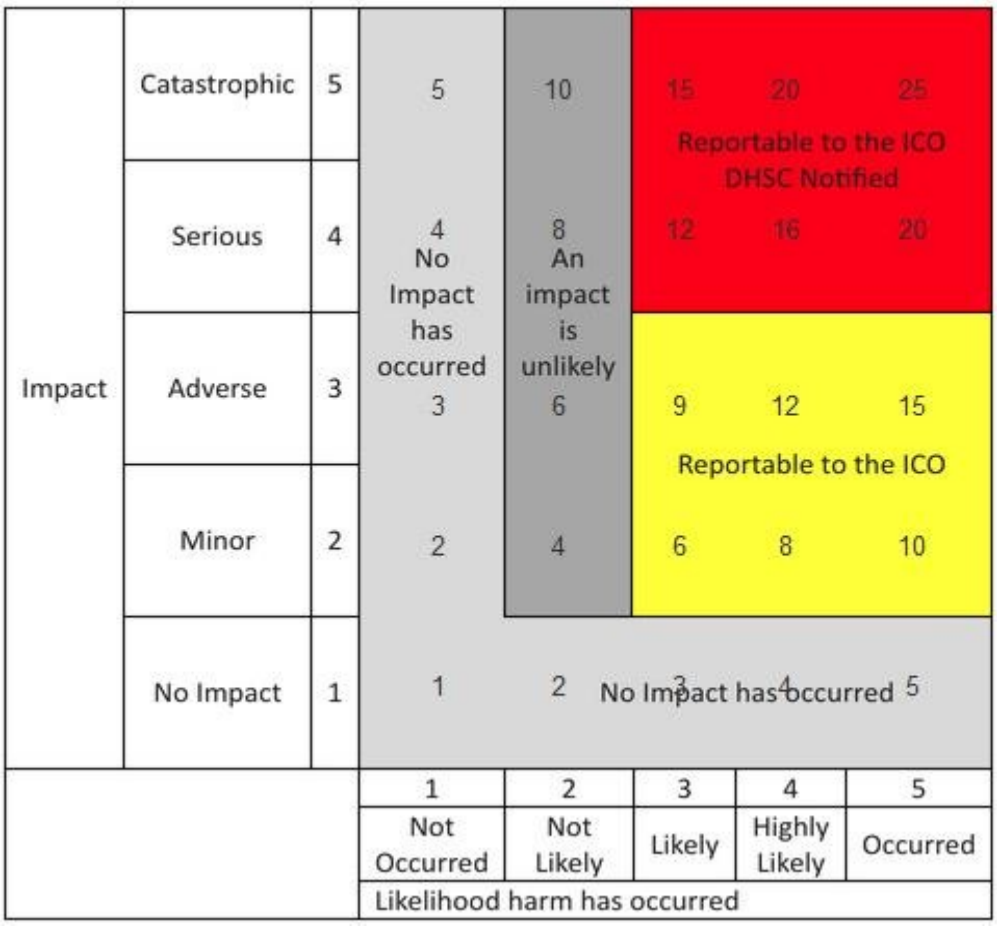
Under the following circumstances notification may not be necessary;

- encryption – Where the personal data is protected by means of encryption.
- ‘trusted’ partner - where the personal data is recovered from a trusted partner organisation.
- cancel the effect of a breach - where the controller is able to null the effect of any personal data breach.

*trusted’ partner – breach contained, sent to wrong department for example, but where recipient may be considered trusted not to read or access data sent in error and to comply with instructions to return it.

Breach Assessment Grid

The operates of a 5 x 5 basis with anything other than “grey breaches” being reportable**.**
Incidents where the grading results is in the red are advised to notify within 24 hours.



Sensitivity Factors

Sensitivity factors have been incorporated into the grading scores and where a non ICO notifiable personal data breach involves one of the following it must still be reported as a level 2 and as such notifiable to the ICO.

If a breach involves certain categories of vulnerable groups, it must be scored as a minimum 2 on both axes of the scoring matrix although it may be higher depending on the severity or likelihood but will not in all circumstances be notified to the ICO;

For clarity special categories under GDPR/DPA18 not listed below include;

- Vulnerable children
- Vulnerable adults
- Criminal convictions/prisoner information

- Special characteristics listed in the Equality Act 2010 where not explicitly listed in this guidance and it could potentially cause discrimination against such a group or individual
- Communicable diseases as defined by public health legislation
- Sexual health
- Mental health

For clarity Special Categories of personal data under GDPR/DPA18 are:

- racial or ethnic origin,
- political opinions,
- religious or philosophical beliefs,
- trade union membership,
- and the processing of genetic data,
- biometric data for the purpose of uniquely identifying a natural person,
- data concerning health,
- data concerning a natural person's sex life or sexual orientation

Assessing risk to the rights and freedoms of a data subject

GDPR/DPA18 gives interpretation as to what might constitute a high risk to the rights and freedoms of an individual. This may be any breach which has the potential to cause one or more of the following;

- Loss of control of personal data
- Limitation of rights
- Discrimination
- Identity theft
- Fraud
- Financial loss
- Unauthorised reversal of pseudonymisation
- Damage to reputation
- Loss of confidentiality of personal data protected by professional secrecy
- Other significant economic or social disadvantage to individuals

Depending on the outcome of the scoring matrix the risk may be high risk and be significant enough to notify to the ICO.

If there is any doubt that a breach is significant enough for notification, or there is any uncertainty then it is always best to contact the Information Governance team at the earliest opportunity.

Records Management

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, all the way through to their lifecycle to their eventual disposal and destruction.

Any information held is only of use if it can be retrieved easily and the data contained within it is accurate and up to date.

It is important that the organisation knows what information it holds, how it is stored and accessed so that it can fulfil its legal requirements as well as being efficient and effective in its day to day activities.

Information contained within corporate records may be required to meet the requirements of legislation such as the Freedom of Information Act (2000) and The Environmental Information Regulations (2004) and as such must be accessible to ensure that the specific time limits set out within the legislation is met.

Clinical records and other personal data may be required to meet the requirements of legislation such as the Access to Health Records Act (1990) and GDPR/DPA18 to fulfil subject access requests.

The organisation appoints Information Asset Owners and Information Asset Administrators to maintain a register of the organisation's Information Assets and record how the information is used, to ensure that any associated risks can be managed.

Staff must feel confident that they know how to access and store information in order for them to carry out their role to the best of their ability.

Identification/Naming of Records

All records should be clearly identifiable from the file name or from the file cover. It should include an accurate title or description of the information contained and where appropriate the department or service to which it relates.

Naming of electronic records

File Names are the names that are listed in the computer's file directory and that are allocated to new files as they are saved for the first time. By naming records consistently, this will enable staff to distinguish similar records at a glance.

Naming records according to an agreed convention will make naming easier for staff as a "rethink" process will not be required on every occasion.

A file title should be:

- descriptive- it says what the document is about and accurately reflects the contents
- helpful- it distinguishes the document from others on the same/ similar topic
- consistent – it follows the conventions set down by the organisation.

Documents should always contain the following elements:

- date
- subject
- document type
- version or status

Naming conventions

- Keep file names short but meaningful- avoid use of personal names (e.g. Staff names should **not** be used as file names i.e. BOB SMITH or BOBS FOLDER) and abbreviations and codes that are not commonly understood or may not be in the future;
- Make sure documents can be identified on their own without the folder in which they are saved, e.g. Audits\2013-14\2015-09-20 Audit report on……;
- When including a number in a file name always give it as a two digit number, i.e. 0199 (unless it is a number with more than two digits);
- Dates should always follow the BS ISO 8601:2004 format, YYYY-MM-DD, to ensure documents are stored in chronological order;
- When adding personal names, always put the Surname first (e.g. Smith B);
- Avoid using common words such as 'drafts' or 'letters' at the start of file names unless it will assist with record retrieval;
- Make sure elements in the file title are ordered in the most appropriate way to retrieve the record. This will depend on the audience e.g. minutes may be retrieved by date so the date element will appear first, whereas policies might be retrieved by the description so this will come before the date.
- A folder name should not be replicated to subfolders within the file (i.e. Audits\ 20102011 rather than Audits\ Audits 2010-2011\);
- Correspondence record titles should always include the following elements: name of correspondent, subject description (if not already in folder name), date of letter, email etc. and 'rcvd' if incoming correspondence.
- Avoid use of non-alphanumeric characters in file names (i.e. * : / \ < > " ! + = £ $ &,).
- Do not use the document creator's name in the title unless this information genuinely adds to a description of the content (e.g. in correspondence). This information can be added directly in the document or accessed in the document or folder's Properties.
- It is better to use a job title rather than the name of the person in the title of a folder or file and it is best to provide the job title in full rather than use an acronym;
- Include a version to the file name for documents which are subject to changes being made e.g. policies and procedure, (see Version Control section below for more information).

Naming of paper records

The organisation will follow the advice and recommendations issued by The National Archives, i.e.:

- Give a unique name to each record;
- Give a meaningful name which closely reflects the record content:
- Express elements of the name in a structured and predictable order;
- Locate the most specific information at the beginning of the documentation name and the most general information at the end;
- Give a similarly structured and worded name to records which are or can be linked (e.g. an earlier or later version);
- Include a version in the title of records which are subject to changes being made e.g. policies and procedures (see Version Control section below for more information).

Version Control

For all records created, version control is important as documents undergo revision and updating on a regular basis. Version control should be used to manage revisions of a document, enabling the reader to differentiate one version of a document from another. It is particularly important as version control should also be used to clearly identify a final version of a document, which will then assist with referencing and, when required, off-site storage. Most documentation will require the use of simple version control techniques such as the use of naming conventions and version numbering to distinguish one version from another. It is recommended that this practice is used for all documentation where more than one version exists.

Use of numbering within version control should be used to reflect major changes from minor i.e. whilst in development, version control should be version 0.1, each subsequent set of amendments to the document after that should increase the last digit by 1- e.g.0.1 then 0.2, 0.3 etc. The file name could also reflect its 'draft' status.

Once there is a final approved version, this will be named 1.0, and any subsequent draft amendments should be saved as version 1.1, 1.2 etc. If further approval is required, it will become version 2.0 and so on. The version number and date should be clearly visible within the document, such as the front cover with the version number being contained within the footer of the document to ensure that it is visible on every page. Final versions could include the word 'final' as part of the file name.

Storage of Records

Electronic records storage

Electronic documents that contain information that supports a decision-making process of any description, undertaken by any directorate/department or service must be managed to the same standards expected of paper records and for this reason, they must be retained on a corporate shared drive or appropriate intranet site.

All work-related files (documents, spreadsheets, etc.) must be stored on the shared network and data that is for your personal use only is stored on your personal drive (you may know this as “My Documents”, U Drive, I Drive etc.).

The disk capacity for the storage of files is limited. It is not permitted to save music files or digital images from personal cameras to the network. The IT Service reserves the right to delete such files without notice.

Access to folders on the shared drive should be restricted, based upon the user’s employment position and requirement under that post to access information.

The organisation should use a clear and logical filing structure for electronic records to support the retrieval and retention of the records. This may reflect the way in which paper records are stored where appropriate to ensure consistency. Alternatively, the names allocated to files and folders should be done in a way that allows intuitive filing.

Paper records storage

Good quality documentation standards are essential to provide accurate records of the organisation’s activities.

Filing

Records and documentation contained within a paper file or filing system should be securely fastened using treasury tags and folder ties appropriate to the record type. Loose papers and plastic wallets should be securely fastened as loose documentation even if placed in a plastic wallet can be easily lost, misplaced or damaged. The use of Sellotape and staples to secure paper and documents into files is not recommended (staples can be used to staple a document together, but not as a method as a secure file fastening.)

Storage requirements

Records should be retained in facilities appropriate to the record type (i.e. confidential information should not be retained on open shelves in open office areas), environmental considerations such as excessive lighting, damp or flooding must also be considered when decisions are made for the housing of records in the work area. Record storage facilities should not be overcrowded and should allow for easy retrieval and return of records.

The papers and documentation contained within records should be arranged and retained in a logical manner, which has structure and is ordered by chronology.

Duplicate documentation should be removed where possible. When a file becomes too large or excessive a second volume should be created and indexing and version control used.

Directorates, Departments and Service Areas should record all record types on the Information Asset Register. This will be used by the organisation as a file plan which will be used for the auditing of records.

Records should be stored securely and not left unattended or accessible to staff who are not authorised to access them. Where records are removed from the work area a tracking system should be used. (See section below- Tracking and Tracing of Paper records for more information.)

Indexing

An index (or register) should be used primarily to signpost staff to the location where paper records are retained (i.e. the relevant folder or file within a filing cabinet), however, it can also be used by staff to identify the information contained within those records. An index should be developed to be a user-friendly structure to aid staff in the easy location and retrieval of records and documentation. (It is not recommended that staff file or retain records in desk drawers as this limits accessibility and may lead to issues with version control as well as record naming and indexing or continuity of patient care). It is requested that all records are retained in central filing systems ensuring accessibility to all appropriate staff as and when required.

Usage/Transfer of records

Access

Access to the shared drive should be managed to ensure that access to the information contained electronically is controlled in the same way as paper documents. This should be done by restricting folders to staff groups and not by password protecting individual documents as this may make them inaccessible in the future should the password be forgotten. Even the IT Service will be unable to remove passwords from Microsoft documents.

Tracking should also take place to ensure that the cross-referencing of electronic records with their paper counterparts can take place and be relied upon that version control is maintained both electronically and in paper format.

Tracking and Tracing of paper records

Records are created and captured in order to be used; therefore record keeping systems must include effective mechanisms for tracking and tracing their whereabouts and use. Effective procedures must be in place to ensure swift retrieval, an audit trail of use and for their accurate return.

A comprehensive tracking system should include:

- Effective aides to identify documents and records and provide the location details and highlight any restrictions appropriate to it.
- The use of tracer cards and a register to track records that have been accessed and relocated.

Depending on the nature of the document/record, authorisation for access may be required. Where most records are available to the public an authorisation procedure is not necessary. However, where records are sensitive due to data protection, commercial confidentiality or security issues, these documents and records will need to be tracked and monitored to ensure that appropriate authorisation processes are in place to approve staff access.

Effective tracking will ensure that records can always be located when required and that records remain controlled and secure, thus enhancing their reliability and authenticity.

As a minimum, a tracking system should include:

- The record reference or unique identifier
- Title or description of the record
- The individual (including job title, telephone number and e-mail address), department and location accessing the record
- Date and signature confirming removal and return of record

Tracking systems ensure records are appropriately tracked when records are sent between staff/departments. However, if a record is being permanently transferred, please contact the IG team for this document.

Procedure for the secure movement of records during team relocation

It is a business need that from time to time, teams and departments will be required to 'relocate' from one premise to another. It is during these times that the organisation is at its highest risk of losing records. For this reason, it is important that there is a clear procedure for staff to follow to ensure the secure movement of organisational records. This procedure relates to the movement of **ALL** organisational records.

Due to the nature of the procedure, it can be assumed that on most occasions, teams will be moving a high number of records. As anything over 50 records is classed by the Department of Health as a 'bulk' removal of records then there is a greater level of security that must be applied to those records in transit.

Scope of the procedure

This protocol covers any work carried out by moving contractors (such as ShredPro), whilst under contract with NHS Herefordshire and Worcestershire CCG. This also includes the expectations and responsibilities placed upon staff, working for the contracted companies, who will be moving the records.

Any records removed shall be in sealed containers and access to those records will not be provided. Therefore, this will not be an information sharing agreement but will instead be an agreement between NHS Herefordshire and Worcestershire CCG and the contractors undertaking the relocation of the records to ensure the secure removal of records.

The responsibility for ensuring the security of records during moves lies with the service area concerned, not the Information Governance team, the Premises team or the moving contractors.

Preparing Records to Be Moved

- All records that are to be moved should be recorded on a movement of records listing sheet, the sheet should include the number and range of records included in the box.
- Teams will need to assign each container a unique identifier which should follow the format of **TEAM/DATE OF MOVE/001** for example IG/01.06.15/001.***
- The containers should be clearly marked with its unique identifier. ***

- Once all records have been listed and placed into the container, the list should be checked and countersigned by a colleague to ensure that the records recorded are placed within the container.
- The container should be sealed immediately and not opened until the records reach their destination.
- A list of all the containers should be recorded. This will need to be signed by the person transporting the records.

*****If moving containers are being used then each box should be sealed using two cable ties (1 at each end). The cable ties must contain a unique number – this is the identifying number that will be assigned to that box and should be listed on the movement of records listing sheet.**

Moving the records using an external company (e.g. ShredPro)

- Sealed containers should be loaded onto the removal van.
- The staff member that has been assigned responsibility for the removal of those records should check all boxes loaded onto the van against the container list and sign to confirm that they are all sealed, intact and loaded onto the van.
- The driver should then complete the same check and sign the container list to confirm that they are taking the responsibility from that point, for the security of those containers and records.
- When the van reaches its destination, the member of staff responsible for those records, should meet the van and perform the following checks:
- Check that the containers are all sealed
- Check that there is no damage to any of the containers
- Check that all boxes that were signed onto the van are present and correct.
- If all checks are carried out and satisfactory the boxes should be removed from the van and should be signed on the container list as having arrived securely.

Moving the records using staff members vehicles

- Sealed containers should be loaded into the vehicle.
- The staff member that has been assigned responsibility for the removal of those records should check all boxes loaded onto the vehicle against the container list and sign to confirm that they are all sealed, intact and present.
- If the staff member assigned responsibility for the removal of the records is also the driver then the container list will need to be countersigned by another member of NHS Herefordshire and Worcestershire CCG staff.
- The vehicle should not be left unlocked or unattended at any time once the records have been loaded into the vehicle.
- The vehicle should go directly to the required destination.

- When the vehicle reaches its destination, the member of staff responsible for those records (or if that is the same person as the driver then this action should be completed by the counterperson), should meet the vehicle and perform the following checks:

- Check that the containers are all sealed
- Check that there is no damage to any of the containers
- Check that all boxes that were signed onto the vehicle are present and correct.

If all checks are carried out and satisfactory the boxes should be removed from the vehicle and should be signed on the container list as having arrived securely.

Retention and Disposal of Records

Disposal is the implementation of a review process and the term should not be confused with destruction. A review decision may result in the destruction of records but may also result in the transfer of custody of records, or movement of records from one system to another.

Records should not be kept longer than is necessary and should be disposed of at the right time. Unnecessary retention of records consumes time, space and equipment use; therefore disposal will aid efficiency. Staff members must regularly refer to the Records Management Code of Practice for Health and Social Care– please see the section on retention periods below for more information.

Retaining records unnecessarily may also incur liabilities in respect of the Freedom of Information Act 2000 and the Data Protection Act (2018). If the organisation continues to hold information which they do not have a need to keep, they would be liable to disclose it upon request. The Data Protection Act (2018) also advises that we should not retain personal data longer than is necessary.

Staff members are recommended to seek specialist advice from the Information Governance team when considering destruction of the organisation's records through a commercial third party.

Staff members are also recommended to seek specialist advice from the Information Governance Team when considering off-site storage of the organisation's records with a commercial third party. When inactive records are sent for offsite storage, they must be tracked so that their precise location is known, and an auditable trail of their movement is created.

Short-lived documents such as telephone messages, notes on pads, post-its, e-mail messages etc. do not need to be kept as records. If they are business critical, they should be transferred to a more formal document which should be saved as a record.

Retention periods

All records that are created have an associated retention period. The length of the retention period depends on the type of record and its importance to the business of the organisation and the legal requirements.

All documents and records should be reviewed on an annual basis to ensure that appropriate storage and retention is maintained.

To ensure that all records are retained for the minimum recommended retention period the guidance in the Records Management Code of Practice for Health and Social Care should be followed:

https://digital.nhs.uk/data-and-information/looking-after-information/data-security-andinformation-governance/codes-of-practice-for-handling-information-in-health-andcare/records-management-code-of-practice-for-health-and-social-care-2016

NHS England have also published guidance which may be more relevant to commissioning organisations that can be used in conjunction with the Records Management NHS Code of Practice. The NHS England **Corporate Records Retention – Disposal Schedule and Guidance** can be found at:

http://www.england.nhs.uk/ourwork/tsd/ig/ig-resources/

Disposal

Once records have reached their minimum retention period deadline, they should be reviewed to establish whether there is any justification for keeping them longer e.g. for historical purposes, new episode of care, research needs etc.

If records need to be kept, a decision should be taken whether to keep them as a current record, archive them off site or store them permanently with the National Archives.

For records that have reached their minimum retention period and there is no justification for continuing to hold them, they should be disposed of appropriately.

Paper records of a sensitive, confidential nature should either be shredded using a cross shredder to DIN standard 4 or put in confidential waste that is appropriately destroyed by a company contracted to the organisation. Confidential waste bins should be kept locked and not over filled to ensure information cannot be retrieved from them. Confidential waste bags should be kept in a locked room until collected for disposal.

Electronic records must be deleted from the device and not simply moved into the Trash folder, known as double deleting. De-commissioning of electronic devices such as computers, laptops, notepads, mobile phones etc. should be undertaken according to procedures outlined so that they are completed wiped before being disposed of/destroyed to avoid data being retrievable in the future.

Business Continuity Plans

Business Continuity Planning is a method used to identify potential impacts that may threaten the operations of an organisation's business/premises.

The fundamental element of business continuity is to ensure that whatever impacts the organisation it continues to operate.

Business continuity plans will help shape organisational resilience to 'threats', plan counteractions and minimise interruptions to it activities from the effects of major failures or disruption to its Information Assets (e.g. data, data processing facilities and communications).

Each team should have Business Continuity Plans in place, and it is the responsibility of members of staff to be aware of the location of plans, and what procedures to follow in the event of potential 'threats' to operations.

For further information regarding Business Continuity Plans, please contact the Corporate Services & Project Manager or the most senior member of staff in your department.

Digital recording of meetings

The digital recording of meetings as an aide memoir to the minute taker is often required. If the meeting is to be recorded for this purpose, please follow the guidance below:

- There would need to be agreement by all members to audio record the meeting, explaining that this recording would be used purely as an aide-memoire for the minute-taker to ensure an accurate transcript of the meeting.
- Written consent should be obtained from all members agreeing for the meeting to be recorded.
- New Terms of Reference would be required identifying agreement to record the meeting, the reason for recording the meeting, where/who will have the only copy of the audio recording and when the recording will be destroyed.
- The Chair of the meeting has discretion to stop or suspend recording if, in their opinion, continuing to do so would prejudice proceedings at the meeting.
- Prior to the meeting, communications should be sent notifying members that the meeting will be digitally recorded. This should also be identified on the formal agenda.
- All panel members should be advised that the digital recording will be held for:
- The same retention as the written transcription for high/board level meetings, i.e. 3 months
- A minimum of 3 months after the written transcript has been ratified by all members for lower level meetings

The recording should then be destroyed once the above stated retention period has been met.

As the audio recording would be a record for the above agreed time, it is important to record the destruction of this record to assist in audit purposes.

Retention of notes and recordings taken as aide-memoire for a minute taker

For High Level / Board Level meetings; notes and recordings should be retained for the same length of time as the written transcription.

For other lower level meetings, it is acceptable to destroy notes and recordings 3 months following the written transcript having been ratified by all members of the group.

Information Risk Assessment and Management Programme

Information and information systems are important corporate assets, and it is essential to take all the necessary steps to ensure that they are at all times protected, available and accurate to support the operation and continued success of the organisation.

There needs to be a comprehensive programme of activity across the organisation to identify information risks and manage them effectively. From the outset this needs to be recognised as an ongoing activity. A number of key activities in the Information Governance toolkit form the basis of building an information risk framework, namely:

- Mapping flows of information
- Identifying and maintaining a register of all information assets
- Setting out continuity plans for periods of information unavailability

Managing Information Assets

Information assets are identifiable and definable assets owned or contracted by an organisation which are 'valuable' to the business of that organisation, such as:

- databases
- data files
- contracts and agreements
- system documentation
- research information
- user manuals
- training materials
- operational/support procedures
- business continuity plans
- back up plans
- audit trails
- archived information

**Please note that this list is not exhaustive.*

Information assets could be kept in a variety of formats and on a variety of media, e.g. paper, on a shared drive, on removable media (e.g. USB memory sticks, CD-ROM).

Examples of paper assets

- patient records
- personnel files
- letters
- referrals
- annual leave sheets
- sickness absence returns
- expenses
- papers for meetings

Examples of electronic assets include:

- spreadsheets
- annual leave/sickness records
- local databases
- scanned documents
- electronic copies of letters

Information Asset Register – U-Assure

Information assets may contain **person identifiable** or **commercially sensitive** information.

An Information Risk Management System has been developed which, with the support of the Information Governance team will allow Information Asset Administrators (IAAs) and Information Asset Owners (IAOs) to identify information assets and record details of their content, the security arrangements in place to protect them, and what business continuity arrangements are in place. For each question, a specified range of answers are provided.

This approach will allow the information assets to be risk assessed using a standard risk scoring matrix to ensure consistency of risk assessments across the organisation.

Further to this, IAOs are required to assess the worst-case scenario of the possible effects the loss of confidentiality, integrity and availability of each information asset would have to the business, including financial, adverse publicity, relationship with patients or NHS and the risks associated with non-compliance with legislation. This process will assess the business criticality of the asset to allow the organisation's critical assets to be identified, providing the basis of this component of departmental and organisational business continuity plans.

All organisations are subject to change brought about by modifications to the operational and technical environments. These in turn change the information assets held by the organisation and the risks associated with them, resulting in a requirement to review any previously recorded information assets and risk assessments. Consequently, the information asset register should be subject to regular maintenance by IAOs and IAAs, with formal review conducted at least annually. It is essential that whenever new information assets are created, the relevant IAA or IAO is informed, to allow them to create an entry in the Information Asset Register.

This formal review of assets and risk assessments will be conducted at least annually.

Person Identifiable Data Flow Mapping

In the NHS, numerous transfers of data take place each day. It has long been recognised that this information is more vulnerable to loss or compromise when outside the organisation, i.e. being carried around or sent/copied from one location to another. The requirement to map information flows has been included in organisational confidentiality audits since 2008/09 (version 6 of the IG toolkit).

To ensure all transfers are identified, the organisation must determine where, why, how and with whom it exchanges information. This is known as Data Flow Mapping and the comprehensive register provided by this exercise identifies the higher risk areas of information transfers requiring effective management. It also allows any Information Sharing Agreements or contracts that should be in place to be identified.

To adequately protect transfers/flows of information, the organisation must identify the transfers, risk assess the transfer methods and consider the sensitivity of the information being transferred. Transfers of all information (including personal information) must comply with the organisations Safe Haven Procedures (above) and relevant legislation (GDPR/DPA18) which requires appropriate technical and organisational measures to be taken against unauthorised or unlawful processing of, and accidental loss or destruction of, or damage to, personal data).

The loss of personal information will result in adverse incident reports which will not only affect the reputation of the organisation but, in the case of disclosing personal information intentionally or recklessly, is also a criminal offence. With effect from May 2018 fines of up to 20,000,000 euros or 4% of an organisation's annual turnover can be imposed by the Information Commissioner's Office on organisations that do not take reasonable steps to avoid the most serious breaches of GDPR/DPA18.

The information recorded in the Information Asset Register allows the identification of all assets of which part or all of their content are sent or received either internally or externally to the organisation. For those assets which are identified as moving in this way, a further

module is completed within the Information Risk Management System by the IAA so further information is collected about how and where the information is transferred. This information is then risk assessed to identify areas of high risk and any areas of non-compliance with the organisation's safe haven procedures.

Through this process, the organisation will actively identify and review where person confidential data (PCD) is held, processed or shared to ensure a legal basis for doing so is identified. Where no legal basis can be found an IG breach will be reported and investigated.

As with the Information Asset Register, data flows are subject to change and should therefore be reviewed regularly. A formal review will be conducted annually.

Data Protection Impact Assessment (DPIA)

Privacy impact assessments (PIAs) have been used for a number of years as a good practice measure to identify and minimise privacy risks associated with new projects.

DPIAs are very similar to PIAs so if you have already carried out PIAs the new process will be very familiar.

The key changes to DPIAs under the new GDPR/DPA18 include:

- DPIAs are mandatory for any processing likely to result in a high risk (including some specified types of processing).
- You must consider the impact on any of an individuals' rights and freedoms, including (but not limited to) privacy rights.
- There are more specific requirements for the content of a DPIA.
- You must seek the advice of the data protection officer (Head of Information & Analytics). You also need to seek the views of people whose data you intend to process, or their representatives, wherever possible.
- If after doing a DPIA you conclude that there is a high risk and you cannot mitigate that risk, you must contact the IG Team before you can start processing.

You must do a DPIA before you begin any type of processing which is "likely to result in a high risk".

This means that although you have not yet assessed the actual level of risk you need to screen for factors that point to the potential for a widespread or serious impact on individuals.

In particular, the GDPR/DPA18 says you must do a DPIA if the plan is to:

- use systematic and extensive profiling with significant effects;
- process special category or criminal offence data on a large scale; or
- systematically monitor publicly accessible places on a large scale.

The ICO also requires a DPIA if the plan is to:

- use new technologies;

- use profiling or special category data to decide on access to services;
- profile individuals on a large scale;
- process biometric data;
- process genetic data;
- match data or combine datasets from different sources;
- collect personal data from a source other than the individual without providing them with a privacy notice ('invisible processing');
- track individuals' location or behaviour;
- profile children or target marketing or online services at them; or
- process data that might endanger the individual's physical health or safety in the event of a security breach.

You should also think carefully about doing a DPIA for any other processing that is large scale, involves profiling or monitoring, decides on access to services or opportunities, or involves sensitive data or vulnerable individuals.

Even if there is no specific indication of likely high risk, it is good practice to do a DPIA for any major new project involving the use of personal data.

The DPIA template to be completed is available through UAssure, if you have not completed a PIA or DPIA then contact the IG Team for training in the first instance.

The DPO/IG Team can also be contacted for advice on:

- whether you need to do a DPIA;
- how you should do a DPIA
- what measures and safeguards you can take to mitigate risks;
- whether you've done the DPIA correctly; and
- the outcome of the DPIA and whether the processing can go ahead.

Information Sharing

It is important to ensure that there is a balance between sharing information with partners for the purposes of quality of care and keeping information secure and confidential. The GDPR/DPA18 imposes a legal obligation on both parties to formalize their working relationship.

The CCG needs to ensure that mechanisms are in place to enable reliable and secure exchange of data within the legal limits, failure to have in place an agreement is a breach of GDPR/DPA18.

This will provide the CCG with the assurance that both organisations understand their obligations, responsibilities and liabilities to help them comply with GDPR/DAP18.

The information sharing agreements document must include:

- the subject matter;
- legal basis for sharing;

- how long it is to be carried out for;
- what processing is being done;
- its purpose;
- the type of personal data;
- the categories of data subjects; and
- the obligations and rights of the data controller

For further advice and guidance on Information Sharing Agreements, please contact the Information Governance team.

Information Security Audits and Spot Checks

It is essential that all staff comply with the procedures put in place by the organisation to ensure information security. This helps minimise the potential risks to themselves and others, as well as reducing the financial costs arising from the loss of data, equipment and personal possessions.

Potential security issues and risks should be identified and mitigated by implementing effective controls and solutions. The organisation's main security objectives are:

- The protection of property against fraud, theft and malicious damage.
- The protection of all records and personal information, regardless of how these are held (electronic or paper records).
- The smooth and uninterrupted delivery of services.

In practice, this is applied through three cornerstones - Confidentiality, Integrity and Availability

- Information must be secured against unauthorised access – Confidentiality
- Information must be safeguarded against unauthorised modification – Integrity
- Information must be accessible to authorised users at times when they require it – Availability

All work areas within the organisation will be subject to Information Security audits and spot checks. The security measures of each building and office will be reviewed and their implementation will be tested. General working practices will be inspected through observations and interviews to ensure compliance with the security procedures and Information Governance guidelines.

The checks will consider:

- Physical security provisions of the building and offices
- Security applied to manual files e.g. storage in locked cabinets/locked rooms
- IT Security Processes e.g. screens locked when not in use
- Security of IT equipment and portable media when not in use
- Security of post handling areas

- Security of confidential fax handling
- Clear desk policy
- Clear screen policy
- Security of offsite storage boxes prior to removal to storage
- Evidence of secure waste disposal
- Use of whiteboards for confidential information

The spot checks will take place during the working day and early morning/late evening to provide a view of compliance both inside and outside of working hours. The focus of the checks may therefore vary dependent upon the time of the audit as some aspects, such as clear screen, may not be applicable outside of working hours.

In addition to the Information Security Spot Checks, audits will be carried out which, rather than being a general appraisal of compliance, will focus on specific information assets to verify and test the security measures specified as being in place in the assets entry in the Information Asset Register, including the methods of transmission for any associated data flows where possible (for example examination of emails to ensure they are encrypted would be beyond the scope of the audit). The audit would also consider arrangements for recording access to manual files where applicable, e.g. tracking cards, access requests under the GDPR/DPA18.

Useful Documents:

Contract, Temporary and Work Placement Staff Confidentiality and Compliance agreement

1. Confidentiality

1.1. In the course of your employment with the CCG you will receive and acquire confidential person/patient identifiable and commercially sensitive information that is the property of the CCG.

1.2. During and after your employment with the CCG you must take all reasonable steps to ensure the confidentiality of information that has been disclosed to or obtained by you is maintained.

1.3. You must not, either during or after your employment with the CCG:

- Disclose any person identifiable or confidential information relating to the business or affairs of the CCG, its service users or associated entities unless specifically authorised to do so in writing.
- Other than to the extent that is necessary to enable you to perform your duties:

i. make extracts from, copy or duplicate confidential information.

ii. make adaptations of confidential information;

iii. make use of confidential information for private purposes, or in any manner which may, or is calculated to cause injury or loss to the CCG, its service users, customers or associated entities; and

iv. other than for the benefit of the CCG make notes, documents, working papers or memorandum relating to any matter within scope of the business of the CCG or concerning any of its dealings or affairs.

1.4. Clauses 1.2 and 1.3 shall continue to apply despite the termination or cessation of your employment by either the CCG or you.

1.5. Without limiting the generality of the above, for the purpose of this clause, "confidential information" means and includes any information relating to the CCG, its business and activity including but not limited to person and patient identifiable information and other sensitive information in whatever form but excluding any matter that has become public knowledge or part of the public domain and all other information provided to you which is either labelled or expressed to be confidential, or given to you in circumstances where one would expect the information to be confidential to the CCG.

2. Compliance

2.1. During your employment with the CCG it is a requirement that you comply with all relevant legislation. These shall include, but not be limited to:

a) General Data Protection Regulation/Data Protection Act 2018
b) The Human Rights Act 1998
c) The Crime and Disorder Act 1998
d) Common Law Duty of Confidentiality
e) Freedom of Information Act 2000

2.2. In addition to the above-mentioned legislation, consideration may also need to be given to the following when sharing personal information:

a) The Caldicott Committee Reports

b) Information Security Standard ISO 27001

2.3. You will ensure that you understand the relevant elements of the applicable legislation that applies to your role within the organisation and ensure that you comply with legislation when carrying out your role.

2.4. During your employment with the CCG you will be required to comply with all relevant policies that are currently in place that relate to the sharing of information and confidentiality.

2.5. You will undertake mandatory Information Governance e-learning, and any other training as required, within the timescales specified by the CCG for any new starters within the organisation.

3. Deletion of data on Cessation

3.1. Upon cessation of your employment, you are required to deliver to the CCG all copies of information, including person identifiable information that you have used in the course of your official duties and to undertake that you will not use any person identifiable information for any use having terminated your employment with the CCG. You must also return any associated removable media in your possession.

I undertake to comply with the above obligations and conditions as required by the CCG and as stated above to protect the organisation's confidential information and all relevant compliance requirements.

Name: _____ (Please print)

Signature: _____ Date: _____