

**Security and Transmission of Personal Confidential Data and Information (Safe Haven) Policy**

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**The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as ‘uncontrolled’ and as such may not necessarily contain the latest updates and amendments.**

**POLICY AMENDMENTS**

Amendments to the Policy will be issued from time to time. A new amendment history will

be issued with each change.

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| --- | --- | --- | --- | --- |
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| 0.1 | Barry Jackson | First draft for comments | NR |  |
| 1.0 | Barry Jackson | Approved version |  |  |
| 1.1  | Helen Sanderson | Update for HSCIC Guidance and Caldicott 2  |  |  |
| 1.2 | Mark Culling | Amendments to reflect the Data Protection Act 1998 (expected to be superseded by a Data Protection Act 2017 incorporating the requirements of the General Data Protection |  |  |
| 2.0 | Hayley Gillingwater | GDPRUpdated Bribery ActData Protection OfficerGDPR/ DPA PrinciplesReferencesSecure Transfers Guidance Removal of guidance on transmission via fax.  | IA&GC 6 Jan 2021 |  |
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**1 INTRODUCTION AND APPLICABILITY**

* 1. The NHS constantly uses and transfers personal confidential data and information (PCD) between people, departments and organisations much of this information is sensitive and/or personal and requires treating with appropriate regard to its security and confidentiality. These are known as data flows. This includes PCD of service users, staff and others. Safe haven requirements should also be applied when processing commercially confidential or sensitive information. It is therefore essential that all departments and services within the North Lincolnshire Clinical Commissioning Group (The CCG) that transfer and/or receive PCD from other organisations and between departments have in place adequate safe haven procedures to protect these data flows:
* At the point of receipt,
* whilst held by the department,
* when transferring information to others, by whatever means,
* whilst stored in archive, and
* at the point of disposal.
	1. The policy applies to all clinical and non-clinical areas within the organisation.

The aim of the policy is to:

• Provide staff with guidance on Safe Haven requirements for distributing PCD.

• Ensure that transfers of PCD adhere to Caldicott principles ,the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

• Protect PCD in areas accessed by the public.

• Ensure that information accessed remotely is done so securely.

**2 ENGAGEMENT**

This policy has been developed based on the knowledge and experience of the Information Governance team. It is derived from a number of national codes and policies which are considered as best practice and have been used across many public sector organisations.

**3 IMPACT ANALYSES**

**3.1 Equality**

An equality impact screening analysis has been carried out on this policy and is attached at Appendix 1.

As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

**3.2 Sustainability**

A sustainability assessment has been completed and is attached at Appendix 2. The assessment does not identify and benefits or negative effects of implementing this document.

3.3 **General Data Protection Regulation (GDPR)**

The CCG is committed to ensuring that all personal information is managed in accordance with current data protection legislation, professional codes of practice and records management and confidentiality guidance. More detailed information can be found in the CCGs Data Protection and Confidentiality and related policies and procedures.

If you are commissioning a project or undertaking work that requires the processing of personal data you must complete a Data Protection Impact Assessment. Please see the CCG’s Data Protection Impact Assessment Procedure and Data Protection by Design & Default procedure available on the website for guidance.

**3.4 Bribery Act 2010**

The Bribery Act is particularly relevant to this policy.  North Lincolnshire CCG has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from the Bribery Act 2010.  Under the Bribery Act 2010 there are four criminal offences:

•           Bribing or offering to bribe another person (Section 1)

•           Requesting, agreeing to receive or accepting a bribe (Section 2);

•           Bribing, or offering to bribe, a foreign public official (Section 6);

•           Failing to prevent bribery (Section 7).

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper.

It should be noted that there need not be any actual giving and receiving for financial or other advantage to be gained, to commit an offence.

All individuals should be aware that in committing an act of bribery they may be subject to a penalty of up to 10 years imprisonment, an unlimited fine, or both.  They may also expose the organisation to a conviction punishable with an unlimited fine because the organisation may be liable where a person associated with it commits an act of bribery.

Individuals should also be aware that a breach of this Act renders them liable to disciplinary action by NLCCG, whether or not the breach leads to prosecution.  Where a material breach is found to have occurred, the likely sanction will be loss of employment and pension rights.

It is the duty of every member of staff to speak up about any genuine concerns in relation to criminal activity, breach of a legal obligation, miscarriage of justice, danger to health and safety or the environment and the suspected cover up of any of these in the workplace.  To raise any suspicions of bribery and/or corruption please contact the Chief Finance Officer.  Staff may also contact the Local Counter Fraud Specialist (LCFS) at – Audit Yorkshire, 01482 866800 email:  nikki.cooper1@nhs.net  or mobile 07872 988939.

The LCFS or Chief Finance Officer should be the contact for any suspicions of fraud. The LCFS will inform the Chief Finance Officer if the suspicion seems well founded and will conduct a thorough investigation.  Concerns may also be discussed with the Chief Finance Officer or the Audit & Integrated Governance Committee Chair.

If staff prefer, they may call the NHS Fraud & Corruption Reporting Line on 0800 028 40 60 between 8am-6pm Monday-Friday or report online at [www.reportnhsfraud.nhs.uk](http://www.reportnhsfraud.nhs.uk).  This would be the suggested contact if there is a concern that the LCFS or the Chief Finance Officer themselves may be implicated in suspected fraud, bribery or corruption.

**4 SCOPE**

This policy applies to all staff, CCG Governing Body Members, temporary staff, seconded staff, contractors and others undertaking work on behalf of the CCG, etc. For those staff covered by a letter of authority/honorary contract or work experience the organisations policies are also applicable whilst undertaking duties for or on behalf of the CCG.

For the purposes of this policy, personal confidential information shall include any confidential information relating to the CCG and/or its agents, customers, prospective customers, service users, suppliers or any other third parties connected with CCG and in particular shall include, without limitation:

* service user information;
* ideas/programme plans/forecasts/risks/issues;
* finance/budget planning/business cases;
* sources of supply and costs of equipment and/or software;
* prospective business opportunities in general;
* computer programs and/or software adapted or used;
* corporate or personnel information; and contractual and confidential supplier information. This is irrespective of whether the material is marked as confidential or not. Responsibilities for the implementation of this policy are as follows:

 **4.1.** **Senior Information Risk Owner (SIRO)**

The SIRO has overall responsibility for the implementation of Safe Haven Policy within the CCG. Safe Haven implementation is key as it will ensure that PCD and commercially sensitive information is handled securely.

The CCG has a particular responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

**4.2 Data Protection Officer (DPO)**

The DPO is responsible for:

* Monitoring CCG compliance with the GDPR
* Providing advice and assistance with regards to the completion of Data Protection Impact Assessments, Data Sharing Agreements etc. Acting as a contact point for the Information Commissioners Office (ICO), members of the public and CCG staff on matters relating to GDPR and the protection of personal information.
* Assisting in implementing essential elements of the GDPR such as the principles of data processing, data subjects’ rights, privacy impact assessments, records of processing activities, security of processing and notification and communication of data breaches.

**4.3 Caldicott Guardian**

The Caldicott Guardian is responsible for the review and agreement of internal procedures governing the protection and use of PCD by staff.

**4.4 Service Managers / Line Managers**

Service managers and line managers are responsible for ensuring that all PCD data flows, into or out of the organisation are included in their departments Information Asset Register. This includes:

* Identifying systems in place and nominating Information Assets Owners
* Identifying all systems that require safe haven procedures within their departments.
* Ensure all staff are aware of their duties and responsibilities in relation to keeping all relevant information confidential and secure. All departments should document and implement safe haven procedures appropriate to the information they process.

**4.4 Nominated Safe Haven Managers (Information Asset Owners)**

Information Asset Owners must ensure that appropriate controls are put in place to protect information by completing the Information Asset Register and associated data flow and risk assessment. When completing the Information Asset Register and associated data flows the controls detailed below (Annex A) should be considered

* Ensure access is properly controlled to staff on a need to know basis only
* Identify routine information flows and ensure that these are mapped.
* Develop and document the local safe haven procedures appropriate to their service.
* Ensure all staff are aware of and understand the procedures for their area.
* Ensure all staff have completed their annual information governance training.
* Regularly review the adequacy of controls in place and implement corrective action where necessary.

The IAR is sent to IAOs to be updated on a bi-annual basis, IAOs are required to respond to the request for updates even if there are no changes to their assets.

**5 POLICY PURPOSE & AIMS**

**5.1 Procedures for the Transmission of Confidential Information**

All staff have a professional responsibility for the information they handle within the organisation, and must use robust methods to keep the information secure.

It is vital that staff choose the most appropriate method of communication based on factors such as:-

* The sensitivity of the information.
* The urgency of the need to share information.
* The operating procedures of the receiving organisation.
* The reason for sending the information.
* The reason for the choice of method of transmission

Staff must not base their choice of communication on ease for them, whilst sending a fax may be convenient and quick would that information be better safeguarded if it was communicated by telephone or secure email?

**5.2 Safe Haven Guidance**

Safe Haven is a requirement for there to be appropriate controls in place to ensure the secure transfer, receipt, storage and disposal of personal confidential information, to protect it from loss, damage or unauthorised access.

Access controls and registered access levels should be in place to restrict access to information on a need to know basis for staff to be able to perform their duties.

It is essential all staff members must be made aware of their own responsibility for ensuring the protection of personal information received.

Organisations should ensure that all information transfers are subject to agreed management and information security controls which comply with NHS information governance standards, including the Caldicott Principles, set out below.

This is primarily aimed at the protection of personal data but will also be necessary for other sensitive information, e.g. commercially sensitive information.

Guidance is detailed in Annex A below, which allows a self-assessment of the controls in place within your department

**Caldicott Principles**

1. Justify the purpose for using the information
2. Only use identifiable information if absolutely necessary
3. Use the minimum that is required
4. Access should be on a strict need to know basis
5. Everyone must understand their responsibilities
6. Understand and comply with the Law
7. The duty to share information can be as important as the duty to protect patient confidentiality. However sharing information should be undertaken on a legal basis and in the best interests of the patient.

**Data Protection/ General Data Protection Regulation Principles**

1. processed **E+W+S+N.I.**lawfully, fairly and in a transparent manner in relation to the data subject (‘lawfulness, fairness and transparency’);

(a) at least one of the conditions in Article 6 of the GDPR is met, and

(b) in the case of sensitive personal data, at least one of the conditions in Article 9 of the GDPR or Schedule 1 of the DPA 18 is also met.

1. collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes shall, in accordance with Article 89(1), not be considered to be incompatible with the initial purposes (‘purpose limitation’);
2. adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed. (‘data minimisation’);
3. accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay (‘accuracy’);
4. kept in a form which permits identification of the data subject for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) subject to the implementation of appropriate technical and organisational measures required by this Regulation in order to safeguard the rights and freedoms of the data subject (‘storage limitation’);
5. Processed in a manner that ensures appropriate security of the personal data; including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures (‘integrity and confidentiality’).
6. Personal data shall be processed in accordance with the rights of data subjects under this Act.**E+W+S+N.I.**
7. Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

**6 IMPLEMENTATION**

The policy will be disseminated by being made available on the internet and highlighted to staff through newsletters, team briefings and by managers.

 *‘Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the CCG’s disciplinary procedure’.*

**7 TRAINING & AWARENESS**

Staff will be made aware of the policy via the website and internal distribution lists.

**8 MONITORING & AUDIT**

Adherence to this policy will be monitored on an on-going basis and breaches may result in disciplinary procedures.

**9 POLICY REVIEW**

This policy will be reviewed in 2 years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, as instructed by the senior manager responsible for this policy.

**10 REFERENCE MATERIALS**

* NHS Confidentiality Code of Practice
* NHS Code of Practice for Records Management
* HSCIC: Code of Practice on Confidential Information
* HSCIC: A Guide to Confidentiality in Health and Social Care
* HSCIC: Sending an encrypted email from NHSmail to a non-secure email address - <https://s3-eu-west-1.amazonaws.com/comms-mat/Training-Materials/Guidance/encryptionguide.pdf>
* Report of the Caldicott2 Review - Information: To share or not to share? The Information Governance Review 2013
* Government Response to Report of the Caldicott2 Review 2013
* The Independent Information Governance Oversight Panel: Annual Report
* The General Data Protection Regulation (GDPR)
* The Data Protection Act 2018

**Safe Haven Self -assessment Questionnaire**

**Annex A**

| **No.** | **Guidance** | ***Current departmental process*** | **Adequate YES/NO** | **Corrective action identified (Where Applicable)** | **Action Date and officer nominated** |
| --- | --- | --- | --- | --- | --- |
| ***General Security*** |
| **1** | The area should be separated from the general public and unauthorised personnel by appropriate access controls when unmanned, e.g. locked doors and all personal and corporate confidential information should be locked away.In the event visitors require access to office areas they should be requested to sign in, and then be met and escorted as appropriate. |  |  |  |  |
| **2** | The area should be protected by appropriate alarm and security systems  |  |  |  |  |
| **3** | Personal Confidential Data (PCD) and Corporate Confidential Information should be secured away when not in use, in a formal secure filing system i.e. Clear desk policy |  |  |  |  |
| **4** | Staff should be aware that the area must be secured if it is to be left unattended.  |  |  |  |  |
| **5** | Where keypad locks are in place the codes should be changed on a regular basis, e.g. quarterly. |  |  |  |  |
| ***Security of Manual Records***  |
| **1** | Access to information must be restricted on a need to know basis appropriate to the staff members job role, this applies to all formats e.g. written records, photos, etc.  |  |  |  |  |
| **2** | All types of files containing (PCD) should be held securely when not in use, e.g. filing cabinets / drawers and computers are locked. |  |  |  |  |
| **3** | Records should be filed in a structured manner. In addition manual records placed in a file should be secured within that file to prevent accidental loss of pages. |  |  |  |  |
| **4** | A comprehensive tracking / tracing and monitoring system for all records and files should be place. This applies to all stages of transit, including where handovers during transit have taken place. |  |  |  |  |
| **5** | As far as possible PCD should not be visible through any file covers. |  |  |  |  |
| ***Security of Electronic Records***  |
| **1** | Monitors and other screens should be placed in such a manner as to avoid the information displayed on them being over looked, e.g. through a window or in an open reception area |  |  |  |  |
| **2** | Electronic information should only be stored on the main server and not a local computer. |  |  |  |  |
| **3** | Proper system access controls should be in place i.e. passwords and access levels for each user.Staff should be made aware of their responsibilities in respect the management and security of passwords and smartcards, e.g. passwords and smartcards must not be shared or left unattended. |  |  |  |  |
| **4** | Staff should be aware that PC’s, laptops etc., should be locked or switched off when leaving it unattended at any time.  |  |  |  |  |
| **5** | PCD or other confidential information should not be copied to any personal PC or media that do not belong to the organisation or is not approved by the organisation. |  |  |  |  |
| ***Working from Home via VPN*** |
| **1** | The organisation allows authorised access via a VPN, in order to provide those members of staff with a legitimate business need to have access to their authorised section of the organisation network, when working away from organisational premises.VPN access should only be used in association with equipment that has been encrypted and issued by the IT department for work purposes. |  |  |  |  |
| **2** | Staff should be aware that all of the guidance set out in this document must also be applied when working from home. |  |  |  |  |
| ***Portable Media and Encryption*** |
| **1** | Only equipment that has been encrypted and issued by the IT department should be used for work purposes. |  |  |  |  |
| ***Transferring Information*** |
| **1** | Staff should be aware of and have access to the NHS Confidentiality, Code of Practice, HSCIC Code of Practice on Confidential Information and HSCIC: A Guide to Confidentiality in Health and Social Care and Data Protection Policy & Standard. |  |  |  |  |
| **2** | Transfers and receipt of PCD should only be undertaken by appropriately trained and authorised personnel.Where PCD is sent in password protected documents via NHS Mail the password to the document must be communicated separately preferably via a phone call directly to the person authorised to receive that information.Staff must also be aware of HSCIC: Sending an encrypted email from NHSmail to a non-secure email address:<https://s3-eu-west-1.amazonaws.com/comms-mat/Training-Materials/Guidance/encryptionguide.pdf>  |  |  |  |  |
| **3** | Where necessary consent is obtained from the data subject for any transfers of PCD in line with the documented information sharing agreement for that service. Where consent is not the basis for the transfer, then a legal justification must be identified and documented. |  |  |  |  |
| **4** | Secure methods of transfer appropriate to the information being transferred have been determined and implemented. |  |  |  |  |
| **5** | Routine transfers of PCD, to and from the organisation, by whatever method, should be recorded on a data mapping spreadsheet, to ensure appropriate controls of the data at all times.An Information sharing agreement should be documented and agreed by all parties to the information sharing |  |  |  |  |
| **6** | If information is to be transferred by means of DVD or memory stick these must be encrypted and the encryption password communicated separately, preferably via a phone call directly to the person authorised to receive that information.The DVD or memory stick should be sent via tracked mail. |  |  |  |  |
| ***Removing Information from secure storage point, including sending to archiving*** |
| **1** | Staff who are required to remove PCD from organisational premises should be approved to do so and the approval recorded.All staff approved should have signed to say they have read and understand the associated policies. e.g. mobile working, safe haven, code of confidentiality, etc. |  |  |  |  |
| **2** | A record made of information to be taken from its storage point should be made in the tracking systems in place. NB/ This tracking system should be completed every time information is removed from its storage point, even if it remains in the office.Should records be transferred between members of staff both inside and outside the office a record of this must be made within the tracking systemThis should be monitored to ensure records are returned. |  |  |  |  |
| **3** | Only the minimum PCD required for the purpose should be taken when taking records off site.These records should never be left unattended. |  |  |  |  |
| **4** | Appropriate transportation methods should be implemented, e.g. carried in a locked container or via encrypted electronic methodology. |  |  |  |  |
| **5** | Staff should be aware that when records are to be transported this must be out of sight i.e. in the boot of the car and that they should not be left in vehicles for long periods, e.g. over night. Where records are to be left in car boots for necessary operational reasons then this should be signed off as agreed by the appropriate governing body. |  |  |  |  |
| **6** | In situations where staff have been authorised to take records home it must be evidenced that they are aware that the records must be kept securely and not accessible to other members of the household or visitors and records must be returned to their secure storage point ASAP. |  |  |  |  |
| ***Incoming Mail***  |
| **1** | Staff should be aware that letters marked private and confidential should be opened by the addressee or appropriate nominee only and opened away from public areas |  |  |  |  |
| ***Outgoing Mail*** |
| **1** | Confirm from verifiable records the correct name, department, and address are being used, for the intended recipient of the correspondence.A record of information being sent should be maintained on the project or patient file, including when, to whom and by what methodWhen necessary ask the recipient to confirm the receipt of the package. If acknowledgment is not received then it must be followed up as this may be the first indication of a potential breach. |  |  |  |  |
| **2** | Staff should ensure packages are addressed correctly, and marked appropriately e.g. **private and confidential** where necessary.Return addresses should be annotated on all outgoing mail, to enable recipients to return incorrectly received correspondence without opening it. |  |  |  |  |
| **3** | Staff should be aware of the correct packaging methods for PCD being sent out and a standard procedure should include a check that the contents being placed in the package are for the addressee of the package. |  |  |  |  |
| **4** | Staff should be aware of the correct method for sending PCD e.g. courier, post, tracked /special delivery, etc.Nb. Sending an item via special delivery needs to be balanced against the risk of any confidentiality breach and practical and cost issues of using special delivery |  |  |  |  |
| ***Secure Email***  |
| **1** | Staff should be aware that only NHS Mail and associated secure government email systems are to be used for the transmission of PCD. Also that only the minimum PCD required for the purpose should be communicated. Guidance on the use of NHS Secure Mail can be found at: <https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb1596-secure-email> |  |  |  |  |
| **2** | All secure email addresses should be checked to ensure the correct email recipient has been selected. Delivery and read receipt options should be selected to verify the message has been successfully sent and the recipient has read it. |  |  |  |  |
| **3** | Recipients of email correspondence should be checked to ensure that it is appropriate for them to receive the PCD for the intended purpose(s)**NB**/ Only recipients with a genuine need to know should receive the PCD this includes CC’s and BCC’s |  |  |  |  |
| **4** | Secure emails containing PCD should be marked confidential. |  |  |  |  |
| **5** | The organisational standard disclaimer has been placed on all emails stating ‘this email is confidential and is intended for the named recipient(s) only. If you have received this email in error please delete it and notify the sender accordingly. Unauthorised copying and or use of this email if you are not the intended recipient may result in legal action being taken.’ |  |  |  |  |
| **6** | PCD sent or received via email should be safely stored and archived, as well being incorporated into the appropriate record, including an audit trail of actions. |  |  |  |  |
| ***Telephone Conversations*** |
| **1** | Staff should be aware that all telephone conversations regarding PCD should be kept to a minimum and take place in a private area where they cannot be over heard by unauthorised personnel |  |  |  |  |
| **2** | When speaking to service users, carers and others, staff should confirm the caller’s identity and their authority to receive the information requested, if in doubt check with a manager. Where applicable job title, department and organisation of the caller should be taken, and then called back using a known verifiable number.It is important to guard against people seeking information by deception this is particularly risky when using mobile telephone numbers.This can be waived where a caller is known to you.  |  |  |  |  |
| **3** | Staff should be aware to use the secrecy (mute) button when putting callers on hold. |  |  |  |  |
| **4** | Where telephone messages containing PCD are received, they should preferably be emailed via NHS Mail to the intended recipient. If this is not possible the message should be placed in an envelope, sealed and addressed to the intended recipient, marked private and confidential. |  |  |  |  |
| **5** | In the event of requests for information by telephone, staff should confirm the identity of the requestor and their authorisation to receive the information. If in doubt staff should be aware to check with a senior manager.This could mean calling the enquirer back via a main switch board. **NB/** **DO NOT** use direct lines for verification purpose as number given by callers may not be genuine. |  |  |  |  |
| ***Incoming Voicemail and Answerphone messages***  |
| **1** | When checking messages on an answer phone staff should ensure they cannot be overheard by unauthorised personnel. |  |  |  |  |
| **2** | Where message books are used is it essential that these are held securely and access to them is on a need to know basis, as appropriate to their staff member’s job role.**NB/** Messages should not contain PCD but should refer readers to proper records. |  |  |  |  |
| ***Answerphones Outwards*** |
| **1** | Staff should be aware that should they need to leave an answer phone message that they should only leave a name and phone number for call back.Do not indicate the reason for the call. |  |  |  |  |
| ***Verbal Transfer of Information*** |
| **1** | Staff should be aware that whenever they are transferring information verbally they must ensure they cannot be overheard by unauthorised personnel. |  |  |  |  |
| **2** | Where service users register at reception it should be ensured that any personal details they need to give cannot be overheard. |  |  |  |  |
| **3** | Where discussions include PCD they must not take place in a communal areas, e.g. shared offices, or anywhere else where you can be overheard by unauthorised personnel.  |  |  |  |  |
| **4** | Where message books are used they should be held securely and access limited on a need to know basis. **NB**/ Messages should not contain PCD but should refer readers to proper records. |  |  |  |  |
| ***Information Sharing***  |
| **1** | Staff should be aware of their responsibilities in respect of information sharing and documented protocols put in place where information sharing forms a routine part of the service provision. |  |  |  |  |
| **2** | Staff should be aware of guidance available e.g. The Confidentiality NHS Code of Practice. |  |  |  |  |
| **3** | Responsibility for making Information sharing decisions should be delegated to appropriate senior personnel. |  |  |  |  |
| ***Subject Access Requests***  |
| **1** | Staff should be made aware of their responsibilities in respect requests received and appropriate staff identified and trained to deal with these requests. |  |  |  |  |
| **2** | Staff should be able to advise individuals on how to apply for a copy of their information. |  |  |  |  |
| **3** | Records are reviewed by a clinician or senior manager as appropriate to ensure no exempt information is sent out and that the correct records are being sent to the correct recipient in response to the request. |  |  |  |  |
| ***Disposal of Information*** |
| **1** | Secure methods of disposing of PCD, whatever format it may be in, should be identified and implemented. This must be done in compliance with the NHS Code of Practice for Records Management. |  |  |  |  |
| **2** | A register of records destroyed must be maintained. This must be done in compliance with the NHS Code of Practice for Records Management. |  |  |  |  |
| ***Reporting Incidents***  |
| **1** | Staff should be aware that all breaches of confidentiality and information security must be reported, including near misses.Staff should be trained in the corporate incident reporting system. |  |  |  |  |
| ***Highlighting Security Weaknesses*** |
| **1** | Staff should be aware that they are responsible for reporting security weaknesses identified to their manager for corrective action |  |  |  |  |
| ***Training***  |
| **1** | All staff have been briefed and are aware of information handling, transferring, sharing and security requirements.IG Statutory and Mandatory Training must be been completed annually and additional Information Governance Training Needs Analysis, training modules identified to be completed as appropriate to the job role. |  |  |  |  |
| ***Business Intelligence Only (Implementation of Accredited Safe Haven)***  |
| **1** | In order to be able to use weakly de-identified PCD the organisation must have been approved as an accredited safe haven via the HSCIC. |  |  |  |  |
| **2** | Where weakly de-identified PCD is used then the number of personnel who can trace NHS Numbers must be kept to a minimum and documented. |  |  |  |  |
| **3** | Appropriate pseudonymisation methodologies must be implemented to pseudonymise PCD before it being released to staff to undertake their duties. |  |  |  |  |
| ***Documented Procedures*** |
| **1** | Controls and procedures put in place, in line with this standard, have been documented, made available to staff and staff trained appropriately |  |  |  |  |
| ***Residual Risks*** |
| **1** | All risks identified in this audit which cannot be mitigated must be reported to and approved by the appropriate governing body and recorded on the risk register. |  |  |  |  |

**Note this list is not exhaustive other controls can be implemented if thought required**

**Appendix 1**

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| 1. **Equality Impact Analysis**

 |
| **Policy / Project / Function:**  | Security and Transmission of Personal Confidential Data and Information (Safe Haven) Policy |
| **Date of Analysis:**  |  02/12/2020 |
| **This Equality Impact Analysis was completed by:** **(Name and Department**)  | Hayley Gillingwater – Senior IG Specialist  |
| **What are the aims and intended effects of this policy, project or** **function ?** | This document provides justification and defines guidance for the transfer of personal confidential data in a secure way. |
| **Please list any other policies that are related to or referred to as part of this analysis?** |  |
| **Who does the policy, project or function affect ?**  Please Tick ✔ |   Employees [x]    Service Users [ ]   Members of the Public [ ]   Other (List Below) [ ]   |

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| 1. **Equality Impact Analysis: Screening**
 |  |
|  | Could this policy have a positive impact on… | Could this policy have a negative impact on… | Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact |
|  | Yes | No | Yes | No |  |
| **Race** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Age** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Sexual Orientation** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Disabled People** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Gender** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Transgender People** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Pregnancy and Maternity** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Marital Status** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Religion and Belief** | [ ]  | [x]  | [ ]  | [x]  |  |
| **Reasoning** |  |
| **If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7** |

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| 1. **Equality Impact Analysis: Local Profile Data**
 |
| **Local Profile/Demography of the Groups affected** (population figures)  |
| **General**  |  |
| **Age** |  |
| **Race** |  |
| **Sex** |  |
| **Gender reassignment** |  |
| **Disability** |  |
| **Sexual Orientation** |  |
| **Religion, faith and belief** |  |
| **Marriage and civil partnership** |  |
| **Pregnancy and maternity** |  |

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| 1. **Equality Impact Analysis: Equality Data Available**
 |
| **Is any Equality Data available relating to the use or implementation of this policy, project or function?** Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *‘Equality Groups’.* Examples of *Equality Data* include: (this list is not definitive) 1. Application success rates *Equality Groups*
2. Complaints by *Equality Groups*
3. Service usage and withdrawal of services by *Equality Groups*
4. Grievances or decisions upheld and dismissed by *Equality Groups*
5. *Previous EIAs*
 |  Yes [ ]   No [x] Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document).  |
| **List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function**  |  |
| **Promoting Inclusivity****How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation** |  |

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| 1. **Equality Impact Analysis: Assessment Test**
 |
|  **What impact will the implementation of this policy, project or function have on employees, service**  **users or other people who share characteristics protected by *The Equality Act 2010* ?** |
|  **Protected**  **Characteristic:** | **No****Impact:** | **Positive****Impact:**  | **Negative****Impact:**  |  **Evidence of impact and if applicable, justification**  **where a *Genuine Determining Reason* exists**   |
| **Gender** (Men and Women)  | X |  |  |  |
| **Race** (All Racial Groups)  | X |  |  |  |
| **Disability**(Mental and Physical)  | X |  |  |  |
| **Religion or Belief** | X |  |  |  |
| **Sexual Orientation** **(Heterosexual, Homosexual and Bisexual)** | X |  |  |  |
|  **What impact will the implementation of this policy, project or function have on employees, service**  **users or other people who share characteristics protected by *The Equality Act 2010* ?**  |
|  **Protected**  **Characteristic:**  | **No****Impact:** | **Positive****Impact:**  | **Negative****Impact:**  |  **Evidence of impact and if applicable, justification**  **where a *Genuine Determining Reason* exists**   |
| **Pregnancy and Maternity**  | X |  |  |  |
| **Transgender**  | X |  |  |  |
| **Marital Status** | X |  |  |  |
| **Age**  | X |  |  |  |

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| 1. **Action Planning**
 |
| **As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?**  |
|  **Identified Risk:**  |  **Recommended Actions:**  | **Responsible Lead:**  | **Completion Date:**  | **Review Date:**   |
|  |  |  |  |  |
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| 1. **Equality Impact Analysis Findings**
 |
| **Analysis Rating:**  | * Red
 | * Red/Amber
 | * Amber
 | * **Green**
 |

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| --- | --- | --- |
|  | Actions | Wording for Policy / Project / Function |
| **Red****Stop and remove the policy** | **Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.  | **Remove the policy**Complete the action plan above to identify the areas of discrimination and the work or actions which needs to be carried out to minimise the risk of discrimination. | No wording needed as policy is being removed |
| **Red Amber****Continue the policy** | As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken. | **The policy can be published with the EIA**List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE).Consider if there are any potential actions which would reduce the risk of discrimination.Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date. | As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason exists which justifies the use of this policy and further professional advice.***[Insert what the discrimination is and the justification of the discrimination plus any actions which could help what reduce the risk]*** |

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| **Equality Impact Findings (continued):** |
|  | Actions | Wording for Policy / Project / Function |
| **Amber****Adjust the Policy** | As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document. | **The policy can be published with the EIA**The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination.Any changes identified and made to the service/policy/ strategy etc. should be included in the policy.Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date. | As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document.***[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]*** |
| **Green****No major change** | As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage. | **The policy can be published with the EIA**Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date | As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage. |

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| **Brief Summary/Further comments** |  |

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| **Approved By** |
| Job Title: | Name: | Date: |
|  |  |   |

**Appendix 2**

**SUSTAINABILITY IMPACT ASSESSMENT**

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| **Policy / Report / Service Plan / Project Title:** |
| **Theme (Potential impacts of the activity)** | **Positive****Impact** | **Negative****Impact** | **No specific****impact** | **What will the impact be? If the impact is negative, how can it be mitigated? (action)** |
| Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020 |  |  | X |  |
| New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements. |  |  | x |  |
| Reduce the risk of pollution and avoid any breaches in legislation. |  |  | x |  |
| Goods and services are procured more sustainability. |  |  | x |  |
| Reduce carbon emissions from road vehicles. |  |  | x |  |
| Reduce water consumption by 25% by 2020. |  |  | x |  |
| Ensure legal compliance with waste legislation. |  |  | x |  |
| Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020 |  |  | x |  |
| Increase the amount of waste being recycled to 40%. |  |  | x |  |
| Sustainability training and communications for employees. |  |  | x |  |
| Partnership working with local groups and organisations to support sustainable development. |  |  | x |  |
| Financial aspects of sustainable development are considered in line with policy requirements and commitments. |  |  | x |  |