Leicestershire Partnership NHS Trust

Clinical System Access and Confidentiality Audit Policy and Procedure

This policy sets out the expectations relating to the access to clinical systems and the confidentiality audit and monitoring undertaken to support assurance that controls are in place to ensure appropriate access and compliance with confidentiality requirements.

Key Words:	Clinical Systems, access, confidentiality, audit, monitoring	
Version:	1	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	10 September 2021	
Name of Author:	Head of Data Privacy/Data Protection Officer	
Name of responsible Committee:	Data Privacy Committee	
Please state if there is a reason for not publishing on website:	n/a	
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Target audience:	*All Staff*	
Type of Policy	Clinical √	Non Clinical √
Which Relevant CQC Fundamental Standards?	Regulation 10 – Dignity and Respect; Regulation 17 – Good Governance	

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
0.1 Draft	10/05/21	First development draft for consultation
1.0 Draft	30/06/21	Final draft for approval

For further information contact:
Head of Data Privacy/Data Protection Officer
LPT-DataPrivacy@leicspart.nhs.uk

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination;
- LPT complies with current equality legislation;
- Due regard is given to equality in decision making and subsequent processes;
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

Definitions that apply to this Policy

Alerts	Notification of an action taken that requires reviewing
Clinical Systems	An information system designed for use in a healthcare environment to record interactions with individuals being provided with care, treatment or support
Confidentiality Audit	Focus on control within electronic records systems to ensure rules around access are adhered to
Confidential personal data/information	Information relating to natural persons who can be identified or are identifiable directly from information or who can be indirectly identified from that information in combination with other information, and where it includes information of a sensitive nature (special category data) such as health data, genetic data, biometric data and ethnicity etc
Controls	Tools used to manage, organise and run in electronic systems
Information Asset Owner	The individual responsible for ensuring specific information assets are handled and managed appropriately.
Information Asset Administrator	Responsible for the day to day management of data
Legitimate relationship	The relationship that exists between a patient and a healthcare professional providing the therapeutic support.
Privacy Officer	The healthcare administrator responsible for safeguarding patient confidentiality
Proactive	Creating or controlling a situation rather than just responding to it.
Reactive	Acting in response to a situation rather than creating or controlling it.
Third Party	Someone who is not one of the main people involved in an activity but who is involved in a minor way.

1.0. Purpose of the Policy

This Policy addresses the access to clinical systems and the appropriate confidentiality audit procedure to monitor access to confidential personal data. This includes:

- Ensure users understand their obligations in relation to accessing the clinical systems
- How access to confidential personal data will be monitored
- Who will carry out the monitoring/auditing of access
- Reporting and escalation processes
- Disciplinary processes

The procedure also ensures that overall responsibility for monitoring and auditing access has been assigned to appropriate senior staff members e.g. Senior Information Risk Owner (SIRO), Caldicott Guardian, Head of Data Privacy (Information Governance Lead for the Trust) and Information Asset Owners (IAO's).

Confidentiality audits will focus primarily on controls within the electronic patient record system (clinical system) but should not exclude paper record systems, the purpose being to discover instances of inappropriate access and whether confidentiality has been breached or put at risk through deliberate misuse of access or because of weak, or non-existent or poorly applied controls.

This document defines the procedure for providing access to systems and carrying out audits relating to access to personal confidential data in the Trust to ensure staff only access the records for individuals with whom they have a legitimate relationship, where there is a legitimate business need, in line with the NHS Care Record Guarantee, Data Security and Protection Toolkit and compliance with Data Protection Legislation.

With advances in the electronic management of information within the NHS, the requirement to monitor access to personal confidential data has become increasingly important. Furthermore, with the increased movement of information via electronic communications, there exists an increasing threat of information being accessed by individuals who do not have a legitimate right to access it.

The procedure applies to all staff who work for or on behalf of LPT (including those working temporarily, on secondment, as students or as part of an integrated team arrangement) and who have access to LPT clinical systems. It also applies to relevant people who support and use these systems such as Application Support Staff in the Leicestershire Health Informatics Services (LHIS).

2.0. Summary and scope of policy

This policy applies to all of the Trust's staff and staff employed by partner organisations including non-healthcare providers who, during the course of their duties, will require access to the information held on the clinical system. Please note

that volunteers do not have access to Trusts' clinical systems; should the need and/or request to share information arise this can be done with the service users consent using other communication methods such as providing the latest copy of a risk assessment or via conversation with the clinical team.

The Policy sets out the processes required to provide access to clinical systems (mainly the electronic patient record) as well as the monitoring and auditing processes that are in place to safeguard personal and personal confidential information held within the clinical systems.

- New User Access requires that staff complete and sign the Registration Authority terms and conditions which outlines their responsibilities when accessing clinical systems. There are additional steps for access required for research purposes as well as those requiring temporary access as a temporary worker (both bank and agency) – See Appendix 7 for flowchart.

- There are circumstances where third party workers i.e. healthcare workers employed by organisations outside of the Trust but working in partnership, require access to the Trusts clinical systems. In these circumstances a Third Party Access Agreement is required to be completed prior to any access being applied.

- Privacy Officer roles are important in the proactive monitoring of confidentiality audit and systems have been put in place to enable monitoring and reporting to the Data Privacy Committee.

- Reactive auditing takes place where there are complaints, concerns or data protection incidents. This process is managed by the Trusts' Data Protection Officer and Deputy Data Protection Officer, with escalation to the Caldicott Guardian and SIRO.

3.0 Introduction

The Data Protection Act 2018 and the Retained General Data Protection Regulation 2016/679 (UK GDPR) require the Trust to implement technical and organisational measures to protect all personal data and information held within its systems. These control measures should support the Trust to manage and safeguard confidentiality, including mechanisms to highlight problems such as incidents, complaints and alerts. Documented procedures should be implemented to ensure these controls are monitored and audited. This forms part of the key assurance requirement and underpins the Confidentiality aspect of the CIA Triad (Confidentiality, Integrity and Availability).

Service users of the Trust expect that information in their clinical record will be treated as confidential. The Trust expects all employees to recognise and act upon their responsibility to maintain patient confidentiality. The duty of confidentiality is confirmed in professional guidelines and contracts of employment.

Trust standards and expectations relating to information security and confidentiality are detailed in the Trusts' Data Protection and Information Sharing, and Information Security and Risk Policies. Any breach of confidentiality with regard to the disclosure of, or inappropriate access to, patient's personal information held by the Trust is a disciplinary offence, and may result in dismissal and/or prosecution.

Leicestershire Partnership NHS Trust (LPT) is required to have processes to highlight actual and potential confidentiality breaches in its systems, particularly where sensitive/personal confidential data is held. The Trust should also have procedures in place to evaluate the effectiveness of controls within these systems. All systems which process personal/sensitive confidential data should have audit trails that can report details of who has viewed and accessed specific records.

Failure to ensure that adequate controls to manage and safeguard confidentiality are implemented and fulfil their intended purpose may result in a breach of confidentiality, thereby contravening the requirements of Data Protection legislation, the Human Rights Act 1998 and the Common Law Duty of Confidentiality.

Types of Confidentiality Alerts:

- Follow ups or failed log-in reports provided for information systems
- Monitoring of incident reports regarding stolen/lost computers/laptops, disclosure of confidential information
- Internal audits of reviews of IT security
- Complaints from members of the public/patients or staff
- Informal alerts made by staff
- Reported near misses
- Privacy Officer alerts generated within the clinical system

'Legitimate access' to a patients' record is defined as 'A clinical reason to access the record'. It is not acceptable to simply search the clinical systems. Should a staff member know a person open to services personally they should declare this to their line manager.

4.0. Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

4.3 Senior Information Risk Owner (SIRO), acts as an advocate for information risk on the Board and will be updated with the findings of the audits and receive copies of reports.

4.4 Head of Data Privacy/Data Protection Officer – the GDPR introduced the legal duty to appoint a Data Protection Officer (DPO) for all public authorities and on organisations that carry out certain types of processing activities.
The DPO will be responsible for ensuring that access to confidential information is audited within the Trust. Ensuring that reports produced from the clinical systems and other local computer systems by LHIS App Support are reviewed and followed up.

The Head of Data Privacy also fulfils the role of the Caldicott Guardian within the Trust's clinical system, which enables the monitoring of access when a clinician self-claims a legitimate relationship to a service user within the system and overrides consent.

4.5 Caldicott Guardian has overall responsibility for monitoring incidents and complaints relating to confidentiality breaches within the Trust and for ensuring that access to confidential information is regularly audited. They will work closely with the Head of Data Privacy to ensure that recommendations and concerns arising from confidentiality audits are actioned in a reasonable timeframe.

4.6 Data Privacy Committee – will be responsible for ensuring that Confidentiality Audit Procedures are implemented throughout the Trust in line with DSPT requirements.

4.7 Information Asset Owners (IAOs) are the Clinical Service Directors who are responsible for ensuring that staff for whom they are responsible are aware of their responsibilities with regard to the confidentiality of information, including ensuring that all staff have undertaken mandatory Data Security Awareness (IG) Training.

They will be responsible for ensuring their staff are fully aware of the mechanisms for reporting actual or potential personal data breaches within the Trust.

4.8 Information Asset Administrators/System Administrators (IAA's) are responsible for ensuring that access to personal confidential data is secure and strictly controlled.
Monitoring should be carried out by the responsible administrator/manager, such that instances of alleged inappropriate access or misuse of confidential personal data can be identified and reported.
Access to personal confidential data must be allocated on a strict need to know basis, by those who require such access to perform their duties. Appropriate documented authorisation must be obtained to demonstrate the need to know prior to any additional access being given.

4.9 Clinical Systems Change Team (LHIS) are responsible for the management, configuration, administration and operational support of the clinical systems. They are responsible for system development, upgrades, testing and ensuring that the system meets with local and national requirements.

4.10 Human Resources are responsible for any investigations in accordance with the Trusts' Disciplinary Policy in conjunction with Trust managers as deemed appropriate based on the severity of the incident.

4.11 Managers and Team leaders are responsible for ensuring that staff for whom they are responsible for are aware of their responsibilities with regard to confidentiality of information and ensure all their staff have completed their data security awareness (information governance) annual training.

They are also responsible for ensuring that their staff are fully aware of the mechanisms for reporting actual or potential confidentiality breaches; complying with confidentiality audits and ensuring subsequent recommendations are complied with within specified time frames.

Access to electronic and/or manual confidential information must be strictly controlled within each manager's area of responsibility. They will be responsible for ensuring appropriate authorisation is gained prior to allowing access to clinical systems and personal confidential data in order that only those with a legitimate right are given access.

4.12 LHIS Registration Authority Team are responsible for ensuring authorisation is documented and retained for monitoring purposes, this should include information as to who has gained access, the department, the reason the access was required, the date access was given etc.

4.13 Designated Privacy Officers and Sub-Privacy Officers are required to monitor failed access attempts (password lockout tasks) where a request for access has been denied or prevented. Regular monitoring should be undertaken in order to highlight potential areas of concern.

4.14 All Staff have a duty to read and work within current policies. They should ensure that personal confidential data is not accessed without prior authorisation and completion of appropriate documentation. Personal confidential information should also not be disclosed to unauthorised recipients.

Any breach or refusal to comply with this policy is a disciplinary offence, which may lead to disciplinary action in accordance with the Trust Disciplinary Policy, up to and including, inappropriate circumstances, dismissal without notice.

All staff should be made aware of confidentiality audits may take place at any time.

5.0 Systems Access

5.1 User Access Request

New system users, including those requiring 'read only' access, will be required to complete an electronic system access form through the LHIS Self Service portal, which will need to be authorised (have an Approver selected). Users must indicate

that they have read and understood this policy and the Registration Authority terms and conditions. Amendments to existing accounts will need to be requested via the same method.

Each request for access will be considered on an individual basis to ensure that the request is clinically appropriate and that the relevant access rights are granted.

5.1.1 Researcher Access Request

Where the applicant for an account is a Researcher, the request for a 'read only' account is made by the Research and Development Team, with the relevant R&D signatory. This is to ensure that the researcher is working on a research project where access to medical records with service user/patient consent has been approved by an Ethics Committee, or where appropriate, approval under Section 251 (access to medical records with patient consent) has been given by the Health Research Authority (HRA).

5.1.2 Non-substantive Worker Access

Access to patient's electronic records is required by all health professionals to facilitate continuation and clarity regarding patients care requirements and documentation of care delivered or issues encountered between all health professionals. It is therefore important that all staff providing care on behalf of the Trust are provided with the appropriate access.

Staff are required to follow the Non-Substantive Staff Access SOP for further information. See appendix 7 Non-substantive Staff Access Flow chart.

5.2 Access for Staff employed by Third Parties

There may be occasions when, in order to support seamless pathways of care, external agencies or partner organisations request that their staff are granted access to the clinical system.
An external agency might include (but not limited to):

- Another NHS Trust
- Local Authority
- Voluntary Sector Provider
- Private Sector Provider

A Third Party Access Agreement and where necessary, a Data Protection Impact Assessment will need to be completed and agreed both by the requester and the Trust and approved before any system access is granted.

All third party personnel requiring access to clinical systems will need to complete required system training and checking with their relevant organisation that they have

completed information governance training. Those third party personnel that require read and write access will need to undertake the relevant training for their role.

All requests for access to clinical systems by external agencies will be reviewed by the Data Privacy Team. A regular update will be provided in the Caldicott Report to the Data Privacy Committee on any requests and data protection impact assessment status.

5.3 Additional Access Requests

The Trust may need to provide access to clinical information to a number of groups including but not limited to: Legal Advisors, Auditors, Commissioners, Police Officers, Independent Medical Staff, Independent Mental Health Advocates and Mental Health Act Commissioners.

Dependent on the request, access may be granted via the subject access request process or via the supervised system access process.

Supervised access to the clinical system will be supported by a nominated member of staff to be able to access the relevant information in a timely manner.

The Data Privacy Team must be notified of each occurrence of supervised access in advance (where notice is provided) via the supervised system access request proforma. A register of all supervised access will be maintained and this will be reported in the Caldicott Report.

5.4 Notification of De-Activation of accounts

Line managers are responsible for requesting the de-activation of clinical system accounts when members of their team leave the Trust.

The manager will ultimately be responsible for all transactions that take place on accounts that should be closed and are still active as a result of non-notification on behalf of their manager. Requests for de-activation of accounts must be made via the LHIS Self Service Portal.

5.5 Review of User Accounts

The Registration Authority Team will conduct bi-monthly reviews of the use of active clinical system user accounts. Accounts that have not had a successful log in during the previous 90-days will be suspended. A request for re-activation of the account must via CIS@leics-his.nhs.uk and approved by an Authorised Signatory/Sponsor.

6.0 Monitoring and Auditing Access

In order to provide assurance that access to personal confidential data is gained only by those individuals that have a legitimate right of access, it is necessary to ensure appropriate monitoring is undertaken on a regular basis. This will be achieved by putting in place arrangements for both proactive and reactive auditing of access and communicated to all staff.

Monitoring may be carried out through the Data Privacy Team or with the Caldicott Guardians express written permission, the IAO in order that irregularities regarding access can be identified. If irregularities are detected these should be reported to the Data Privacy Team through to the Caldicott Guardian and action taken by the IAO to rectify the situation, either through disciplinary action, the implementation of additional controls or other remedial action as necessary.

Actual or potential breaches of confidentiality should be reported immediately to the Data Privacy Team and by logging this as an incident on Ulysses (incident reporting system – eIRF), in order that the incident can be assessed and action taken to prevent further breaches.

The Data Privacy Team will be responsible for informing the Caldicott Guardian and SIRO of any concerns highlighted as a result of monitoring activity.

Should unauthorised access to personal confidential data be gained by any individual or if information is disclosed to unauthorised recipients, this will be dealt with in accordance with the requirements of the Disciplinary Policy.

6.1 Proactive Monitoring

This will generally achieved for systems where an automated function exists for alerting of user access to records for subsequent review by someone with Privacy Officer/Caldicott Guardian roles within the system.

Examples of proactive monitoring systems accessed by LPT staff include:

- Summary Care Record
- SystmOne

These generate alerts when users access or override one of the information governance controls.

The alerts will prompt receiving staff to establish if the access was justified or potentially inappropriate, which will warrant further investigation. A reasonable sample size of alerts will generally be reviewed on a monthly basis.

The outcome of these reviews will be escalated for further investigation as appropriate, and issues/themes will be discussed at the Trust Privacy Officer Group in order to identify any lessons/review controls.

The role of the Privacy Officer and Sub-Privacy Officer is outlined in the Privacy Officer Standard Operating Procedure.

6.2 Reactive Monitoring

Reactive confidentiality audits will generally fall into two scenarios:

1. Where misuse of a system is alleged in relation to privacy/confidentiality breaches;
2. Where evidence is required to support management's concerns/investigations about staff conduct, e.g. excessive use of the internet, email activity or conduct (where the primary concern is not about privacy/confidentiality however the audit may have privacy implications).

This procedure addresses audit requests where privacy/confidentiality breaches are reported or suspected; and procedures for conducting audits in relation to staff conduct, management concerns/investigations will also be covered under relevant policies (i.e. Information Security and Risk Policy; Data Protection and Information Sharing Policy).

7.0 Confidentiality Audit and Escalation Process

7.1 Reactive Audit Process

Where an audit of user activity or access to records is required as part of an investigation, the request should initiated by the commissioning manager or an appropriate senior manager and audit requests should generally include a brief outline of the report/allegation and the information required, giving justification of the relevance of the audit information to the investigation.

An audit request form (Appendix 6) should be completed for audit requests and forwarded to the Data Privacy Team mailbox for the Data Protection Officer/Deputy Data Protection Officer to authorise and who has the responsibility to ensure that where necessary, a legitimate reason for access to the information is determined and where appropriate consent is obtained and the privacy of staff is not unnecessarily breached.

Approved requests will be sent to the LHIS Cyber Security Manager for logging as a service request.

Caldicott principles should be adhered to at all times, with only the relevant information being shared regarding the need for the audit.

Upon completion of the audit, the LHIS Cyber Security Manager will provide the audit report to the Data Privacy Team to review and remove any irrelevant information and feedback to the commissioning manager. It is important that audit reports are only seen by as few staff as possible; and the audit report kept securely.

Reactive/Investigation audits may identify evidence of:

- Unauthorised viewing/access to confidential/patient/staff records;
- Failed attempts to access confidential information;
- Repeated attempts to access confidential information;
- Successful access of confidential information by unauthorised staff;
- Evidence of shared login sessions and smartcards;
- Inappropriate communications with patients/service users;
- Inappropriate recording and/or use of sensitive/patient information;
- Inappropriate allocation of access rights to systems or other data;
- Inappropriate staff access to secure/restricted physical areas.

The Data Privacy Team, where required, will be responsible for liaising with HR colleagues to co-ordinate investigations into confidentiality breaches.

Investigation and management of confidentiality events and alerts will be conducted in conjunction with the relevant Privacy Officer and in line with the Trust's Disciplinary Policy and the Incident reporting Policy.

7.2 Proactive Audit Process

The Data Privacy Team will work with the Trusts Clinical Safety Officers and Privacy Officers to undertake sample audits of staff access within their relevant SystmOne Units during the financial year. A timetable will be developed and shared with the Data Privacy Committee in Quarter 4 in order that there is a clear audit and reporting schedule.

7.3 Providing Audit information to Patients/Service Users

Both the National Information Board in 'Personalised Health and Care 2020' and Dame Fiona Caldicott in the 'Report of the Caldicott Review' have reaffirmed the commitment made in the NHS Care Record Guarantee to ensure that a record of who has accessed a service user's/patient's record can be made available in a suitable form to service users/patients on request. All requests of this nature need to be directed to the Data Privacy Information Request Team.

8.0 Management of IG incidents

The Data Privacy Team monitors IG related incidents logged via the Trusts Incident Reporting system and will follow up all IG incidents via the Incident Review Meetings to achieve a satisfactory outcome in liaison with investigating managers. More serious incidents are managed using the Incident Reporting Tool on the Data Security and Protection Toolkit and are reported to the Data Privacy Committee, which will escalate any unsatisfactory outcomes to the Operational Executive Board and communicate pertinent IG messages/issues to staff using the Staff Newsletter, targeted communications etc.

Trends in incidents will be monitored in order to learn lessons and provide continual service improvement.

9.0 Training needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training.

10.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
13	Sample size of Privacy Alerts reviewed	Section 6.1	Privacy Officer Alert management	Privacy Officer Group	Monthly
13	Review of access in response to concern or investigation	Section 6.2	Caldicott Report	Data Privacy Committee	Quarterly
14	Liaison with HR to co-ordinate investigations	Section 7.2	Caldicott Report	Data Privacy Committee	Quarterly
15	Monitoring IG incidents of unauthorised access/disclosure	Section 8	Caldicott Report	Data Privacy Committee	Quarterly
15	Sample access audits	Section 7.2	Privacy Officer Management	Data Privacy Committee	Quarterly

11.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Data Security and Protection Toolkit assertion 4.1.2	The organisation knows who has access to what systems – list held of access granted
Data Security and Protection Toolkit assertion 4.1.3	An audit of user lists and profiles provided
National Care Record Guarantee, Commitment 2 - *'everyone looking at your record, whether on paper or computer, must keep the information confidential. We will aim to share only as much information as people need to know to play their part in your healthcare'*	An audit of user access to monitor compliance

12.0 References and Bibliography

The policy was drafted with reference to the following:

Data Protection Act 2018
Retained Regulation (EU) 2016/679 (UK GDPR)
The Care Record Guarantee, *'Our Guarantee for NHS Care Records in England', Version 5, 2011*

Non-Substantive Staff Access Standard Operating Procedure
Data Protection and Information Sharing Policy
Information Security and Risk Policy
LHIS Registration Authority Policy

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	Privacy Officer
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) x Role specific ☐ Personal development
Division(s) to which the training is applicable:	x Adult Mental Health & Learning Disability Services x Community Health Services x Enabling Services x Families Young People Children ☐ Hosted Services
Staff groups who require the training:	*Those individuals designated through their Clinical Safety Officer as a Privacy Officer within the EPR SystmOne*
Regularity of Update requirement:	Once
Who is responsible for delivery of this training?	CSO
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	x ULearn ☐ Other (please specify)
How is this training going to be monitored?	Report from Learning Management System

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	x
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	x

Appendix 3

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Chris Biddle	LHIS Cyber Security Manager
Ian Maslin	LHIS Deputy Programme and Training Manager
Afroz Kidy	LHIS Security, RA & Assurance Manager
Claire Mott	Clinical System Change Lead – Document Scanning
Pat Upsall	CHS Clinical & Operational Lead, IM&T, Data Quality & IG, Clinical Safety Officer
Tom Gregory	Clinical Safety Officer/DMH IM&T Clinical Lead

Circulated to the following individuals for comment

Name	Designation
Trust Privacy Officers	

Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	Clinical System Access and Confidentiality Audit Policy
Date Screening commenced	11 May 2021
Directorate / Service carrying out the assessment	Enabling/Data Privacy
Name and role of person undertaking this Due Regard (Equality Analysis)	Sam Kirkland, Head of Data Privacy
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To provide clear instruction around the processes for assigning access to systems and monitoring the activity against those systems in line with Data Protection Requirements	
OBJECTIVES: Provide clear instruction on the process for providing access to systems Provide clear instruction on the processes and escalation of monitoring and audit of systems	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No impact
Disability	No impact
Gender reassignment	No impact
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	No impact
Race	No impact
Religion and Belief	No impact
Sex	No impact
Sexual Orientation	No impact
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
The Policy is designed to ensure that the security and confidentiality of patient information held in the Trusts' electronic patient record is maintained and access monitored to ensure compliance with staff responsibilities for maintaining confidentiality.			
Signed by reviewer/assessor	Sam Kirkland	**Date**	30/06/21

Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Sam Kirkland	**Date**	30/06/21

Appendix 5

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Clinical System Access and Confidentiality Audit Policy	
Completed by:	Sam Kirkland	
Job title	Head of Data Privacy	**Date:** 11.05.2021

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	Yes	Where a disciplinary issue is identified
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	Yes	Where a disciplinary issue is identified
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Sam Kirkland, Head of Data Privacy**

Date of approval	30.06.2021

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 6

Request for Audit form

Please complete all sections

The request must be approved by the Information Asset Owner (Clinical Service Director)

Please complete sections 1-5 and email to LPT-DataPrivacy@leicspart.nhs.uk

1. The Person the audit is to be carried out on:

Name:	
Job Title:	
Base:	

2. System to be audited

Email:	
Internet:	
SystmOne Unit:	

3. Background reasons for the request

4. Specifics of audit requested: e.g. times, dates, patient IDs

5. Person requesting the audit

Name:	
Job Title:	
Designation to the above person:	
Contact details:	

Information Asset Owner Authorisation:	An authorisation email can be sent from the authorising IAO to LPT-DataPrivacy@leicspart.nhs.uk

Please note

LHIS staff with treat this as a matter of strict confidence. In some cases, they will need to remove the PC or Laptop concerned for investigation. From the time your request is logged, LHIS staff will keep a written notes of action taken, which will form an audit trail.

LHIS staff can provide advice/evidence from a technical perspective only.

If you have any questions about how the evidence should be treated in regard to a disciplinary policy/investigation, please contact HR.

To be completed by the Data Privacy Team

6. Is the request approved

Date request received:	
Audit Request Reference:	
Is audit approved?:	Yes No – Reason?

7. Feedback from Audit findings

Appendix 7

LPT Bank & Agency Workers Emergency Only Temporary Access to SystmOne