Information Security and Risk Policy

This document describes the controls, processes and risk management put in place to maintain the confidentiality, integrity and availability of information stored and processed on Leicestershire Partnership NHS Trust IT infrastructure

Key words: IT, cyber, information, security

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SUMMARY & AIM

The objectives of this policy are to establish and maintain the security and confidentiality of information, information systems, applications and networks owned or held by Leicestershire Partnership NHS Trust by:

- Describing the principles of security and explaining how they are implemented in the organisation. introducing a consistent approach to security, ensuring that all members of staff fully understand their own responsibilities.
- Creating and maintaining within the Trust a level of awareness of the need for information security as an integral part of the day to day business.
- Protecting information assets under the control of the Trust.

KEY REQUIREMENTS

All staff are personally responsible for ensuring that no breaches of IT security result from their actions and shall comply with this policy and the LPT Digital Acceptable Use Policy.

Other authorised users of Trust IT resources are personally responsible for ensuring that no breaches of IT security result from their actions and shall:

- Comply with this policy, its related processes, guidance and safe working practices;
- Confirm such agreement in writing, via contract, memorandum of understanding or other mutually agreed mechanism.

TARGET AUDIENCE:

This Policy applies to all substantive and bank staff, volunteers and any other individual who has legitimate approved access to Trust devices and systems.

TRAINING

All staff are required to complete annually Data Security Awareness Level 1 training.

1.0 Quick look summary

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

1.1 Version control and summary of changes

Version	Date	Author	Status	Comment
0.1	Oct. 2001	Vicky Hill	Initial Draft	
0.2	Aug. 2002	Vicky Hill	Draft	Post audit review
0.3	Mar. 2003	Vicky Hill	Final Draft	For approval
0.4	Jan. 2008	Vicky Hill	Draft	Update in line with standard 27001. Plus introduction of encryption tools.
0.7	May 2010	Vicky Hill	Draft	Regular review
0.8	Nov. 2011	Vicky Hill	Final	TCS Alignment Information Risk/ Security and Recording policies. Inclusion of LPT RA Policy and Access to Systems Policy. Expansion of e-commerce policy.
0.9	Oct. 2014	Vicky Hill		Review in line with ISP1
1.0	November 2016-17	Vicky Hill		Detailed review supporting ISP1 and ISO27001/2 2013
2.0	April 2018	Vicky Hill	Final	Amendments in line with changes in Data Protection Law and DSPT
3.0	July 2020	Head of Data Privacy	Draft	Full review including alignment with changes in the Data Security and Protection Toolkit and merger of various policies (Information Risk; IG Forensic Readiness) into one coherent policy
4.0	February 2023	Hannah Plowright	Draft	Full review and update to include reference to the LHIS Registration Authority Procedure as a requirement of the NHS Digital registration authority management
5.0	September 2024	Head of Data Privacy	Draft	Review in light of Audit feedback.

6.0	March 2025	Head of Data Privacy	Final	Disaggregation into two policies and the addition of Artificial Intelligence information. Information relating to individual user responsibilities has been moved to the Digital Acceptable Use Policy

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1.2 Key individuals involved in developing and consulting on the document

- Sarah Ratcliffe, Head of Data Privacy, LPT
- Chris Biddle, Cyber Security Manager, LHIS
- Afroz Kidy, Security, RA and Assurance Manager, LHIS

1.3 Governance

Level 2 or 3 approving delivery group
Data Privacy Group

Level 1 committee to ratify policy
Finance and Performance Committee

1.4 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.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 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.

1.6 Definitions that Apply to this Policy

Artificial Intelligence	Artificial intelligence (AI) is a set of technologies that enable computers to perform a variety of advanced functions, including the ability to see, understand and translate spoken and written language, analyse data, and make recommendations.
Anti-Virus	Software that provides an electronic defense mechanism mitigating the risk of a computing device being infected with or affected by malware.
Asset	Any information system, hardware, software, resource.
Breach	Any event or circumstance that led to unintended or unexpected harm, loss or damage.
Caldicott Principles	Set of Principles developed in the NHS relating to the management of patient information.
Digital Evidence	Any digitally stored evidence which may be captured and used to support a specified investigation.
Electronic Resource / Equipment	This includes computers (server, PC/workstation, laptop or any personal digital device), network assets, and any other peripheral equipment linked to the network, and also mobile phones and web enabled devices authorised for use for business which may not be linked to the network but could be used to send and receive text messages or other data.
Firewall	A firewall is security mechanism that limits access across a network connection.
Forensic/Incident Investigation readiness	The collection of digital evidence to meet the business risk assessment, and in advance of any incident occurring.
Hardware	Equipment concerning or connected to a computer is often referred to as hardware. This equipment is divided into two categories, hardware and peripherals. Hardware is the heart of any computer system enabling the processing and storing of electronic data. Hardware includes: • The base or tower unit of PC's – normally containing the processor and hard disk drive • Notebook or laptop computers • Network servers • Removable or external hard disk or zip drives • Removable or external tape drives. • Any other removable data storage devices • Smart devices (see hand held devices below)

Information Asset	A body of information, defined and managed as a single unit so it can be understood, shared, protected and exploited effectively.
Information Asset Owner	A named senior manager who is able to influence the SIRO and has responsibility for the security of identified assets.
IT Security/Cyber Security	IT security/Cyber security is the body of technologies, processes and practices designed to protect networks, computers, programmes and data from attack, damage or unauthorised access. The overarching aim to ensure confidentiality, integrity and availability of data and IT systems.
Information Security Management System	A systematic approach to managing sensitive information relating to the business, so that it remains secure. It includes people, processes and IT systems by applying a risk management process.
Media	Removable digital, laser, magnetic, optical or paper based information store. Examples include: • Medical records • Letters, documents, computer print-outs • Floppy disks • Magnetic Tape – (incl. audio, computer and video) • CD-R + CD-RW • USB drives • Any other make/type of equipment meeting this criterion.
Mobile Device	Any electronic device capable of creating, receiving, transmitting and storing portable data, with the ability to connect to, and exchange information with, a PC or laptop computer. This includes devices known as: • Hand held computers • Smart phones and tablets (including iOS and android devices). • Any other make/type of equipment meeting this criterion.
Monitoring	The interception of communications, monitoring systems, logging, recording, inspecting and auditing; and communication of this with nominated investigators to satisfy organisational responsibilities and obligations under the law.
Network	An infrastructure which is configured and maintained to assure performance, availability and integrity of information exchange between the computers and peripherals it connects.

Peripherals	Equipment connecting to hardware to enable input and output of electronic data; peripherals are often inter-changeable. They do not store data. Peripherals include: • Monitor • Keyboard • Mouse/trackball • Scanner • Printer • Projector
Personal Confidential Data (PCD)	The Caldicott review interpreted' **personal**' as including the **Data** Protection Act **definition of personal data**, but included **data** relating to the deceased as well as living people, and '**confidential**' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'sensitive'. The GDPR's definition of personal data is now also much broader than under the DPA. Article 4 states that "'personal data' **means** any information relating to an identified or identifiable natural person ('**data subject**')".
Registration Authority	The RA manages the registration process within the Trust, which includes the creation, distribution, and control of NHS Smartcards required for access to any NHS Care Records Service (NHS CRS), such applications include SystmOne and Electronic Staff Record.
Risk Management	The identification, assessment, and prioritization of risks. The level within the management hierarchy at which a risk is currently being managed at / has been escalated to
Senior Information Risk Owner (SIRO)	Director level manager who sits in the Board and is responsible for reporting information risk to the Board and Chief Executive.
Software	Programs loaded onto hardware may enable the user to create process and store information. Software may require a licence. Software includes the operating system, Microsoft Windows and application suites such as Microsoft Office, which comprises Access, Excel, Outlook, PowerPoint and Word.

Surveillance	**Intrusive –** defined by RIPA as covert surveillance which is carried out in relation to anything taking place in any residential premises or in any vehicle and involves the presence of an individual on those premises. NHS bodies **cannot** undertake this type of surveillance. **Directed –** Defined as covert surveillance which is not obtrusive, and is undertaken for a specific investigation and in a manner likely to obtain private information about a person. This is relevant here, only in fraud related cases

2.0 Purpose of the Policy

The aim of this policy is to establish an overarching framework, outlining the approach, methodology and responsibilities for Information security and risk that provides assurance that:

- IT resources, (including systems and the information contained within) are managed securely and consistently according to national/industry standard and corporately specified standards and practices.
- Safe and secure IT environments are provided for storage and use of the Trust's information and that information is accessible only on a 'need-to-know' basis.
- Information security risks are identified and controlled.

3.0 Summary and Key Points

The objectives of this policy are to establish and maintain the security and confidentiality of information, information systems, applications and networks owned or held by Leicestershire Partnership NHS Trust by:

- Ensuring that all members of staff are aware of their roles, responsibilities and accountability and fully comply with the relevant legislation as described in this and other data security and protection policies.
- Working with other partners/agencies to develop collaborative approaches, systems and processes relating to information security.
- Describing the principles of security and explaining how they are implemented in the organisation. introducing a consistent approach to security, ensuring that all members of staff fully understand their own responsibilities.
- Creating and maintaining within the Trust a level of awareness of the need for information security as an integral part of the day to day business.
- Protecting information assets under the control of the Trust.

4.0 Introduction

Leicestershire Partnership NHS Trust is a public body, with information processing as a fundamental part of its purpose. It is important, therefore, that the Trust has a clear and relevant Information Security and Risk Policy. This is essential to the Trust's compliance with data protection and other legislation and to ensure that confidentiality is respected.

Information is of greatest value when it is accurate, up to date and accessible from where and when it is needed; inaccessible information can quickly disrupt or devalue mission critical processes. This policy aims to preserve the principles of:

- ***Confidentiality*** – that access to data shall be confined to those with appropriate authority and protected from breaches, unauthorised disclosures of or unauthorised viewing.
- ***Integrity*** – that information shall be complete and accurate. All systems, assets and networks shall operate correctly, according to specification and not allow unauthorized modification of data.
- ***Availability*** – that information shall be available, delivered to the right person, at the right time when it is needed and protected from disruption, loss and denial of service attack.

Information stored on IT systems of the Trust, together with the various applications provided by these systems, are increasingly valuable corporate assets and it is therefore essential that the confidentiality, integrity and availability of all information stored and processed on Trust systems, together with the services provided by these systems, remains protected against known and emerging threats. The Trust's provision of healthcare must not be jeopardised through any breach, loss, or unavailability of our information systems.

This policy includes all IT resources under the ownership of the Trust and applies to:

- All information (digital, hard copy, photographic or audio) collected, processed, stored, produced, and communicated through the use of IT resources by or on behalf of the Trust.
- IT information systems owned by or under the control of the Trust.
- The Trust's networks, infrastructure, and websites.
- Any device or equipment that connects to the Trust's network which is capable of accessing, reproducing, storing, processing or transmitting information.
- To all users (including substantive employees, voluntary and bank workers, contractors, agency and sub-contract staff, locums, partner organisations, suppliers and customers) if the Trust IT resources and information contained within.

5.0 Policy Quick Reference Guide

For quick reference the guide below is a summary of the expectations of this policy. This does not negate the need for all staff to be aware of the detail outlined but is intended to assist staff in understanding their roles and responsibilities at a glance.

- The Trust employs systems to monitor use of its IT resources and, whilst conditional personal use of some IT resources is permitted, there must be no expectation of user privacy.

- All proposed changes to the Trust IT infrastructure and services (e.g., software upgrades / installations and new IT services) must gain approval through the Software Approval Process before implementation.

- Failure to comply with the requirements of this policy or inappropriate use of resources controlled by this policy is a serious matter and may result in the rights to use Trust systems and/or resources being withdrawn, disciplinary action or prosecution under law.

6.0 Duties within the Organisation

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

6.2 The **Trust Policy Committee** is mandated on behalf of the Trust Board to adopt policies.

6.3 **Trust Board Sub-Committees** have the responsibility for agreeing policies and protocols.

6.4 **Senior Information Risk Owner** (SIRO) is accountable for:

- Information risk within the Trust and advises the Board on the effectiveness of information risk management across the Trust;
- The Trust's information risk assessment process and information management;
- Overseeing adherence to this Policy to the satisfaction of the Trust;
- Ensuring documentation and appropriate action is taken where non-compliance to this policy or a need for improvement is identified.

6.5 **Caldicott Guardian** is responsible for ensuring implementation of the Caldicott Principles, National Data Guardian Standards and confidentiality and appropriate sharing of service user information throughout the Trust.

6.6 **Chief Digital Information Officer** is responsible for developing information technology (IT) strategy and maintaining the computer systems required to support an enterprise's objectives and goals.

6.7 **Data Privacy Group** is responsible for ensuring that this policy is:

- In accordance with data security and protection standards;
- Implemented and understood across the Trust

6.8 **Data Protection Officer** has responsibility for ensuring that data security and protection standards are implemented effectively across the Trust. Including:

- The co-ordination, action planning and reporting of information security work and activity;
- Maintaining the Trust's Information Asset and data flow mapping registers and their regular review;
- Ensuring that investigation into all data loss is completed,

6.8 **Service Directors and Heads of Service** are Information Asset Owners and System Managers and are responsible for the protection, security and day-to-day management of designated assets/systems, including:

- Development and enforcement of system security policies and appropriate operational and administrative procedures;
- The environments in which core and critical IT equipment are housed and information is processed and stored;
- The control and level of access (including privileged and administrative rights) granted to individual users of IT systems, networks and restricted areas housing core and critical IT equipment.
- Providing regular information security risk and vulnerability assessment and submission of results and mitigation plans to the SIRO;
- The development and maintenance of necessary business continuity and disaster recovery plans and verification of their regular testing;
- Appropriate reporting, investigation and necessary remedial/corrective action relating to incidents, security breaches and data loss associated with respective information assets.

6.9 Human Resources Department is responsible for ensuring:

- Information security requirements are addressed during recruitment and all contracts of employment contain appropriate confidentiality clauses;
- Information security responsibilities, duties and expectations are included within appropriate job descriptions, person specifications and HR policies and codes of conduct;
- Data security awareness training is included in the Trust's staff induction process and annual mandatory training;
- Supporting the LHIS cyber security specialists in any IT forensic investigations.

6.10 Head of Leicestershire Health Informatics Service (LHIS) is responsible for:

- Ensuring that the configuration and management of the Trust's IT equipment and networks is controlled through documented authorised policies and procedures based upon NHS and industry standards, best practice and recommendations;
- Authorising IT resources to be used by the Trust;
- Ensuring this policy is implemented and adhered to by the LHIS staff.

6.11 LHIS and its staff are responsible for ensuring the continuity and availability of Trust IT resources and the security and integrity of the data within its network. In addition to the other responsibilities and duties detailed in this policy, LHIS will:

- Ensure that all IT assets for which it is assigned responsibility are controlled by and subject to prescribed asset management procedures and processes;
- Ensure that IT equipment purchased on behalf of the Trust is added to the asset register, security labelled, protected and stored safely;
- Ensure IT equipment is appropriately configured for use and loaded with relevant licensed software;
- Allocate and configure individual user accounts and ensure associated user authentication of each authorised user of the Trust's IT resources;
- Provide and control external connections to the Trust's network in accordance with NHS standards and requirements;
- Ensure the removal of sensitive information and identity from the Trust's IT equipment,

its secure disposal and deletion from the asset register;
- Perform routine tests of disaster recovery procedures for core and critical IT equipment and key IT systems of the Trust;
- Ensure the provision of systems to monitor compliance with the Trust's IT policies and its legal and statutory obligations;
- Provide advice and guidance to users of the Trust's IT resources.
- Manage the day-to-day operation of the Registration Authority which manages Smart-card registration and access control processes.

6.12 Managers and Team leaders are responsible for ensuring that their permanent and temporary staff and contractors have read and understood this policy and, in addition to the other responsibilities and duties detailed in this policy, that:
- Staff are instructed in their security responsibilities, work in compliance with this policy, related processes, guidelines and safe working practices;
- Staff are appropriately trained in the use of the Trust's IT resources and systems;
- Property registers in Electronic Staff Records (ESR) are kept up to date with IT equip-ment that has been assigned to staff;
- Agreements are in place with suppliers and external contractors that ensure staff and sub-contractors comply with appropriate policies and procedures before access to Trust systems or use of its IT resources is permitted.

6.13 All staff are personally responsible for ensuring that no breaches of IT security result from their actions and shall comply with this policy and the LPT Digital Acceptable Use Policy.

6.14 Other authorised users of Trust IT resources are personally responsible for ensuring that no breaches of IT security result from their actions and shall:
- Comply with this policy, its related processes, guidance and safe working practices;
- Confirm such agreement in writing, via contract, memorandum of understanding or other mutually agreed mechanism.

7.0 Policy Requirements

7.1 Use of IT Resources

The Trust's IT resources are business tools and users are obliged to use them responsibly, ethically, effectively and lawfully. Users of the Trust's IT resources shall comply with Trust policies, current safe working practices and NHS standards and best practice guidance.

Confidentiality and security clauses associated with the use of the Trust's IT systems, other IT resources and information contained within shall be appropriately included in terms and conditions of employment and addressed during recruitment.

Members of staff shall receive appropriate training in the use of the Trust's IT systems, other IT

resources and personal security responsibilities before authorisation of their use is granted.

Members of staff provided with enhanced and privileged access rights (e.g. system and database administrators, Super Users, LHIS staff and similar) shall use their rights solely in the proper undertaking of their duties, and shall not deliberately access sensitive information without express and authorised permission.

With the exception of penetration and vulnerability testing that has been authorised by the SIRO, attempting to gain illegal or unauthorised access to data or systems, or seeking and exploiting weaknesses in IT systems or networks for unauthorised purposes, is a serious contravention of Trust policy and a criminal offence. It is strictly forbidden and is not tolerated under any circumstances by the Trust.

7.2 System Monitoring

In the interests of maintaining system security, complying with legal requirements, detecting and investigating unlawful activity and ensuring compliance with policies and standards is maintained, the Trust reserves the right to monitor use of its IT resources and information. This may include network access and activity, in-bound and out-bound traffic, device status and usage, session activity, password quality, e-mail usage, virus activity, web-browsing and critical event alerting.

Whilst conditional personal use of some IT resources owned by the Trust is permitted (e.g. email and internet), users should be aware that there must be no expectation of privacy. If privacy is expected, the Trust's IT resources must not be used for personal matters.

System monitoring reports will be provided as part of the cyber and information security metrics to the Data Privacy Group for scrutiny and identification of any further actions, which may include awareness messages.

7.3 Information Risk

Information risk management is part of the Trust's overall risk management framework, as information risk should not be managed separately from other business risks, and will be considered as an element of the overall corporate governance framework.

In assessing the risks related to individual information assets priority must always be given to those that comprise or contain personal information about service users, their families, carers and staff.

The table below sets out the main groups of information assets that are considered within each information risk.

Information Asset Description	Type of Information Held
Software	**Personal Information**

Information Asset Description	Type of Information Held
Applications and systems Data encryption Development and maintenance tools	Databases and data files, e.g. ESR Paper records, e.g. staff records, clinical records Paper reports, e.g. corporate records Audit data Back up and archive data
Hardware	**Other Information Content**
Computing hardware, e.g. servers, PCs, PDAs, IP Phones, laptops, removable media, cameras Network connections	Databases and data files e.g. ESR Audit data Back up and archive
Other Information Assets	**Other Information Assets**
Environmental services, e.g. power and air conditioning People skills and experience Shared services, including networks and printers Server rooms Training rooms and equipment Record libraries and archive stores	System information and documentation Operations and support procedures Manuals and training materials Contracts and agreements Business continuity and disaster recovery plans

Information risk is not the sole responsibility of IT or Information Governance staff. All staff have a responsibility to protect the security of confidential information particularly when it is person identifiable. All staff therefore should actively participate in identifying potential information risks in their areas and contribute to the implementation of appropriate action.

This requires a structured approach with the clear identification of specific roles and responsibilities to ensure that risks can be managed across all levels in the organisation. The Trust bases this approach on the clear identification of information assets. All information systems and equipment where data is held will be recorded on the Trust's asset register (database).

Ownership for each asset is allocated to a senior accountable manager. Information asset administrator roles are allocated to operational staff with day to day responsibility for managing risks within their designated information asset. Administrators are supported where appropriate by the Health Informatics Service with responsibility for providing technical assistance on information risk management.

7.3.1 Information Asset Management

An information asset is a body of information, defined and managed as a single unit so it can be understood, shared, protected and exploited efficiently. Information assets have recognisable and manageable value, risk, content and lifecycles.

Business continuity is a core component of corporate risk management and emergency planning. Its purpose is to counteract or minimise interruptions to an organisation's business activities from the effects of major failures or disruption to its Information Assets (e.g., data, data processing facilities and communications).

Information Asset Owners have a responsibility to consider the criticality of their assets defined in the table above and to ensure that they have appropriate plans in place in the event of an inability to access or use the asset.

Each department should assign an IAO who is directly accountable to the SIRO and must provide assurance through annual review that information risk is being managed effectively in respect of the information assets that they "own". The SIRO/IAO hierarchy identifies accountability and authority to effect change where required to improve identified risk. Information Asset Owners may assign Information Asset Administrators to support with this task.

The Trust Information Asset Register and Record of Processing Activity is managed by the Data Protection Officer. To ensure the Asset Register remains current, accurate and complete it will be subject to a rolling programme of annual review linked to the Data Security and Protection Toolkit submission. Information Asset Owners should undertake regular reviews to manage the information risks associated with their relevant assets. The Data Privacy Team will work with Information Asset Owners to capture essential information relating to the security, use, data type, storage location and criticality of each information asset. This information will then be collated and submitted to the SIRO for review via the Data Privacy Group.

7.3.2 Privacy and Safety by Design

Data Protection Impact Assessments (DPIA)

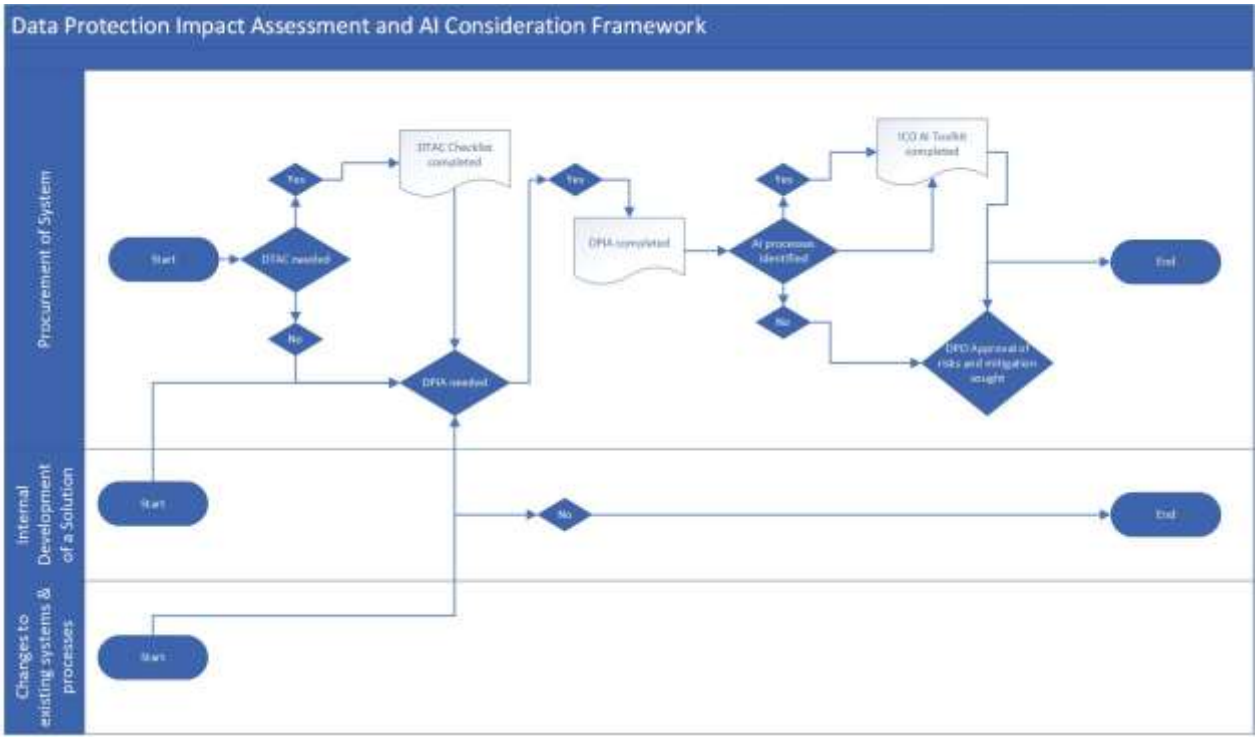
Data Protection Impact Assessments (DPIA) are an integral part of the project and change management process helping to assess privacy risks to individuals in the collection, use and disclosure of data. There is a statutory legal requirement for organisations to complete a DPIA under the UK General Data Protection Regulations and the Data Protection Act 2018.

Data Protection Impact Assessments must be carried out where there are any changes are made to systems or processes, new products or systems procured, or information shared or used in a different way and the processing of personal data is impacted.

The Trust framework includes the consideration of all types of Artificial Intelligence as one of the elements of assessing the impact of data processing on individuals' rights and freedoms. One of the key considerations is who an individual can hold accountable for the decision made about them. When it is a decision made directly by a human, it is clear who the individual can go to in order to get an explanation about why they made that decision. Where an AI system is involved, the responsibility for the decision can be less clear. There should be no loss of accountability when a decision is made with the help of, or by, an AI system, rather than solely by a human. Where an individual would expect an explanation from a human, they should instead expect an

explanation from those accountable for the AI system.

The Trust has adopted the following process which includes the Information Commissioner's Office Toolkit for Artificial Intelligence.



For further information on DPIA's refer to the LPT Data Protection Impact Assessment Policy and for further information on personal responsibility in relation to the use of Artificial Intelligence refer to the Digital Acceptable Use Policy.

Clinical Safety Assessment

Adopting digital clinical tools changes clinical practice, it changes the skill set required of clinicians and the inter-relationship with patients. To manage this there is a Clinical Safety Officer and a framework of support in place. The Trust has a responsibility to comply with guidance issued by NHS England and to comply with the Medical Device Regulation, as it relates to standalone software and Information Standard notices DCB1029 and DCB0160.

Clinical Safety Assessments are a form of risk assessment required for assets dealing with patient information and undertaken by the clinical safety officer.

7.3.3 Contract Obligations

There is a statutory legal requirement for organisations to manage contracts effectively to minimize data risk under the UK General Data Protection Regulations and the Data Protection Act 2018. Third party contracts which involve access to personal information and/or confidential corporate information will require a detailed assessment and sign off by the Data Protection Officer (DPO) and the equivalent senior approval at the contractor's organisation.

7.3.4 Adoption of Specific Action to Protect Patient Information

The Trust places significant importance on the need to protect personal confidential data particularly where release or loss may result in harm or distress to the individuals concerned.

The Trust will therefore identify and manage risk in secure ways associated with the transfer of data to and from other organisations where release or loss could result in a breach of confidentiality or data protection. All personal data will be protected to the same level and will encompass as a minimum all data falling into the categories below:

- Any information that links one or more identifiable living person with information about them whose release would put them at significant risk, harm or distress. This includes all types of sensitive personal information (i.e. age, gender etc.).

The Trust undertakes an annual information flow mapping exercise and from this exercise to determine the information risks regarding its data flows within the organisation and with its delivery partners.

The Trust undertakes to minimise the risk from unauthorised access to protectively marked information. This includes holding and accessing data on IT systems in secure premises, secure remote access, reducing and avoiding the use of removable media apart from where it is in an encrypted form, ensuring that all portable computers are encrypted. It also includes ensuring the secure destruction and disposal of electronic and paper media through a clearly defined destruction policy and set of procedures which includes shredding, confidential waste removal erasure and degaussing.

Action is taken to minimise the risk prevented by unauthorised access to protect information. This will be achieved through a variety of measures, including:

- Enforcing stringent access controls to both electronic and paper information systems which hold person identifiable information.
- Having in place arrangements to log and audit activity of data users.

7.3.5 Vulnerability Assessments (due diligence)

These assessments are undertaken:

- To ensure that new IT infrastructure is installed in an appropriate secure manner and when existing IT infrastructure undergoes a significant change;
- For any new system providing access to the Trust's or NHS data;
- When there is a significant change to a system that could affect its security (e.g. change to authorisation/authentication mechanism, interface change, etc).

All users of the Trust's IT resources are personally responsible for ensuring that no actual or potential security breaches occur as a result of their actions.

Potential and actual information security breaches associated with the use of the Trust's information and IT resources shall be reported and investigated in accordance with the Trust's Incident Reporting Policy and procedures.

In instances where collection, preservation and protection of digital evidence is required for legal or disciplinary matters, the Cyber Security Team will be contacted at the earliest opportunity.

7.4 Incident Management

Information incident reporting is in line with the Trust's overall incident management reporting processes. Information incidents will be reported as soon as possible and recorded in accordance with the Incident Reporting Policy, on an e-IRF. In addition, information incidents should also reported through the LHIS Service desk to the LHIS Information Security Manager.

Information incidents involving personal data are to be reported and managed in line with explicit guidance on the management of incidents involving personal data set out by NHS Digital via the Data Security and Protection Toolkit Incident Reporting Guidance.

7.4.1 Information Forensic Readiness

Information Technology Forensics provides a systematic, standardised, and legal basis for the admissibility of digital evidence that may be required to resolve formal disputes or support the legal process.

In the event of a suspicion that a computer or information system may have been used for a criminal or inappropriate purpose, persons appropriately trained and experienced in securing digital evidence from computers will be consulted in line with agreed procedures. The expert gathering of evidence will be undertaken by the authorised computer forensic investigators within by the Health Informatics Service.

This aspect of the Information Security and Risk Policy defines a systematic and pro-active approach to the gathering and preservation of evidence to meet the business needs. This is complementary to and an enhancement of many existing information security activities undertaken and seeks to highlight the links.

There are established policies and procedures for Incident Management, escalation of Serious Incidents (SIs), and including fast tracking of incidents which require admissible digital evidence to be gathered.

The process is supported by an incident management team, human resource expertise, qualified and authorised computer investigation experts and support staff (acting under instruction), in ensuring that evidence found in an investigation is preserved and that the continuity of evidence is maintained.

7.4.1.1 Business Risk Assessment

The following business scenarios are identified as the key risk areas which may require digital evidence. These will be reviewed annually.

- Reducing the impact of computer related crime (including cyber crime, intellectual property protection, fraud, extortion, content abuse, privacy invasion and identity theft)
- Dealing effectively with court orders to release data
- Demonstrating compliance with regulatory or legal constraints
- Producing evidence to support disciplinary issues
- Supporting contractual and commercial agreements
- Proving the impact of a crime or dispute

7.4.1.2 Evidence Collection Requirement

Where evidence required is not currently collected, collection will be subject to a cost benefit analysis. The SLSP documents the system owner (IAO and IAAs) and the forensic readiness, monitoring, retention and storage arrangements for the system. There is a detailed security risk assessment which includes consideration of the wider business risks identified in this policy e.g. computer crime, fraud and the business scenarios identified as needing digital evidence.

Named managers with responsibility for security (IAOs and IAAs) review system details and assurances, including forensic readiness, regularly and report assurances, weakness and risks to the SIRO.

7.4.1.3 Capability for Secure Gathering

The capability for secure gathering of legally admissible data to meet the requirement is delivered by authorised and suitably qualified computer forensic investigators, supported by the LHIS.

7.4.1.4 Approach to Surveillance

Surveillance must not be considered without obtaining advice and guidance from the organisation's Local Counter Fraud or Local Security Management Specialist.

Any surveillance undertaken must be logged in a Surveillance Log.

7.4.1.5 Digital Evidence Usage

Preparation to use digital evidence may include;

- Enhanced system and staff monitoring
- Technical, physical and procedural means to secure data to evidential standards of admissibility
- Processes and procedures to ensure that the importance and legal sensitivities of evidence is understood by staff
- Appropriate legal advice and interfacing with law enforcement.

7.4.1.6 Storage and Handling of Digital Evidence

Secure storage and handling of potential evidence, for example, that gathered through routine log files, or specific monitoring or surveillance activities will be

- Stored and handled with security measures that ensure the authenticity of the data

- Include procedures to demonstrate that the evidence integrity is preserved.

7.4.2 Managing Digital Evidence in Investigations

Incident capture, investigation, escalation, storage and handling of potential evidence and incident review, includes referral to the police where required.

There is fast track reporting of incidents which may require digital evidence to be used, to the SIRO. Under director level instruction, advice is taken from an authorised computer forensic investigator who liaises with the Incident Lead, Human Resources, the Local security manager, and the Counter Fraud lead as appropriate.

Legal review is requested as necessary.

See Appendix 5 for the range of possible evidence sources.

7.5 Control and Management of IT Assets

All IT resources of the Trust (hardware, software, networks, systems or data) are the property of the Trust; they shall be recorded in appropriate asset registers and have a named information asset owner or system manager who is responsible for the control, management and security of that asset.

All IT resources of the Trust will be securely and appropriately configured and managed following change management procedures. The networks of the Trust including firewalls are protected through the implementation of a set of well balanced technical and non-technical measures that provide effective and cost effective protection commensurate with assessed risk and vulnerabilities.

Unless approved by the SIRO, all systems procured for use by the Trust will comply with the minimum requirements set out within the relevant IT guidelines and be assessed to identify potential security threats, vulnerabilities and risks that might be introduced by their implementation.

System level security policies must be developed by information asset owners and system managers for all core IT assets and key IT systems.

The use of legacy hardware and software (that is products for which the vendor no longer provides support) shall be minimised and, where unavoidable, plans will be made to move to supported products as soon as possible. Where legacy products remain in operation the information asset owner or system manager shall regularly consult with LHIS technical teams to agree timely controls to be implemented to minimise risks that may occur from continuing usage (including ongoing monitoring effectiveness of implemented controls).

IT equipment owned and controlled by the Trust, and equipment that has been used for the storage of sensitive information, shall only be removed from its premises (temporarily or permanently) with prior, appropriate authorisation/documented release. Equipment will not be removed by a third party (e.g. the supplier, a repairer or disposal agent) until a signed confidentiality and transfer responsibility agreement has been exchanged or the equipment has been

appropriately sanitised to remove all data.

All mobile devices (including laptops, smartphones and removable media) will be encrypted at rest to prevent the data being read if the device is lost or stolen in accordance with NHS encryption standards. The Trust will use a Mobile Device Management (MDM) solution, to remotely delete data from mobile devices and revoke access.

In instances where IT (including removable media) equipment is to be allocated to a different user, or where it is to be repurposed, LHIS service desk shall be consulted to advise upon and carry out necessary clearing and sanitisation prior to reassignment.

At the end of life, all IT equipment (including removable media) owned or controlled by the Trust must be returned to LHIS for erasure of data and secure disposal in accordance with NHS standards and guidelines.

The Trust takes seriously its duties and obligations to use software responsibly, lawfully and in compliance with licensed terms and conditions. All software and systems used by the Trust will be:

- Properly licensed, and authorisation to use software and systems shall be dependent upon the availability of licenses;
- Used within the terms and conditions of the software license;
- Approved, tested, reliable and robust software that can be supported effectively by LHIS or a suitably qualified reputable third party supplier (only with the agreement of LHIS);
- Deployed or installed by LHIS or their authorised representative.

All changes associated with the deployment of new services, systems, software and IT solutions shall be subject to and managed via a formal and appropriately authorised change control procedure which may include the undertaking of a Data Protection Impact Assessment.

7.6 Access Control

Access to the Trust's IT resources and systems is restricted to users who have a justified business need to access the information contained within and are authorised by the relevant information asset owner or system manager.

Identification, authentication, passwords and/or smartcards are used to ensure access to the Trust's systems, devices and information is controlled and restricted to authorised users only.

7.6.1 Access Management Control

Access to Trust systems can be granted to the following types of individuals:

- Employees of the Trust – Staff directly employed by the Trust;
- External/Contract Employees – Staff employed by an external company and contracted to the Trust. This includes locums, secondees, students on placement, trainees and staff employed on the Trust's Bank;
- External Third-party support – Employees of external organisations that provide support for certain Trust systems may be granted restricted access;

- Access may be granted to others outside of the above categories in exceptional circumstances provided that there is a legitimate business requirement and that the access has been approved by the Head of Data Privacy or an appropriate deputy, with supporting Third Party Access Agreements in place.

7.6.2 User Account Types

Access privileges, including enhanced and privileged rights, shall be based upon the function of the role and not status of the user's post. They will be modified or removed as appropriate when a member of staff changes their role or leaves the employment of the Trust.

There are various types of user accounts to support role function which are set out below:

- Standard: The most common type with restricted rights to install software, change settings or access privilege systems. Standard accounts must be used only by the individual that has been assigned to them. Sharing of usernames and passwords is a breach of data security and protection which will be reported and investigated and may be subject to disciplinary proceedings.

- Shared: An account that may be used by multiple individuals for a specific purpose. Due to the inability to effectively audit their usage shared accounts are only provided where there is a strong business related reason for them. Shared accounts will be highly restricted to allow only access to the resources needed to carry out their purpose. Access to the Internet, email and other areas open to abuse will be disabled or highly restricted as appropriate

- Temporary: A short-term account to be used by a named individual. Similar to a standard account, temporary accounts will only be considered where users only require access for no more than a month, there is a high turnaround of staff or where there is a legitimate reason for access at short notice. All temporary account users must have a User Account Form completed for standard user account access and this must be authorised by the authorising manager.
- Privilege: An account with elevated access rights to enable access to a specific system or systems to allow a user to carry out business functions.
- Administrator/Super User: A type of privileged account that is granted the highest level of access.

Shared, temporary and pivileged accounts must be authorised by the Data Privacy Team or the Cyber Security Manager.

LHIS Information Security personnel will audit account types on a regular basis and may revoke access if deemed appropriate.

Remote access by third party suppliers of systems and software for support and maintenance purposes shall be subject to prior written agreement (either as part of a contract or specific separate agreement), and commitment to maintain confidentiality and integrity of the Trust's information and data.

7.6.3 User Account Creation

User accounts can only be requested by an authorising manager which is verified from the LPT IT Authorised Signatory list (managed by the Data Privacy Team).

Access to Trust systems will be set to automatically expire at a given time where an expected end date is known. Expired accounts can only be re-enabled following a request from the authorising manager.

All users will receive a standard user account. By default this will have the following access:

- Email account
- Internet access
- StaffNet access
- Personal data storage area (H drive)

Additional access rights to file share or to clinical systems etc. must be requested separately by the authorising manager/sponsor.

If assigned as an owner to a resource (such as a shared network folder), it is the duty of that owner to be fully responsible for this resource at all times. They should ensure the correct staff members have permissions to access the resource and to transfer ownership to a new owner upon leaving their role.

In some instances, the owner of a resource may delegate the right to request additional access rights to appropriate staff. In these cases, it is the responsibility of the owner to ensure that the list of delegates is kept up to date and that they carry out regular (at least annual) audit of requests made by these delegates.

It is the responsibility of the authorising manager to ensure that their staff are familiar with this policy and any associated policies regarding the secure use of user accounts and equipment.

Staff user accounts will be assigned the name, job title etc. that have been recorded by the Human Resources Department in the Electronic Staff Record (ESR). Where ESR has not been used to record all staff details (certain staff such as contractors are not always entered into ESR) the authorising manager must specify the required name when requesting access. Incorrect spelling of a name will result in a delay in the account being created or issues with the staff member logging in.

7.6.4 Changes to User Accounts

Where ESR has been used as the source of the account name etc., then any changes to this information must be requested via the Workforce Information Team using the HR Change of Circumstances form.

All changes to accounts must be requested via the LHIS Service Desk or the LHIS self service portal.

Staff changing job role, either permanently or as a result of secondment, must have their old access rights revoked and new access rights requested. It is the responsibility of both the

previous authorising manager and the new authorising manager to ensure these requests are made via the LHIS Service Desk or LHIS Self Service Portal, as the changes made to ESR may not always be directly applicable to the user's account details.

7.6.5 Disabling User Accounts

As soon as an individual leaves the Trust all their access to Trust systems and buildings must be revoked.

LHIS will carry out regular audits of inactive accounts and disable those that have not been used within 90 days. If they have been inactive for legitimate reasons, they can be re- enabled at the request of the authorising manager.

A regular list of staff leavers will also be passed to LHIS via ESR. It is still the responsibility of the authorising manager to ensure that the user account has been disabled.

Where staff are absent for an extended period, such as maternity leave or long-term sickness, it is the responsibility of the of the authorising manager to contact LHIS Service Desk so that the account can be disabled pending the staff member's return.

When a user account is disabled, all current access rights will be removed. Disabled accounts must never be allocated to a new individual.

Disabled accounts will be archived to prevent reuse of the username. Associated data for the accounts will be retained and only be deleted in line with the Trust's data retention policies.

7.6.6 NHS Smartcards and Registration Authority Procedure

Please refer to the LHIS Registration Authority Procedure for more detail on the use and management of Smartcards

The Registration Authority (RA is administered from within LHIS who are responsible for ensuring that all aspects of registration services and operations are performed in accordance with national policies and procedures along with providing arrangements that will ensure tight control over the issuance and maintenance of electronic smartcards. Information on national policy and procedure is available via the following link: https://digital.nhs.uk/Registration-Authorities-and-Smartcards

Role	Responsible for	Name
Board/EMT Accountable	The Board/EMT individual must report to the Board/EMT annually on RA activity and must sign off on RA via the Data Security and Protection Toolkit.	Sharon Murphy

Role	Responsible for	Name
RA Manager(s)	Running the governance of RA in the organisation agree and sign off on local operational processes and should assure themselves regularly that these processes are being adhered to, registering RA staff in their own organisations and any RA Managers in child organisations, ensuring the effective training of RA Agents and Sponsors within their organisation.	Afroz Kidy
Caldicott Guardian	This is a smartcard specific role that enables the user to action Caldicott Guardian tasks on SystmOne. These tasks include assessing requests to delete clinical record entries. This is a delegated role on behalf of the LPT Caldicott Guardian performed by Senior Members of the Data Privacy Team.	Dr Bhanu Chadalavada

Smartcard Use
Smartcards must be kept at all times with the card holder and all users must sign the nationally set Terms & Conditions of Smartcard use. This reminds them of their responsibilities and obligations, including not sharing the card, leaving the card unattended, and not disclosing their passcode/PIN to others.

Cancellation of Smartcard
All leavers must retain their NHS Smartcard if there is any possibility in the future that the user will access Spine enabled systems. If leaving the NHS, they should have their access revoked accordingly and hand in their Smartcard to the RA Agent.

Lost, Stolen or Damaged Smartcards
In the event a staff member has lost, stolen or damaged their Smartcard, they should report this immediately through the LHIS ServiceDesk. The cardholder must register the incident on the incident reporting system so that it can be investigated in line with Trust policy.

Replacement of lost, stolen and damaged Smartcards incurs a cost to the NHS.

Sponsors and Smartcard Unlocking
The following options are some which are available to Sponsors using the Care Identity Service (CIS);

- Raising and approving requests to assign and remove a user to a position
- Unlocking Smartcards and renewing certificates

7.6.7 Privilege Management

Accounts with elevated privileges will be strictly controlled and only provided where there is a demonstrable business requirement for it.

A record of who has privilege accounts and the reason for those accounts will be maintained by the relevant system or service owner.

Privilege access will be audited on an annual basis or immediately following an incident where a privilege access played a role. The audit results will form part of the Cyber Security Managers Cyber and Information Security Report to the Data Privacy Group.
Where privilege access is no longer appropriate it should be removed immediately.

Regular auditing of log files showing the use of privileged accounts will be carried out by the appropriate system owners or LHIS Information Security personnel.

7.6.8 Segregation of Duties

Where practical segregation of duties should be enforced to minimise the opportunity for unauthorised, unintentional or malicious access, modification, or denial of service of the Trust's information security assets.

7.6.9 Access to Log Files

Access to sensitive log files will be restricted to appropriate system owners, delegated admin teams and the LHIS staff.

Logs will be maintained in a secure environment that prevents unauthorised modification or deletion.

Regular audit of access to log files will be carried out and the outputs included in the Cyber and Information Security Reports to the Data Privacy Group.

Log file retention times are specified in the Retention Guidelines for Log files. If a log file contains relevant information that is useful for future reference, a pending transaction, or as evidence of a management decision, it should be retained. These log files should be retained for a period of six-months.

If a log file is retained for these purposes, it is the responsibility of the information asset administrators (IT support system support staff) to move these specific logs to a separate network location prior to the destruction of the log.

7.6.11 Other Access Considerations

- Access to and use of Trust's information in public areas and outside its premises is subject to additional measures of authentication, protection and requirements as specified in the Trust's Mobile and Remote Working guidelines.
- Only authorised personnel who have a justified and approved business need shall be given access to restricted areas of Trust buildings containing core and critical IT equipment. Staff entering and working in such areas will at all times comply with the Trust's current safe working practices associated with access to such areas.

7.6.12 Data and System Access

Access to Shares, Public Folders, Shared Calendars, and Shared Mailboxes will require authorisation from the owner or any assigned authorisers for that resource. For global distribution groups this can only be approved by Data Privacy Team who will support the identification of the owner of that group.

7.6 Systems, Databases and Application Development, Management and Maintenance

Local database or application creation or development must not be undertaken without prior consultation and agreement with LHIS and the Trust's Data Privacy Team. Where agreement is given all database creation and development must align with the Trust wide IM&T Strategy and comply with minimum standards for interoperability, data formats, capacity, auditing, performance and maintainability.

In house application development shall comply with the standards and working practices detailed in the relevant Trust IT guidelines.

Changes to IT systems shall be documented and assessed for their impact upon other systems prior to the change taking place.

All new releases of software applications and application developments shall be assessed in appropriate test environments prior to their release and be subject to satisfactory functional, non-functional and end-user-testing before being put into operational use.

Unless expressly and appropriately authorised, live sensitive information must not be used for testing, training or demonstration purposes unless it is transformed so that identification of any individual is not possible.

Live and test data shall be separated: If data is to be moved between live and test environments its migration shall be strictly controlled and subject to formal change control procedures.

Each IT system shall have a suitably trained administrator and documented operational procedures in place together with appropriate maintenance agreements.

7.7 Equipment Protection and Security

All IT hardware, software and systems purchased must comply with standards as defined in IT guidelines at the time of purchase.

IT equipment and systems not purchased through LHIS will not be connected to the Trust's network until it has been through testing and appropriate authorisation gained for connection.

Portable equipment (including removable media) shall be subject to the additional measures of protection and requirements as specified in the Trust's Remote and Mobile Working Guidelines.

7.8.1 Network Security

To minimise the risk of date leakage and malware propagation, network segregation will be

carried out using technology such as VLANS (Virtual Local Area Networks).

Individual systems may be isolates from the wider LAN to ensure that they meet internal, external or statutory security requirements.
VLANs will be managed by appropriately authorised LHIS staff The Network Security Policy provides further details.

7.8.2 Physical Security

- IT equipment will be sited where reasonably practicable to reduce risk from environmental threat and unauthorised access. Where equipment is kept or installed in public areas of Trust buildings, it will be positioned as far as reasonably practicable, to reduce risk of unauthorised access or casual viewing.
- Reasonable and appropriate measures shall be taken to minimise the risk of theft of the Trust's IT equipment including the secure anchoring of equipment in public areas.
- Environmental controls and monitoring systems that trigger alarms should problems occur shall be installed to protect the Trust's core and critical IT equipment.
- Ingress/Egress rights must be assigned to an individual via the use of a token such as a smartcard, fob or other physical object.
- Visitors will be provided with visitor badges for the duration of their visit and may be granted rights to non-sensitive areas at the discretion of the authorising manager and the LHIS Information Security Team
- Visitors **must not** be left unattended at any time in secure areas.
- It is the responsibility of the last person leaving a secure area to check that all the windows and doors are locked and that any alarm is activated.
- In the event of long term absence, such as sickness or maternity leave, it is the responsibility of the authorising manager to ensure that physical access rights have been revoked pending the staff member's return.
- Access to areas housing the Trust's core and critical IT equipment will be restricted and kept secured at all times.
- Where possible core and critical IT equipment of the Trust shall be connected to secured power supplies, using uninterruptible power supplies and generator backup services to ensure that it does not fail during failure of the mains supply or switchover between mains and generated supplies.
- Uninterruptible power supplies shall be dimensioned to ensure that relevant equipment and key IT systems can be shutdown by controlled processes in the event of continuing supply failure.
- IT and communications cabling shall be protected from interception or damage (via physical fabric of the building or in conduit) and sited in accordance with relevant standards in relation to electrical and heating services.

7.9 Information Storage and Sharing

Sensitive information shall:

- Only to be stored on Trust owned or controlled IT resources or authorised systems;
- Not to be intentionally placed on personal or privately owned devices and storage resources;
- Only to be sent outside the Trust with the authorisation of an appropriate Trust representative.

Staff shall only share information that is appropriate, relevant and authorised. Information that is shared electronically shall only be shared using Trust approved systems and solutions.

Information shall only be shared via email in accordance with the criteria and conditions detailed in the Trust Internet and E-Communications Policy, and Use of Electronic Communications with Service Users Policy.

Portable and removable media shall only be used to share information where secure direct transfer methods are not available, and under the following conditions:

- That it shall be in accordance with the requirements of the Trust's Remote and Mobile Working Procedures and associated IT Guidelines;
- That it is encrypted in accordance with NHS standards and guidelines;
- That, if not being transported personally by an authorised representative of the Trust, it is sent by a Trust approved courier or special (registered) delivery and confirmation of receipt must be obtained by the sender.

7.10 Operational Management and Procedures

Core and Key IT systems and services shall be backed up according to an appropriate schedule to ensure that business and operational functions of the Trust are not jeopardised and that data is retained for adequate intervals before being overwritten.

Back-up media shall be:

- Reputable and high quality media and devices;
- Clearly labelled and securely stored/located separate from the system location to protect against building loss.

Restoration processes shall be adequately documented to enable other (suitably qualified) staff to understand and employ them.

Backup data and restoration processes shall be regularly tested to ensure that they are effective and the results of those tests should be kept for the appropriate retention period.

Appropriate boundary protection controls and secure configuration techniques shall be used to ensure that:

- IT systems, devices and software are successfully and securely configured and locked down.
- Gateways are successfully and securely managed.
- Networks are securely designed and effectively monitored, and incidents are promptly responded to. Appropriate cryptographic controls that comply with NHS national standards and requirements will be used to ensure the integrity and confidentiality of communication, processing and storage of the Trust's information.

To ensure that risk disruption is maintained at an absolute minimum, all data residing on the Trust's network or flowing from it shall be protected against virus, malicious and mobile code software attack and cyber-attack.

All IT equipment (including portable equipment and removable media) should be scanned for viruses and malware before being connected to other Trust equipment or its network.

IT equipment and systems infected with viruses or malware that protective measures have not been able to deal with shall be quarantined by LHIS until they are virus free.

Operating systems, core and critical software, key applications and firmware shall be regularly updated with published security patches.

7.11 Business Continuity Planning

Business continuity and disaster recovery plans shall be put into place and regularly tested for all mission critical IT systems, applications and networks. Results of tests must be kept of the appropriate retention period.

Where possible and practicable, IT systems shall be designed to include controls that check for data corruption that has resulted from processing errors or other possible deliberate acts.

8.0 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 mandatory and role development training.

9.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
1	Asset approval process in place	Sec 6.3.1.1	Software approvals presented	IM&T Delivery Group	As required
2	Business continuity plans in place	Sec 6.3.1.1	Confirmation as part of DSPT requirement	Data Privacy Group	Annually
3	Contract obligations Due Diligence undertaken	Sec 6.3.2	Confirmation as part of DSPT requirement	Data Privacy Group	Annually
4	Data Flow mapping undertaken	Sec 6.3.3	Reports presented as part of assurance work for DSPT	Data Privacy Group	Annually
5	Disabling accounts	Sec 6.6.5	Numbers of accounts disabled included in Cyber and Information Security Reports	Data Privacy Group	Bi-monthly

6	Privilege account requests	Sec 6.6.7	Number of Privilege Account requests included in Cyber and Information Security Reports	Data Privacy Group	Bi-monthly
7	Audit of log files is undertaken	Sec 6.6.9	Outputs of Audit included in Cyber and Information Security Reports	Data Privacy Group	Bi-monthly

10.0 Standards / Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CQC Regulation 17 Good Governance	Submission of Standards Met for Data Security and Protection Toolkit on an annual basis

11.0 References and Bibliography

The policy was drafted with reference to the following:

- Incident Reporting Policy
- Data Protection Impact Assessment Policy
- Digital Acceptable Use Policy
- Agile Working Policy
- National Data Guardian Standard 2017
- Data Protection Act 2018 incorporating UK GDPR
- Regulation of Investigation Powers Act 2000

12.0 Fraud, Bribery and Corruption Consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	Data Security Awareness Level 1
Type of training: (see study leave policy)	x Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development
Division(s) to which the training is applicable:	x Mental Health x Community Health Services x Enabling Services x Families Young People Children/LD/A x Hosted Services
Staff groups who require the training:	All Staff
Regularity of Update requirement:	Annually
Who is responsible for delivery of this training?	eLearning via ULearn
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?	Monthly training reports to Managers

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 yes/no

Work continuously to improve quality services and to minimise errors yes

Support and value its staff yes

Work together with others to ensure a seamless service for patients yes

Help keep people healthy and work to reduce health inequalities yes/no

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes

Appendix 3

Stakeholders and Consultation

Circulated to the following individuals for comment

Name	Designation
Members of Data Privacy Group	
Members of IM&T Delivery Group	
Sharon Murphy	Exec Director Finance and Performance/SIRO
Gareth Jones	Group CDIO
Dr Bhanu Chadalavada	Medical Director/Caldicott Guardian
Trust Policy experts	

Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	Information Security and Risk Policy
Date Screening commenced	06/03/2025
Directorate / Service carrying out the assessment	Data Privacy Team Finance, Business & Estates
Name and role of person undertaking this Due Regard (Equality Analysis)	Head of Data Privacy/Data Protection Officer
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The policy and procedure sets out the activity in relation to information risk management.	
OBJECTIVES: Supporting the safe and effective use of digital technology within the organisation..	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	Neutral
Disability	Positive – Section 6.6.10 outlines specific support to those with a disability and requiring additional resources
Gender reassignment	Neutral
Marriage & Civil Partnership	Neutral
Pregnancy & Maternity	Neutral
Race	Neutral
Religion and Belief	Neutral
Sex	Neutral
Sexual Orientation	Neutral
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 tick 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.

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
The purpose of clinical coding is to support the outputs of clinical care and ensure that through the conversion of codes to financial currency, the correct level of care can be commissioned.			
Signed by reviewer/assessor	Sarah Ratcliffe	Date	03/03/2025
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Signed by head of service	Sarah Ratcliffe	Date	03/03/2025

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:	Information Security and Risk Policy	
Completed by:	Sarah Ratcliffe	
Job title	Head of Data Privacy/Group DPO	**Date** 03/03/2025

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.	Yes	Where a new system or software is procured but there is an approval process in place to assess the risk to data privacy and security
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	Dependent on requests made but there are processes in place to assess the risk before agreement for the data flow
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?	Yes	Where a new system or software is procured but there is an approval process in place to assess the risk to data privacy and security
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.	Yes	Where a new system or software is procured but there is an approval process in place to assess the risk to data privacy and security
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	Dependent on requests made but there are processes in place to assess the risk before agreement for the data flow
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.	Yes	Dependent on requests made but there are processes in place to assess the risk before agreement for the data flow
8. Will the process require you to contact individuals in ways which they may find intrusive?	Yes	It is possible dependent on requests made but there are processes in place to assess the risk before agreement for the data flow

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:	Sarah Ratcliffe, Head of Data Privacy/ Group Data Protection Officer
Date of approval	03/03/2025

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

Appendix 6

Information Forensic Investigation – range of possible sources of evidence

- Equipment such as routers, firewalls, servers, clients, portables, and embedded devices;
- Application software, such as accounting packages for evidence of fraud, ERP packages for employee records and activities (e.g. in case of identity theft), system and management files; Plus documents and data necessary to comply with legal or regulatory requirements.
- Monitoring software such as Intrusion Detection Software, packet sniffers, keyboard loggers, and content checker;
- External storage media / removable media;
- General logs, such as access logs, printer logs, web traffic, internal network logs, Internet traffic, database transactions, and commercial transactions, email traffic.

All but the simplest of computer systems require a password or authenticating device before allowing admission. Usually, these access control systems can be configured to maintain records of when usernames and passwords were issued, when passwords were changed, when access rights were changed and/or terminated. In addition, many systems also maintain logs of accesses or, at the least, of failed accesses. These logs, properly managed and preserved, are powerful evidence of tracking activity on a computer system.

All computers contain files which help to define how the operating system and various individual programs are supposed to work. In the current generation of Windows systems, the most important set of configuration information is the registry. From this, forensic technicians can discover a great deal about recent and past activity, including recently accessed files and passwords. Often, there are important configuration files associated with individual programs. Many operating systems also generate error and other internal logs.

- Other sources, such as CCTV, door access records, phone logs, PABX data, telco records and network records, call centre logs or monitored phone calls, and recorded messages; cell phones, PDAs (These last can hold substantial amounts of data. Technical methods for preserving and investigating them are more complex than those for PCs; in addition there may be additional legal problems as ownership and privacy rights may not be wholly clear)
- Back-ups and archives, for example, laptops and desktops; If individuals are under any form of suspicion, the organisation will need to be able to seize their PCs and make a proper forensic “image”, which produces a precise snapshot of everything on the hard disks (this includes deleted material which technicians may be able to recover).