Greater Manchester Information Governance Group (GMIGG)[1]

Data Protection Impact Assessment (DPIA)

The instrument for a privacy impact assessment (PIA) or data protection impact assessment (DPIA) was introduced with the General Data Protection Regulation (Art. 35 of the GDPR). This refers to the obligation of the controller to conduct an impact assessment and to document it before starting the intended data processing. Article 35(1) of the General Data Protection Regulations says that you must do a DPIA where a type of processing is likely to result in a high risk to the rights and freedoms of individuals:

"Where a type of processing in particular using new technologies, and taking into account the nature, scope, context and purposes of the processing, is likely to result in a high risk to the rights and freedoms of natural persons, the controller shall, prior to the processing, carry out an assessment of the impact of the envisaged processing operations on the protection of personal data. A single assessment may address a set of similar processing operations that present similar high risks."

The DPIA Process

The Data Protection Act is mainly concerned with the disclosure of personal data outside the data controller's own boundaries.[2]

*If the data is to be **anonymised** **PRIOR** to any processing you may not need to complete this DPIA and should review:*

- *question 1.20*
- *section 2*

and liaise with your IG Lead to confirm completion is not required.

Otherwise:

1) Please complete each section 1 - 4 with as much detail as possible. Your IG lead can complete section 5 but may need additional information from you. Section 6 onwards can be completed together with your IG Lead.
2) Once you submit the DPIA for approval to/via your Information Governance Lead/Data Protection Officer (DPO)
    a. The DPIA proforma will be vetted and you may receive some comments / questions asking for further information. Please answer these promptly and resend the DPIA again.
    b. The DPIA then goes for approval. It is considered for approval by the relevant IG internal approval process.
3) Once approved, the process / system can start to be introduced or modification to an existing system / process can continue.
4) ***If you proceed with the initiative without completing the DPIA and without approval via the IG DPIA approval process, you are putting the organisation at risk of being in breach of the DP legislation which may result in disciplinary procedures being invoked***.

Initiative/System/ Process name:	Greater Manchester Care Record (GMCR) – direct care
Link to any wider initiative: *(if applicable)*	NHS X National Shared Care Records Programme (ShCR) NHS X IG Framework for Integrated Health and Care GM Health and Social Care Partnership (GM HSCP) Digital Strategy
Date Initiative due to go live/commenced:	Initiative already live as detailed in GMCR DPIA version 1.0 April 2020
Date DPIA V1.0 review commenced:	05/07/2021

[1] GMIGG is one of the regional Strategic Information Governance Networks (SIGN) groups that feed into the national SIGN supported by NHS England and NHS Digital.

[2] ICO – Anonymisation code

DPIA Contact Details: ***Please list all main contacts involved in completing the DPIA including relevant service lead***	
Role	**Organisation/dept.**
GM Head of IG	GM Health and Social Care Partnership/Health Innovation Manchester

Version	**Date**	**Amendment History**
V1.0	23 April 2020	Approved
1.1 draft	12 July 2021	Revised draft for consultation
1.2 draft	2 September 2021	Revised draft following feedback to consultation
1.3 draft	8 October 2021	Further revised draft following 2nd consultation feedback
V2.0	20 Jan 2022	Final revision following 3rd consultation: • 1.2 & 1.3 wording moved into Appendix A • Graphnet deletion process moved to Appendix and risk action (5) added at GMCR2 section 6 • 1.8, 1.10, 1.11, 1.15 wording updated • 1.12 sentence removed • Appendices renumbered • Appendix B opening sentence amended to clarify the reason for an organisation needing to complete the onboarding application form. Additions made to updating public website and for onboarding organisation(s) to sign up to DSA or JCA as applicable

DPIA consultation reviewers and feedback		
Role/Group	**Organisation/Representing**	**Version(s)**
GMIGG-I members	Health and Care • CCGs • NHS Trusts • GP Practice DPOs • Hospices • Out of Hours • GM LA ERG reps x 3 • University of Manchester	All
GM Local Authority IG Expert Reference Group	Social Care	All
Manchester Health and Care Commissioning Information Strategy and Advisory Group	Member organisations	All
IG Lead/DPO GP practices Stockport	IG-Health	All
SIRO/DPO	Northern Care Alliance NHS FT	All
IT Business Systems Manager	Bolton CCG/Bolton Care Record	All
IG Manager/DPO	Graphnet	All

Glossary of terms	
Anonymised data	Data in a form that does not identify individuals and where identification through its combination with other data is not likely to take place.
Authority Service Recipients	Organisations who will benefit from the Services under the terms of the Graphnet contract.
GM	Greater Manchester
GM Analytics & Data Science platform	Procured by the GM Health and Social Care Partnership the Analytics and Data Science Platform (ADSP) is a multi-cloud (Azure and Gcloud) based datastore which comprises the technical components to manage, process, analyse and report pseudonymised record and aggregate level data. The cloud environments (Arden and GEM Azure and Snowflake Gcloud) meet all the required security and access requirements for processing sensitive health data and have been sanctioned for this use by NHS Digital. Technical components within this cloud environment include DataRobot, Tableau, Matillion, eLabs and Interworks Curator.
GMIGG	Greater Manchester Information Governance Group – members include IG leads and DPOs across health and care services
GMSS	Greater Manchester Shared Services - NHS corporate and IT services provider hosted by Salford Royal NHS Foundation Trust.
GP DPR	GP Data for Planning and Research – see link here.
Integrated Care System (ICS)	An ICS brings NHS providers, Clinical Commissioning Group (CCGs), local authorities and voluntary sector partners together to collaboratively plan and organise how health and care services are delivered in their area.

Glossary of terms	
	There are currently 42 ICSs across England (GM being one of them) and each covers a population size of 1-3 million. The goal is that ICSs will remove barriers between organisations to deliver better, more joined up care for local communities. While they are currently informal partnerships, the government's white paper states that the forthcoming NHS Bill will make ICSs legal bodies, and give them responsibility for funding, performance and population health. For further information see link here.
JIRA	Issue and project tracking software used by Graphnet
Locality	GM is made up of 10 commissioning localities: Bolton, Bury, Heywood-Middleton-Rochdale (HMR), Manchester, Oldham, Salford, Stockport, Tameside and Glossop, Trafford, Wigan.
Northern Care Alliance (NCA)	Now the Northern Care Alliance NHS Foundation Trust is an NHS Foundation Trust (NCA FT) created by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust. The NCA FT was formally established on 1 October 2021. The NCA has been working together as a group since 2016.
Organisation(s)	A commissioner or provider of NHS health and care services within Greater Manchester
Patient	An individual referred into, receiving or having received health and/or social care treatment/services. Understanding Patient data advises *"Don't use terms like 'citizen', 'consumer' and 'user' – our research suggested people much prefer the term 'patient'"* – see link here.
PHR	Personal Health Record
Sector(s)	of the health and care system e.g. nursing, GP, social services
Sustainability and Transformation Partnerships (STPs)	Sustainability and Transformation Partnerships or 'STPs' were formed in 2016 from NHS and social care providers, commissioners, and local councils in 44 areas covering the whole of England to improve the care they provide. STPs aim was to produce place-based (rather than organisation-based) plans for everyone using health and care services in 44 areas across England. They were grouped into geographical 'footprints' and will become an Integrated Care System (ICS). Greater Manchester is an STP and will become an ICS.
Sysman	Is the Graphnet CareCentric in-built System Manager application that includes: • User management e.g. adding new users • User group management e.g. managing an existing user group • Configuration managements e.g. adding new GP practices to the system
URL	Uniform Resource Locator – a reference (address) to a resource on the internet.

Section 1: Project Information

Description, purpose of and reason for the initiative (GDPR Art. 35(7)): *Specify how many individuals will be affected or state the detail in relation to the demographic e.g. all adults over the age of 65 in the [area/borough(s) of ….]. Embed any relevant project documentation e.g. PID, service specification, business case, flow diagrams of how the data will be processed.*

Description, purpose and benefits:

The Greater Manchester Care Record (GMCR) is being implemented to provide health and care staff, who are treating and caring for individuals in Greater Manchester, electronic access to records of participating partner organisations.

Version 1 of the DPIA was developed as a result of the accelerated implementation of the GMCR in response to the Covid pandemic. It is now timely to review the DPIA to ensure it remains current and appropriately draws out the privacy risks and any mitigating actions needed regarding the data processing.

National context

NHS England and Improvement has made it clear that each Integrated Care System (ICS) needs to 'develop or join a shared care record joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management'.

The letter to NHS organisations from Sir Simon Stevens NHS Chief Executive and Amanda Pritchard, NHS Chief Operating Officer 31 July 2020 specified that …"all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health"

The NHS Shared Care Records (ShCR) programme (formerly known as the Local Health and Care Record (LHCR) programme) aims to help local organisations move to a position where an individual's record is shared across the health and care system. The programme has developed an Information Governance Framework, currently a working iteration for exemplar sites (of which Greater Manchester is one) to be published in Summer 2021 to provide a structured approach to ensure ShCRs meet their legal obligations.

The NHS Integrated Care Systems design framework published in June 2020 references that:

"*ICS bodies are expected to:*

- *Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest information."*

Regional context

Shared care records utilising the Graphnet CareCentric product have been in place in GM localities in some cases for a number of years. These, however, have been locality based. In recent years, and even more so during the Covid

Description, purpose of and reason for the initiative (GDPR Art. 35(7)): *Specify how many individuals will be affected or state the detail in relation to the demographic e.g. all adults over the age of 65 in the [area/borough(s) of ….]. Embed any relevant project documentation e.g. PID, service specification, business case, flow diagrams of how the data will be processed.*

pandemic, experience has shown that it is essential that services providing all forms of treatment and care have access to supporting information beyond the boundary of each locality to treat individuals effectively, quickly and safely.

The Greater Manchester Care Record (GMCR) platform (the "GMCR Solution") is being implemented on a single GM wide instance for direct care purposes within Health and Social Care services in response to:

- The national context specified above
- one of the five key principles of the GM Health and Social Care Partnership digital strategy, which is to combine information, share records and bring together applications across all health and social care participants, allowing the right information to be in the right place at the right time so that better, safer decisions can be made; and
- the Health & Social Care (Safety & Quality) Act 2015 which supports the 7th Caldicott principle and 'The duty to share information can be as important as the duty to protect it'.

Further information on the Graphnet CareCentric product is attached at Appendix A.

Benefits

There are benefits peculiar to the densely populated and highly mobile Greater Manchester region. For example, Tameside residents with a suspected stroke will be taken to the specialist stroke centre at Stepping Hill Hospital. Stroke clinicians can look up that person's medical history on the spot, check their medications and move immediately to provide safe, swift and specialist treatment that can make a huge difference to stroke recovery.

Likewise, practitioners will have the information they need at their fingertips if a resident is referred to a specialist hospital such as the Christie, regardless of whether they live in Bolton, Oldham or Trafford.

A Benefits Realisation Plan was supported by the GMCR Programme Board in July 2020. An Interim Benefits report was produced in September 2020 and a follow up report in April 2021 – see link here.

1.2 How will you collect the data? Data is collected from the individual at the point of care by each organisation providing data to the GM Care Record. It is captured within the organisation's own electronic record system and then fed into the Graphnet CareCentric Highway integration engine which integrates the data from a wide range of provider feeds.

This data is stored in a single clinical data repository, which enables data to be sorted and filtered from multiple sources quickly. From here, CareCentric links the data from multiple systems, using the NHS Number as the primary identifier, and presents it to end-users in a unified manner within a single care record for that individual.

Data is also collected from National feeds e.g. National Immunisation Management Service (NIMS), Pillar 2 testing and other national flows.

1.3 How will you use the data? To support the care and treatment of individuals that have a GM Care Record.

1.4 Where and for how long will the data be stored?

See also section 3 - data that is extracted from source systems is stored within a server hosted by Greater Manchester Shared Services (GMSS). The data storage is currently being replicated into the Microsoft Azure cloud and will be fully moved into the cloud in Q3 2021/22 as set out in the Cloud Migration DPIA – see link to GMIGG site here.

The flow of patient information will cease as soon as a patient death is recorded in the source system. The patients record contained within the system is marked as being deceased and the date of death shown. However, if any of the source providers do not record the death within their source system that data will still flow and be viewable.

Where a patient moves out of the GM area the GP practice code is amended to a dummy practice code and the data stops flowing.

The retention periods for the data are set by the Records Management Code of Practice for Health and Social Care (2021) as follows: "Integrated records: all organisations keep their own records but enable them to be viewed by other organisations - retain for relevant specialty period".

1.5 What processes will be in place to delete the data when it is no longer required to be retained?

Any requests for deletion of data will be handled via an email request to **[E-mail Address Redacted]** from the data controller(s). Depending on the request it may need review by GMIGG to understand and consider any information governance implications and by the Clinical Reference Group (See Governance at Appendix C) to understand and consider any clinical safety implications – see action at Risk Section 6. Social Care data will be considered via the GM Local Authority IG Group. The email account referenced is managed via the GM Digital Office (a combination of members of Health Innovation Manchester (HInM) and the GM Health and Social Care Partnership (GM HSCP)).

Description, purpose of and reason for the initiative (GDPR Art. 35(7)): *Specify how many individuals will be affected or state the detail in relation to the demographic e.g. all adults over the age of 65 in the [area/borough(s) of ….]. Embed any relevant project documentation e.g. PID, service specification, business case, flow diagrams of how the data will be processed.*

GM Shared Services (GMSS) hosted by Northern Care Alliance NHS FT (the lead controller as referenced in the Joint Controller Agreement) has the functionality to raise a JIRA request on behalf of data controllers and will action following instruction by the GM Digital Office.

A process flow chart is attached at Appendix D.

Note: the source system provider would need to review and amend any data feed at source to prevent data being re-submitted that should not be in a continued feed.

1.6 What is the source of the data? E.g. the individual themselves, 3rd party the individuals themselves and the individuals providing their support/care and treatment e.g. parent/carer/clinician.

1.7 Will you be sharing the data with anyone? If yes, specify which organisation/team and the purpose of the sharing
See Section 3 and Appendix E Annex 3 – Authorised Service Recipients. Other organisations may be onboarded following the onboarding process set out in Appendix B.

1.8 Specify the demographic/cohort/criteria: all individuals receiving treatment or care in Greater Manchester (subject to any upheld objection set out at 1.15).

1.9 Specify the borough(s) or GM wide: GM wide

1.10 Specify the organisations involved in the processing (*include any suppliers of e.g. databases*):

Data controllers – see Appendix E – Annex 3 – all users are listed as 'Authorised Service Recipients'

Data processors – Graphnet Health Ltd.
Microsoft Azure – Sub processor to Graphnet Health

The Northern Care Alliance NHS FT –hosting GM Shared Services (GMSS) will manage the contract with Graphnet on behalf of the data controllers.
GMSS will also:

- host the CareCentric (Core) module until it is fully migrated and live in Microsoft Azure.
- provide triage and second line support to all GM organisations for the duration of the contract with Graphnet.

1.11 What contractual arrangements are in place (specify contract terms or embed or attach relevant sections of contract/SLA?
There were previously 10 separate application contracts held between the 10 GM CCGs and Pennine Care NHS FT, and the supplier (Graphnet) for Application Services. These contracts differed between CCGs depending on the date they were established. To some extent the contractual structure reflected the historical nature of how the GMCR has evolved.

Greater Manchester CCG partners have now merged into a single instance of the application, resulting in the contracting model being reviewed to put in place a single contract model that reflects the cross-locality nature of the GMCR, the need for integrated decision making and unifies GM buying power with the supplier.

This contract was signed off in August 2021by Salford Royal NHS Foundation Trust (via the NCA Committee in Common) who subsequently became Northern Care Alliance NHS FT in October 2021 (as Lead controller) on behalf of GM health and social care organisations). The contract effective date is 1 April 2021 to all the activities that have taken place since the beginning of the financial year.

The transition from multiple contracts held by the 10 CCGs and Pennine Care to a single GM 3-year contract, held by GMSS, alongside the GM cloud migration, was supported by the GMCR Programme Board, GM Digital Coordination Group and CCG CFOs (February 2021).

To effect this decision and benefit from advantageous GM-wide pricing, existing contracts (expiry 31st March 2022) were terminated early with effect from 1st April 2021 (at no additional cost to GM) and be replaced by the new single contract. There is therefore no point at which parties are out of contract as during April – August 2021, GM continues to be covered by existing CCG contracts.

Once the ICB is established as a legal entity, it will become the contract holder, and the contract will be novated to the ICB to provide the defined services.

Description, purpose of and reason for the initiative (GDPR Art. 35(7)): *Specify how many individuals will be affected or state the detail in relation to the demographic e.g. all adults over the age of 65 in the [area/borough(s) of ….]. Embed any relevant project documentation e.g. PID, service specification, business case, flow diagrams of how the data will be processed.*

The IG relevant clauses from the contract are documented in Appendix E. Graphnet has its own contractual arrangements with Microsoft Azure as a sub-processor and have confirmed via email that this is based on Microsoft Azure standard terms see link here to standard terms.

1.12 How often will you be collecting and using the personal data? GP, Mental Health, Community and Social Care feeds are provided from daily overnight feeds. The Acute feeds are sent in real time. Graphnet are working with systems 3rd party suppliers on roadmap functionality to enable live data feeds from source systems.

1.13 How long do you expect this initiative to last?

☑ End of contract period

☐ Specific time period – specify? Click here to enter text.

☐ Lifetime of system (where the initiative or project relates to a new or revised ICT system)

☐ Other – specify …….. Click here to enter text

1.14 What is the nature of your relationship with the individual data subjects for this initiative? ***This enables IG to ascertain the lawful basis for processing***

Provision of health/social care ☑ | Protecting the health of the general public ☐ |

Local audit to assure safe health and social care ☐ | Checking quality of care, beyond local audit ☐ |

Supporting research ☐ | Staff employment ☐ | Other - specify: Click here to enter text.

1.15 How much control will the data subjects have over the data being processed?

A shared care record will be automatically created via a feed from the participating GP Practice's electronic patient record. Where the patient has raised an objection to the sharing to their GP Practice, and had that objection upheld, there are specific codes that can be applied to prevent the sharing.

The solution uses the relevant codes (READ, CTV3 and SNOMED CT) from the GP systems to allow patients to control opt-out and opt-in for data sharing into the shared care record. The opt-out/opt-in status from the GP record is taken as the primary status. Patients who are opted out of their GP record at inception of the project or data load will not have any data sent to the shared record GP system and/or their shared GP data will not be stored or will be isolated so that it cannot be viewed.

Where the user has had a relevant opt out code applied to their GP record, the system will display a message to that effect which is shown when trying to access a Shared Care Record for that person.

In addition to individuals being able to object to the organisations providing their care, a single point of contact (SPOC) is being created by the GM Digital Office that will enable individuals to contact that SPOC ([**E-mail Address Redacted**]) to:

- identify if any of their information is flowing into the GMCR
- enable access to a copy of that information if requested
- raise an objection to the flow of data that can be passed to the relevant controllers

There is the functionality within SysMan to opt out a patient from the whole of Carecentric.

This process is currently being worked through – see action at Risk Section 6.

Reason to view/patient Informed screen
A screen has been implemented for GM wide sharing which is a single 'pop up' screen that directs the user to inform the patient of the record access prior to proceeding and click the direct care reason for access. If the patient is absent or lacks capacity, then the user can still enter the record by clicking proceed. This screen is an interim screen until the supplier is able to develop a revised one-click screen – See action at Risk Section 6.

The screen is implemented to demonstrate the legal ***necessity*** for accessing the record along with a prompt to advise the patient of the access.

1.16 Would they expect you to use their data in this way?

Yes ☑ | No ☐ | Don't know ☐ | Click here to enter text.

Description, purpose of and reason for the initiative (GDPR Art. 35(7)): *Specify how many individuals will be affected or state the detail in relation to the demographic e.g. all adults over the age of 65 in the [area/borough(s) of ….]. Embed any relevant project documentation e.g. PID, service specification, business case, flow diagrams of how the data will be processed.*

There is a reasonable expectation that patients/service users generally expect their health and care information is shared with those providing their care and treatment. A public communications campaign has been developed for the GM Care Record to fulfil the Duty of Transparency around the use of public data both for direct care and secondary uses/research. The GM public website is available via this link here.

It is supported by primary care engagement to ensure that data controllers a) understand how data is being used in Greater Manchester, b) that communications resources can be shared via practices directly to their patients.

- To support the activity, a full toolkit of communications resources has been shared across NHS organisations including resources for online and offline communications with patients. Communications resources for the campaign: https://gmwearebettertogether.com/toolkit/

- Stakeholder brief on the GM Public Data Sharing Campaign: https://healthinnovationmanchester.com/wp-content/uploads/2021/06/GMCR-Stakeholder-Brief-on-Public-Campaign.pdf

NHS Constitution

As part of the NHS Constitution …." the NHS commits:

- to ensure those involved in your [the Patient's] care and treatment have access to your health information so they can care for you safely and effectively (pledge);

- to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge).

1.17 How will you consult with them to seek their views on the data processing – or justify why it is not appropriate to do so:
The communications campaign will be monitored, and any feedback/views/responses received through the campaign will be captured. In addition, a community engagement programme is being developed to explore views around data sharing and processing. This will build on recently completed citizen jury work by the University of Manchester and the National Institute for Health Research (NIHR) Applied Research Collaboration (ARC) Greater Manchester that specifically sought the views of a representative group of GM residents on issues around data sharing – A news article and link to a report about the citizen's juries in GM around data sharing is available via this link here.

The community engagement work takes the following steps:
- Review existing insight work in GM and nationally that has already completed around data sharing/processing and shared care records.
- Prioritise community groups based on insights from the research that warrant further investigation on views around data sharing. These may include 'seldom heard/served' groups including the homeless, BAME communities, people with disabilities etc.
- Developing a targeted engagement plan for each group and topics for further engagement around data sharing/processing.

1.18 Do you need to consult with anyone else internally or externally?
See Governance structure at Appendix C.

1.19 Will individual's personal information be disclosed outside of the parties to this initiative in identifiable form and if so to who, how and why?
☐ **Yes – provide details below** **No** ☑

1.20 If the information is to be anonymised or pseudonymised in any way, specify how this will happen

Not applicable – direct care

1.21 If personal data is being transferred outside of the EEA, describe how the data will be adequately protected (e.g. the recipient is in a country which is listed on the Information Commissioner's list of "approved" countries - see link here). *(This would include database/information hosted on ICT applications outside the UK)*

Not applicable – data not being processed outside the UK ☑

1.22 Are there any approved national codes of conduct or sector specific guidelines that apply to the data e.g. ICO/DoH&SC/NHS England/NHS Digital etc. (GDPR Art. 35(8)) (*Remove or add to the below list as necessary*)

Description, purpose of and reason for the initiative (GDPR Art. 35(7)): *Specify how many individuals will be affected or state the detail in relation to the demographic e.g. all adults over the age of 65 in the [area/borough(s) of ….]. Embed any relevant project documentation e.g. PID, service specification, business case, flow diagrams of how the data will be processed.*

- NHSX Information Governance Framework for Integrated Health and Care: Shared Care Records – September 2021
- GOV.UK NHS Constitution – updated Jan 2021
- GOV.UK Handbook to the NHS Constitution – updated Feb 2021
- ICO Data Sharing information hub – including:
  - Data Sharing Code of Practice
- NHS X Information governance portal – for current IG guidance/policy
  - Records Management Code of Practice for Health and Social Care 2021
- NHS Digital:
  - A Guide to Confidentiality in Health and Social Care
  - Code of practice on confidential information
  - Information security management NHS code of practice
- NHS Digital Clinical Information Standards
- HM Government's Technology Code of Practice
- UK Government's Open Standards Principles
- NHS Digital, Data and Technology Standards
- Department of Health Social Care Code of Conduct for data-driven health and care technology dated February 2019
- NHS Digital Clinical Risk Management Standards – DCB0129 and DCB0160

1.23 How will you prevent function creep i.e. the gradual widening of the use of a technology or system beyond the purpose for which it was originally intended, especially when this leads to potential invasion of privacy?

This DPIA will remain under monitoring and review processes to ensure that any future development or wider roll out is appropriately governed.

1.24 How will you ensure data quality? Each organisation providing data has their own processes for ensuring the quality of data within their systems. During the testing process prior to 'go live' with new feeds, each organisation and Graphnet review the quality of the data items sent. This is signed off by each organisation prior to 'go live'.

The Graphnet solution also has a data quality assurance facility to ensure the data is linked appropriately to the correct individual. If patient records don't match or are not imported, they will not be set on the GM Care Record. All original messages/files sent to the GM Care Record are held for up to 30 days prior to being purged. Graphnet further advise that "*in relation to matching and validation, each feed has a particular standard, however, the approach for matching and validation follows a similar pattern. All incoming data is validated before processing (message schemas, data schema), and matching is carried out on key identifiers, typically the tenant ID (so we recognise the sending organisation), the NHS number OR nominated unique identifier such as hospital number. When it comes to linking the demographic entry to other organisations, we use NHS number, Surname and DOB OR a traced NHS number for linking.*"

The process for checking data quality when there are system upgrades to avoid, for example, disappearance of data, is currently being agreed, documented and resourced. A Task and Finish group has been established and has identified a suite of data quality reports to be made available by Graphnet – available to GMIGG members via this link here.
[HYPERLINK REDACTED – Leads to website that can only be accessed with a provided account

There will also be an agreed data quality policy/process/function that specifies who is responsible for what. This issue and action to address this is picked up within the actions at Section 6.

Also - see above NHS Digital Clinical Information Standards via link here which are published so that information about the health and care of individuals can be shared and compared across the health care sector, using data that are defined consistently.

Section 2: Data Items

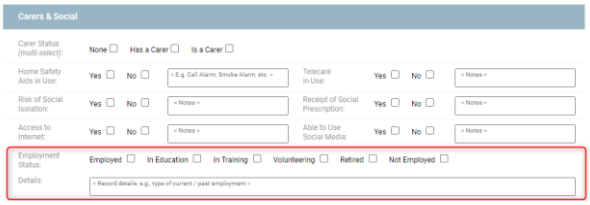
Specific data item(s)
Personal details - Check all that apply:
☑ Forename(s) ☑ Surname ☑ Address ☑ Postcode (full) ☑ Postcode (partial) ☑ Date of Birth ☑ Age ☑ Gender
☑ Physical description ☑ Home Telephone Number ☑ Mobile Telephone Number ☑ Other Contact Number
☐ Email address ☑ GP details ☑ Legal Representative Name (Next of Kin) ☑ NHS Number ☐ National Insurance No.

☐ Photographs/Pictures of persons ☐ Location data e.g. IP address

☐ None of the above ☑ Other – List any other data items or attach as an appendix Source system ID

Justification and compliance with data minimisation principle Reason that the data items(s) above are needed including any consultation/checks regarding the data items being adequate, relevant and limited to what is necessary – this must stand up to scrutiny
To ensure the correct personal details are held for the correct patient/service user to support their treatment and care

Other data item(s)	**Justification and compliance with data minimisation principle** Reason that the data items(s) are needed including any consultation/checks regarding the data items being adequate, relevant and limited to what is necessary – this must stand up to scrutiny
Information relating to the individuals **physical or mental health or condition**. *NB. For mental health this would include the mental health status i.e. whether detained or voluntary under the Mental Health Act.* ☑ Yes ☐ No List any data items or embed document or attach as an appendix Click here to enter text.	Acute Hospitals: referrals, attendance (inpatient/outpatient, A&E), waiting list, medications, alerts, allergies, pathology results and radiology reports GP Practices: diagnoses, treatments, medications, allergies, results, disease register, co-morbidities and family history Community and Mental Health: care plans, problems, interventions, medical and social alerts, medications, referrals and clinical summaries Social Care: care teams, keyworkers, contacts and other involvements, assessments, needs and care provision details There is a GM Dashboard that contains details of all the data items being sent by each organisation available to IG leads/DPOs via the NHS Futures GMIGG Forum – see link**. [HYPERLINK REDACTED – Leads to website that can only be accessed with a provided account** The information is used to support the care and treatment of the individual.
☐ Genetic data ☐ Biometric data – *for the purpose of uniquely identifying an individual* List any data items in the next column along with the justification or attach as an appendix ☑ None of the above	Click here to enter text.
Information relating to the individual's **sexual life or sexual orientation** ☑ Yes ☐ No List any data items in the next column along with the justification or attach as an appendix ☐ None of the above	This information may be coded within the patient's GP record and flowed into the shared care record. It may be used where it is relevant to the health and treatment of the individual. It also may be shared within relevant care plans.
Information relating to the **family of the individual and the individual's lifestyle and social circumstances** ☑ Marital/partnership status ☑ Carers/relatives ☑ Children/dependents ☑ Social status e.g. housing ☐ Other – please specify below: ☐ None of the above List any data items in the next column along with the justification or attach as an appendix	To support the treatment and care of the patient where necessary and appropriate
Information relating to any **offences committed or alleged to have been committed** by the individual ☑ Yes ☐ No List any data items in the next column along with the justification or attach as an appendix ☐ None of the above	The mental health data feeds include Mental Health Act status. There are a number of Sections that would reference that a patient is going through or has gone through the criminal justice system. For example, if a patient is on Section 37/Section 41 of the Mental Health Act 1983 this would demonstrate that the patient has been convicted of a crime and the courts have sent the individual to hospital instead of prison. Under Section 37/41 of the Mental Health Act 1983 the courts can do this if the individual has a mental disorder and needs hospital treatment. This information is justified for anyone treating the patient to support their care and treatment.
Information relating to **criminal proceedings outcomes and sentences** regarding the individual ☑ Yes ☐ No	

List any data items in the next column along with the justification or attach as an appendix ☐ None of the above	
Information which relates to the **education and any professional training** of the individual ☐ Education/training ☐ Qualifications ☐ Professional training ☑ Other – List any data items in the next column along with the justification or attach as an appendix ☐ None of the above	There is an Integrated Care and Support plan available within the GMCR that has a number of tiles, one of which is the lifestyle & environment tile. The following data items may be recorded by the individual providing care and treatment where it is deemed necessary and proportionate to the care and treatment being provided 
Employment and career history ☐ Employment status ☐ Career details ☑ Other – List any data items in the next column along with the justification or attach as an appendix ☐ None of the above	
Information relating to the **financial** affairs of the individual ☐ Income ☐ Salary ☐ Benefits ☐ Other – List any data items in the next column along with the justification or attach as an appendix ☑ None of the above	Click here to enter text.
Other special categories of data: ☑ Racial or ethnic origin ☐ Political opinions ☑ Religious or philosophical beliefs ☐ Trade union membership ☐ None of the above	For example, in relation end of life wishes, dietary requirements, pastoral support, medication – to support the treatment and direct care of the patient
You must confirm that the data items you have ticked above are relevant and necessary to your project and there is a justified reason for it – (*if they are not you must amend the above selections to remove those items not relevant/necessary)* if the data is to be used for any other subsequent purpose then this DPIA will need to be reviewed or a 2nd DPIA will need to be completed – IG will be able to advise	
Confirm understanding ☑	

Section 3 – Data Flows – *It is essential that each flow of data is identified, documented and specifies the security measures in place. Nb. Even if the data is only being viewed in a system it is a flow of data and should be included. If you are not clear on this yet, liaise with the IG Lead*:

Flow No. and name	Going from	Going to	Method of transfer and control	Specify the security control(s) in place for the transfer	Where will the data be stored after transfer?	Specify the security control(s) in place for the view/access
GMCR1 – GM Care Record – direct care flow	All source system providers	GM Care Record - to be viewed by authorised staff in approved organisations – ***Appendix E Annex 3***	Data transfer	The record is extracted by system providers and sent via secure network connections to the CareCentric product (software used to build the shared care record supplied by Graphnet). Graphnet then store the extracted data within the CareCentric database and display the data on the GM Care Record front end.	Current approach: Wigan Data Centre hosted by GM Shared Services – UK based off site server Future approach (Q4 2021/22) In secure public cloud, Azure, UK South/UK West – operated by Graphnet Health UK (Cyber Essentials + Accredited) see	Network logins, password controls, RBAC in the GM Care Record plus for users with Single Sign-on (SSO) they must be logged on to their own organisations systems first before they can access the GM Care Record.

Flow No. and name	Going from	Going to	Method of transfer and control	Specify the security control(s) in place for the transfer	Where will the data be stored after transfer?	Specify the security control(s) in place for the view/access
					Appendix E – Cloud Computing	
GMCR2 – Graphnet secure analytics platform (for direct care dashboard and secondary uses which will be subject to a separate DPIA)	CareCentric live GM Care Record	CareCentric Business Intelligence (BI) Analytics Platform	Data transfer	Via secure system to system encryption using SFTP (Secure File Transfer Protocol) and encrypted replication processes	In secure public cloud, Azure, UK South/UK West – operated by Graphnet Health UK (Cyber Essentials + Accredited) See Appendix E – Cloud Computing	Two methods of access: Firstly, data views (dashboards) will be published within the live GM Care Record. Security controls include Network logins, password controls, RBAC in the GM Care Record plus for users with Single Sign-on (SSO) they must be logged on to their own organisations systems first before they can access the GM Care Record. The second method for authorised 'super users' is via a 2-factor authentication to the secure analytics platform.

For data flows - see also slide deck at Appendix F

Section 4: Information Technology -

Where a data system is in use as part of the project/initiative confirm the following:
Appropriate technical & organisational security measures in place to protect data. (Including specifications, information security policies, certifications (e.g. ISO27001), independent penetration test reports for any application/database and hosting Infrastructure)
Yes ☑ See also Cloud Computing DPIA – available to GMIGG members via this link here **[HYPERLINK REDACTED – Leads to website that can only be accessed with a provided account** or the cloud security document embedded in Appendix E Annex 2. **[REDACTED – Exempted under Section 43(2) of the Freedom of Information Act (2000) pertaining to Commercially Sensitive Information]** System Health reports – are also being developed to cover the following areas:

Report Tile	Intended Use/Purpose
Feed Coverage Report("T-Lights"")"	Traffic light report of the timeliness of data feeds from source systems
Data Latency Report	Latency of individual data items and the date when the field was last updated

Staff access is audited

Yes ☑ Explain process:

CareCentric includes audit trail functionality such that each user action, (e.g. successful or failed login attempts and access to shared care records, plans and assessments, etc.) is time and date stamped and attributed to individual users, so that they are available in the audit trail. All system administration actions are similarly recorded in the audit trail.

Audit Reports
Audit Reports can be accessed, but not amended through the CareCentric Administration application (SysMan) by authorised users in line with agreed process e.g., auditors, system administrators.

When the parameters for the report have been selected the user can perform a search with the results displayed in a number of columns. These columns can be hidden or shown as required.

Any Audit Report Generated can be exported as a .CSV file. The audit reports are read-only, and the details cannot be changed.

The current audit reports identified by the GMIGG Task and Finish group are available to GMIGG members via this link here.
[HYPERLINK REDACTED – Leads to website that can only be accessed with a provided account

Appropriate role-based access controls are in place for all staff who have access:
Yes ☑

Users access the record for which they have a legitimate relationship in one of two ways:

CareCentric Embedded – Single Sign On (SSO) gives users direct access to a Patient's medical and social care records from within their own existing IT system. It provides direct and secure access to the up-to-date patient information held in CareCentric - within patient context and without having to log on again.

Login via Web Client – URL accounts - where an existing SSO connection is unavailable e.g. for NWAS (North West Ambulance Service) users can request these accounts from GM Shared Services. For the standalone web-based version of the CareCentric web client, users can log-in directly using usernames and passwords and search for the individual being offered care and treatment. User logins are maintained through the System Management function and managed via GM Shared Services.

User Groups within the system are used to determine permissions to view tiles and enable the system to provide pre-configured views tailored to meet the needs of those different groups of users. These RBAC groups are pre-determined and Graphnet have worked to define these based around aspects of the National NHS RBAC model.

User Groups are used to control what patient information (Landing Page data access) a user has access to, and what actions they can perform on the system (functional access). The RBAC roles available in CareCentric align with National RA (Registration Authority) roles, to aid interoperability between systems and future integration with Active Directory and NHS Spine Services.

Several different RBAC User Groups are available on the GM Care Record. Users should only be assigned to a single RBAC User Group.

There are 6 combinations of landing page / levels of functionality available to each user. GM Shared Services have created a User Access Requests and Account creation process document that is under review by the GMCR Operational Group and GMIGG. This draft document can currently be accessed by GMIGG members via this link here. **[HYPERLINK REDACTED – Leads to website that can only be accessed with a provided account**

The following list details the landing pages available on the GM Care Record:
Landing Page: Admin/Clerical (LHCR1 Clinic Receptionist)
Landing Page: NWAS HCA (LHCR2 Care Navigator)
Landing Page: Social/Community/Mental Health (LHCR3 Summary)
Landing Page: Common (LHCR4 Extended)
Landing Page: General Practitioner (LHCR4 Extended)
Landing Page: Unscheduled Care (LHCR4 Extended)

Organisations that utilise an existing SSO User Account are responsible for enabling/disabling any embedded access provided to users in their respective native systems and applying their local RBAC processes.

Organisations that utilise URL (Web Access) User Accounts are allocated via a request process to GM Shared Services.

See also action at Risk Section 6.

iv)	An Information Asset Owner (IAO) and Information Asset Administrator (IAA) been assigned for the system	Yes (specify below) ☑ No ☐ Don't know ☐ IAO: Chair of GMCR Programme Board IAA: GM Digital Office/GMCR Operations Group

Section 5: Information governance project assurance **(to be completed by Information Governance)**

GDPR Article 35(3) and ICO guidance 35(4)		Yes	No	Unsure	Comments *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
i)	Is there to be **systematic and extensive profiling with significant effects**: "(a) any systematic and extensive evaluation of personal aspects relating to natural persons which is based on automated processing, including profiling, and on which decisions are based that produce legal effects concerning the natural person or similarly significantly affect the natural person"	☐	☒	☐	Click here to enter text.
ii)	Is there **large-scale use of sensitive data**: "(b) processing on a large scale of special categories of data referred to in Article 9(1), or of personal data relating to criminal convictions and offences referred to in Article 10".	☒	☐	☐	3m+ health and care records
iii)	Is there **monitoring of the public**: "(c) a systematic monitoring of a publicly accessible area on a large scale"	☐	☒	☐	Click here to enter text.
iv)	Does the processing involve the use of **new technologies**, or the novel application of existing technologies (including AI).	☐	☒	☐	Click here to enter text.
v)	Is there any **denial of service**: Decisions about an individual's access to a product, service, opportunity or benefit which is based to any extent on automated decision-making (including profiling) or involves the processing of special category data	☐	☒	☐	Click here to enter text.
vi)	Does the initiative involve **profiling of individuals on a large scale**?	☐	☒	☐	Click here to enter text.
vii)	Is there any processing of **biometric** data?	☐	☒	☐	Click here to enter text.
viii)	Is there any processing of **genetic** data other than that processed by an individual GP or health professional, for the provision of health care direct to the data subject?	☐	☒	☐	Click here to enter text.
ix)	Is there any **data matching**: combining, comparing or matching personal data obtained from multiple sources?	☒	☐	☐	Combining data from multiple sources to create a shared care record
x)	Is there any **invisible processing**: processing of personal data that has not been obtained direct from the data subject in circumstances where the controller considers that compliance with Article 14 would prove impossible or involve disproportionate effort.	☐	☒	☐	Click here to enter text.
xi)	Is there any **tracking** of individuals: processing which involves tracking an individual's geolocation or behaviour, including but not limited to the online environment.	☐	☒	☐	Click here to enter text.
xii)	Is there any **targeting of children or other vulnerable individuals**: The use of the personal data of children or other vulnerable individuals for marketing purposes, profiling or other automated decision-making, or if you intend to offer online services directly to children.	☐	☒	☐	Click here to enter text.
xiii)	Is there any **risk of physical harm**: Where the processing is of such a nature that a personal data breach could jeopardise the [physical] health or safety of individuals	☒	☐	☐	Potentially if there was a data breach

			Action required – ensure covered in section 6
5.1	Is the initiative supporting the delivery direct care[3]?	Yes ☑ No ☐	
5.2	Is it supporting the delivery any other main purpose?	No ☑ Yes ☐ Commissioning ☐ Public health ☐ Monitoring health and social care ☐ Research ☐ Related to staff employment ☐ other ☐ specify: Click here to enter text.	As specified in 1.1 and section 3, copies of the data will be processed to populate a secure analytics portal and the GM Analytics & Data Science platform to support secondary uses/population health management/research. These will be subject to separate DPIA(s).
5.3	Are the arrangements for individual's to either ***object*** to their information being shared for direct care or to ***opt-out*** of the initiative for indirect care, once they have been provided with appropriate communication about it, appropriate? (See 1.4 – 1.6)	Yes ☐ No ☑ ……Specify any action required and document in action plan at section 6	Due to national policy initiatives e.g. GP DPR there may be confusion amongst the public and stakeholders. There is an action to address this at Section 6.
5.4	Confirm appropriate subject access handling/information rights procedures in place?	Yes ☐ No ☑ state reason if no - Click here to enter text. Not applicable ☐	Each organisation has subject access processes in place however the public may also want a single point of contact to enable their request to be actioned. Section 6.
5.5	Who are the controllers in this initiative?	The organisations feeding data into the GM Care Record and/or accessing the data for direct care as set out in Annex 3 Appendix E.	
5.6	Are there any data processors and have the processors had oversight and opportunity to input into this DPIA?	Not applicable – no processors ☐ Yes ☑ No ☐ Planned ☐ Don't know ☐	Graphnet Health Ltd.
5.7	Are the contractual terms at 1.11 sufficient to satisfy IG?	Yes ☑ No ☐ Don't know ☐	See Appendix E
5.8	Does each party confirm that information governance training is in place and all staff with access to personal data have had up to date training	Yes ☑ No ☐ Don't know ☐	
5.9	Confirm all parties have appropriate measures in place to report incidents and share learning?	Yes ☑ No ☐ Don't know ☐	
5.10	Is each party involved in the processing of personal identifiable data a 'trusted' organisation e.g. completed a satisfactory Data Protection and Security Toolkit Assessment or other recognised standard?	Yes ☑ No ☐ Don't know ☐ If yes, enter details: Click here to enter text.	Each organisation can be checked via this link here
5.11	Has each party involved in the processing paid the ICO registration fee? https://ico.org.uk/about-the-ico/what-we-do/register-of-fee-payers/	Yes ☑ Registration No. and renewal date Click here to enter text. No ☐ Don't know ☐	Each organisation can be checked via this link here
5.12	Does there need to be an Information Sharing agreement between the relevant parties that covers the processing arrangements?	Not required ☐ *sufficient information in this DPIA and associated documentation to progress without an ISA* Yes ☑ – specify reasons why: Joint controller arrangements need to be documented	Data sharing agreement currently out for consultation – GMIGG members can access this via the link here
5.13	Confirm all relevant organisations have appropriate cyber security measures	Yes ☑ No ☐	Graphnet maintain all relevant certifications and are certified

[3] The definition of direct care is: A clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals. It includes:-

- supporting individuals' ability to function and improve their participation in life and society
- the assurance of safe and high quality care and treatment through local audit,
- the management of untoward or adverse incidents
- person satisfaction including measurement of outcomes

undertaken by one or more registered and regulated health or social care professionals and their team with whom the individual has a legitimate relationship for their care

			Action required – ensure covered in section 6
	and/or are working towards cyber essentials	Don't know ☐ Attach or embed confirmation e.g. email from IT if yes:	under ISO27001:2013, ISO9001:2015 and Cyber Essentials Plus

5.14 **Lawful Basis for processing**:

See Appendix G Legal Gateway Matrix –with thanks and acknowledgement to NHS SOUTH, CENTRAL AND WEST COMMISSIONING SUPPORT UNIT and shared via the Shared healthcare Record (ShCR) regional leads		
GDPR	Article 6 condition(s) for processing: (e) Public task Choose an item. Choose an item.	Article 9 condition(s) for processing: (h) Health or social care Choose an item. Choose an item.
DPA 2018	Schedule 1, Part 1, condition(s) for processing: (2) Health or social care If health and care is selected specify the purpose below: (d) provision of health care or treatment (e) provision of social care If public health is selected, confirm the processing is carried out: Choose an item. Choose an item. If research is selected confirm the that the processing: (a) is necessary for archiving purposes, scientific or historical research purposes or statistical purposes (b) is carried out in accordance with Article 89(1) of the GDPR, and (c) is in the public interest Confirm ☐	
Human Rights Act	By complying with the data protection legislation and the common law duty of confidentiality there is no interference with human rights. For patients who lack capacity it is deemed to be in their best interests to have their information shared.	
Common Law duty of Confidentiality	Implied consent	

National Data Opt out (The national data opt-out allows a patient to choose if they do not want their confidential patient information to be used for purposes beyond their individual care and treatment - for research and planning.) For more information see link here.

N/A Individual patient care

Section 6 – Privacy issues identified and risk analysis

Consider the potential impact on individuals and any harm or damage that might be caused by your processing – whether physical, emotional or material. In particular, look at whether the processing could possibly contribute to:

- unauthorised access to data
- undesired modification of data
- disappearance of data
- loss of control over the use of personal data;
- reputational damage;
- loss of confidentiality;
- re-identification of pseudonymised data; or
- inability to exercise rights (including but not limited to privacy rights);
- inability to access services or opportunities;
- discrimination;
- identity theft or fraud;
- financial loss;
- physical harm;
- any other significant economic or social disadvantage

Include any sources of the risk i.e. person or non-human source that can cause a risk either accidentally or deliberately:

Source of risk	Examples			
Internal human sources	A negligent or rogue employee, proximity of the system, skills, privileges and available time are potentially high, possible lack of training and awareness	negligent or rogue user, family member or friend having access to the service	Various motives are possible, including: clumsiness, error, negligence game, malicious intent, revenge, spying	
External human sources	A rogue or naïve neighbour, by having a physical proximity, hacking into the devices data	A hacker targeting a user by using the knowledge he/she has of the user and some of the information concerning him/her	A hacker targeting one of the organisations/suppliers by using the knowledge he/she has of the organisations/suppliers that can undermine their image	An unauthorised third party company using its privileged access to illegitimately access information
Non-human sources	Incident or damage at one of the organisations (power cut, fire, flood, etc.)			

Specify any issues identified, recommendations and actions needed to secure the data if appropriate controls not in place within the risk assessment.

The risks should be reviewed, scored using the risk matrix below and incorporated into a risk register.

The level of risk is scored out of 25. A score of 0-5 is attributed to both the impact on the rights and freedoms of the individual, and the likelihood of those rights and freedoms being compromised. The two scores are then multiplied to create the composite risk score using the risk matrix below. This should be recalculated in the final columns to take into account proposed solutions/actions.

Risk	Description	Risk Score see matrix below			Proposed solutions/actions	Responsibility and date	Revised risk score when actions addressed see matrix below		
		Impact	Likelihood	Risk rating			Impact	Likelihood	Risk rating
GMCR1	Insufficient public engagement leading to inability to exercise rights	4	3	12	1. Ensure campaign momentum is maintained to plan 2. Build stakeholder feedback into ongoing campaign 3. Maintain currency of public comms 4. Advise data controllers to link their websites to the public comms to ensure transparency 5. Continually monitor and review	GM CR Communications lead/GM Digital office By February 2022 2,3&5 will remain ongoing	4	1	4
GMCR2	Deletion of data without following due process to consider IG/Clinical Safety implications	4	2	8	1. Data controller(s) to raise request via specified email account 2. GM Digital office to consider need to liaise with GMIGG/CRG/GM LA ERG 3. GMIGG to liaise with Clinical Safety officer for GMCR and relevant data controller(s) IG lead/DPO. 4. JIRA process to be followed if deletion of data appropriate 5. Process to be reviewed in liaison with Graphnet to ensure it remains viable	1. Data Controller – at point deletion of data is deemed necessary 2. GM Digital office Within 3 working days of receiving request 3. GMIGG via extraordinary meeting if urgent or via regular meeting 4. GM Operations Group 5. GM Digital office/Graphnet Timeframe – ongoing throughout programme	4	1	4
GMCR3	Inconsistent application of Role based access - varying access to functionality across localities/sectors	2	3	6	1. Undertake gap analysis across localities to identify roles and allocation of functionality 2. Include in gap analysis users utilising URL or SSO accounts 3. Establish common policy for allocation of roles to users 4. Implement policy 5. Monitor policy implementation	GM Digital office/Operational group/GMSS by End Sep 2022	2	1	2
GMCR4	Individuals unclear about who to contact to make enquiries or to object to their data flowing	4	3	12	1. Single point of contact to be established considering various methods of contact for individuals e.g. telephone, post, on-line (in addition to individuals contacting data controllers directly) 2. Communications to be developed for stakeholders explaining right to object and process to action 3. Communications to be developed for individuals to explain objection/opt out methods	GM Digital office/Communication Lead – by 31 March 2022	4	1	4
GMCR5	Data is shared after the individual has objected to the sharing and had that objection upheld	4	2	8	Organisation feeding data is responsible however a process will be documented as follows: a. If individual agrees to SPOC data flows can be monitored to check if data is flowing b. SPOC can check with data feed organisation in case the individual has now agreed for data to flow, or to stop data flow if individual still objects	GM Digital office/GMIGG/GMCR Operations Group/ GM CRG April 2022 and ongoing	4	1	4
GMCR6	Failure to keep 'Reason to view/Patient informed' screen 'current' and 'necessary' depending on removal of COPI notice and national policy requirements	2	4	8	1. Revise screen 2. Identify actions/timing needed to refresh screen if agreed necessary 3. Consult with stakeholders	GM Digital office/GMIGG/GMCR Operations Group/ GM CRG To commence October 2022	2	2	4

					4. Develop revised screen if deemed necessary 5. Operationalise revised screen if deemed necessary				
GMCR7	Insufficient monitoring of data quality leading to incomplete or inaccurate data	3	4	12	Organisations remain responsible for own data quality however the following GMCR programme actions can be undertaken: 1. Develop programme DQ reports 2. Develop programme DQ review and reporting process 3. Consult/Inform stakeholders 4. Implement programme DQ reports and report to required governance 5. Monitor and review	GM Digital office/GMSS/GMCR Operations Group/GMIGG 1. Completed 2. Commenced 2021 work ongoing Jan/Feb 2022	3	1	3
GMCR8	Insufficient audit capability and process leading to unauthorised access to data	3	4	12	1. Develop Audit reports 2. Develop Audit review and reporting process 3. Consult/Inform stakeholders 4. Implement Audit reports and report to required governance 5. Monitor and review	GM Digital office/GMSS/GMCR Operations Group/GMIGG 1. Completed 2 – Commenced 2021 work ongoing Jan/Feb 22	3	2	6
GMCR9	Loss of control – alerts are shared without sufficient GM consensus of policy in place	2	2	4	1. Assess use of alerts across GM 2. Consult with stakeholders to identify any alerts deemed necessary 3. Document process and inform stakeholders 4. Monitor and review	GMIGG/GM Operations Group April 2022 - ongoing	2	1	2
GMCR10	Loss of control – new functionality/Integrated care and support plans are developed and implemented without sufficient consultation and approval processes in place	3	2	6	1. New functionality/care plans to go through due process to ensure IG and project controls 2. Consultation to be undertaken with relevant stakeholders 3. DPIAs to be completed and signed off as necessary	GM Digital office/GMSS/GMCR Operations Group/GMIGG Heart failure care plan completed and shared with relevant controllers – further DPIAs to be considered as necessary	3	1	3
GMCR11	Loss of control - Excessive data is shared/insufficient data is shared based on recommended minimum data sets	2	5	10	1. Data feeds monitored (GMCR dashboard) 2. Liaison with stakeholders sharing excess/insufficient data 3. Escalated via Governance as necessary	GM Digital office/GMSS/GMCR Operations Group/GMIGG completed but monitoring will be ongoing via GMCR Board	2	2	4
GMCR12	Regulatory action – failure to meet accountability principle - data controllers fail to approve/sign up to JCA/DSA/DPIA and switch off data feeds	4	4	16	1. Stakeholder engagement to advise of DSA/DPIA consultation and timeframes 2. Stakeholder feedback fed into revised DSA/DPIA to satisfaction of controllers/DPOs 3. Governance structures support approval and sign off 4. Information pack for sign off shared with data controllers	GM Digital office/GMIGG/Comms Completed Awaiting feedback from sign off	4	1	4
GMCR13	Unauthorised access to data – user accounts not reviewed to remove starters/leavers/unused accounts	3	4	12	1. Review accounts to identify inactive users 2. Agree deletion period for unused accounts 3. Ensure Starter/Leavers process in place for URL accounts	GM Digital office/GMSS Feb/Mar 22 and ongoing	3	2	6

	Impact (How bad it may be)		**Likelihood** (The chance it may occur)			**Risk Rating** **Likelihood x Impact = TOTAL RISK RATING**				
						Impact				
						1	2	3	4	5
5	Very High *(Will have a major impact)*	**5**	Almost certain *(almost certain to happen/recur; possibly frequently)*	**Likelihood**	5	**5**	**10**	**15**	**20**	**25**
4	Major *(highly probable it will have a significant impact)*	**4**	Likely *(Will probably happen/recur, but is not a persisting issue or circumstance)*		4	**4**	**8**	**12**	**16**	**20**
3	Moderate *(Likely to have an impact)*	**3**	Possible *(Might happen or recur occasionally)*		3	**3**	**6**	**9**	**12**	**15**
2	Minor *(May have an impact)*	**2**	Unlikely *(Do not expect it to happen/recur, but it is possible it may do so)*		2	**2**	**4**	**6**	**8**	**10**

1	Negligible *(Unlikely to have any impact)*	**1**	Rare *(This probably will never happen/recur)*		1	**1**	**2**	**3**	**4**	**5**

Total Risk Rating	Risk
1-3	Low
4-6	Moderate
8-12	High
15-25	Extreme

Section 7 – Conclusion (tick one of the following)

☑ All privacy risks have been identified and actions are underway to mitigate, accept or remove the risks. This action plan will now be reviewed and monitored via the Greater Manchester Information Governance Group (GMIGG)

☐ All privacy risks have been identified and actions completed to mitigate, accept or remove the risks

☐ Not all privacy risks can be removed or reduced and the processing remains high risk, therefore the ICO must be consulted

Nb. Where the processing remains high risk, that cannot be mitigated or remove, the ICO must be consulted:

ICO Review required Yes ☐ No ☑

If yes, ICO review outcome and date Click here to enter text. Click here to enter a date.

Section 8: Participant to complete approval and sign off:

Approved by:

Organisation	Name	Date
Click here to enter text.	Click here to enter text.	Click here to enter a date.

For [*enter approval body*] use only – Nb. The following can be completed by each organisation and retained locally – it does not need to be collated for each organisation involved

Data Protection officer (DPO) review	☐	**Name and organisation:** Click here to enter text. Click here to enter a date.
DPO review not required	☐	Decision made by: Click here to enter text.
Approved – no actions required	☐	Click here to enter a date.
Approved with action plan	☐	Click here to enter a date.
Declined (give reason)	☐	Click here to enter text. Click here to enter a date.
Incorporate data flows into data flow mapping or onto the Information Sharing Gateway (ISG)	☐	Click here to enter a date.
Incorporate assets into the asset register or onto the ISG	☐	Click here to enter a date.
Confirm staff handling subject access requests are aware of new or changed information asset	Yes ☐ Not applicable ☐	Click here to enter a date.
Confirm Information Sharing arrangements documented: • within this DPIA and ISA not required ☐ • within a separate IS agreement ☐ • uploaded into the Information Sharing Gateway ☐ • planned within the DPIA action plan ☐ • Within a Data processing contract ☐ Other: specify - Click here to enter text.		Click here to enter a date.
Monitor and review of this DPIA	Who by: Click here to enter text.	When Click here to enter a date.

Appendix A

Further detail regarding Graphnet CareCentric core and PHR module

[REDACTED – Exempted under Section 43(2) of the Freedom of Information Act (2000) pertaining to Commercially Sensitive Information]

.

GM CARE RECORD – ONBOARDING FOR THE PURPOSE OF DIRECT CARE

Prior to any access to the GM Care Record – new providers/consumers, **not currently listed as an authorised service recipient in the GM Care Record contract with the data processor and/or, not classed as a 'joint' controller** are required to:

1. Go through due diligence within the GP registered locality/localities for which they provide a service – this may be via a project lead who can act as a sponsor to aid progression of the application process
2. Ensure appropriate organisational accountability to process personal data

Once due diligence has been agreed within the locality/localities the following must be completed fully in all cases

A1: Organisation type and Sector – tick one of the following:

☐	**AQP Clinical Services**	An organisation that has an AQP contract to provide clinical services to NHS patients, such an organisation will be carrying out clinical assessment of NHS patients
☐	**AQP Non-Clinical Services**	An organisation that has an AQP contract to provide non-clinical services to NHS patients, for example, providing a wheelchair or appliance based on another service's clinical assessment of the patient
☐	**Care Home**	A voluntary / third sector organisation working with NHS and/or local authority organisations to deliver care /advice to service users e.g. advocacy services (supporting individuals to access other services, etc), care homes and residential homes (unless these are contracted under AQP contracts)
☐	**Charity**	
☐	**Domiciliary Care organisation**	
☐	**Dentist (NHS)**	This is a practice that has agreed with their commissioning organisation to provide NHS clinical and educational dental services.
☐	**Dentist (Private)**	
☐	**Optician**	Optician, ophthalmologist, optometrist etc providing NHS services: A provider that has agreed with their commissioning organisation to provide NHS primary eye health services, such as NHS sight testing
☐	**Community Pharmacy**	A pharmacy that has agreed with their commissioning organisation to provide NHS pharmaceutical services in their area, i.e. advice and guidance, and dispensing medications against NHS prescriptions.
☐	**Prison Health**	This is a prison-based service responsible for providing healthcare to people in prison or detention centre / repatriation centre. Service providers may include PH in their own assessment or complete a separate DSPT assessment
☐	**Other (specify)**	Click here to enter text

A2: Commissioning contract between the onboarding organisation and the commissioner of the service

Contractual status – *requesting organisation must be contracted to provide a service to GM GP registered patients:*

Contract ref: Click or tap here to enter text.

Contract holder and onboarding sponsor: Click or tap here to enter text.

Contracting parties: Click or tap here to enter text.

Contract start date: Click or tap to enter a date.

Contract end date: Click or tap to enter a date.

Confirm contract is under NHS Terms and Conditions: Yes ☐ No ☐

If no, specify relevant IG clauses contained within the contract:

Click or tap here to enter text.

B: Population level access required – ***note, any access to a single GP registered population will include access to data for organisations providing multi-locality services e.g. NCA/MFT/PCFT/GMMH/The Christie and will require sign off by GM as in I – K below***

Specify patient cohort - Click here to enter text.

☐ **All GM localities (10 localities)**
☐ **Multiple localities Specify:** Click or tap here to enter text.
☐ **Single locality level* Specify:** Click or tap here to enter text.
☐ **Resident population only (e.g. care home residents)**
☐ **Other: Specify:** Click or tap here to enter text.

C: Clinical/care justification for access (include reasoning for multi-locality/GM wide access if applicable)**:**

Click or tap here to enter text.

D: Name(s) of organisation – Add appendix list where there are more than 3 organisations:

Organisation Name	ODS code[4]	Address	Contact	Email address	ICO registration no. and renewal date

E: Due diligence undertaken (including security risks e.g. technical hardware security)

1. What due diligence has taken place with the relevant locality/localities shared care record forum(s)?

[4] a unique code created by the Organisation Data Service within NHS Digital and used to identify organisations across health and social care. ODS codes are required in order to gain access to national systems like NHS mail and the Data Security and Protection Toolkit (DSPT)

Click here to enter text

Or

GM Wide: Click here to enter text

2. DSPT status (*Note if more than one organisation as in D include DSPT within appendix for each organisation***):**
☐ Standards met
☐ Standards not met with action plan
Clarify reason standards not met: Click here to enter text

Version: Click here to enter text. Date submitted: Click to enter a date.:

3. If IG Training is a reason standards not met in 1. above, confirm that specific staff that will be accessing data have/will receive appropriate IG training prior to accessing the GM Care Record:

☐ Not applicable – standards met
☐ Yes
☐ No
☐ Plan to achieve by Click or tap to enter a date.

4. How will auditing of access be carried out and by whom? Click here to enter text

5. Staff levels requiring access:

☐ **Health/care practitioner**
☐ **Administration (access to clinical data)**
☐ **Administration (no access to clinical data)**
Other: Specify Click here to enter text

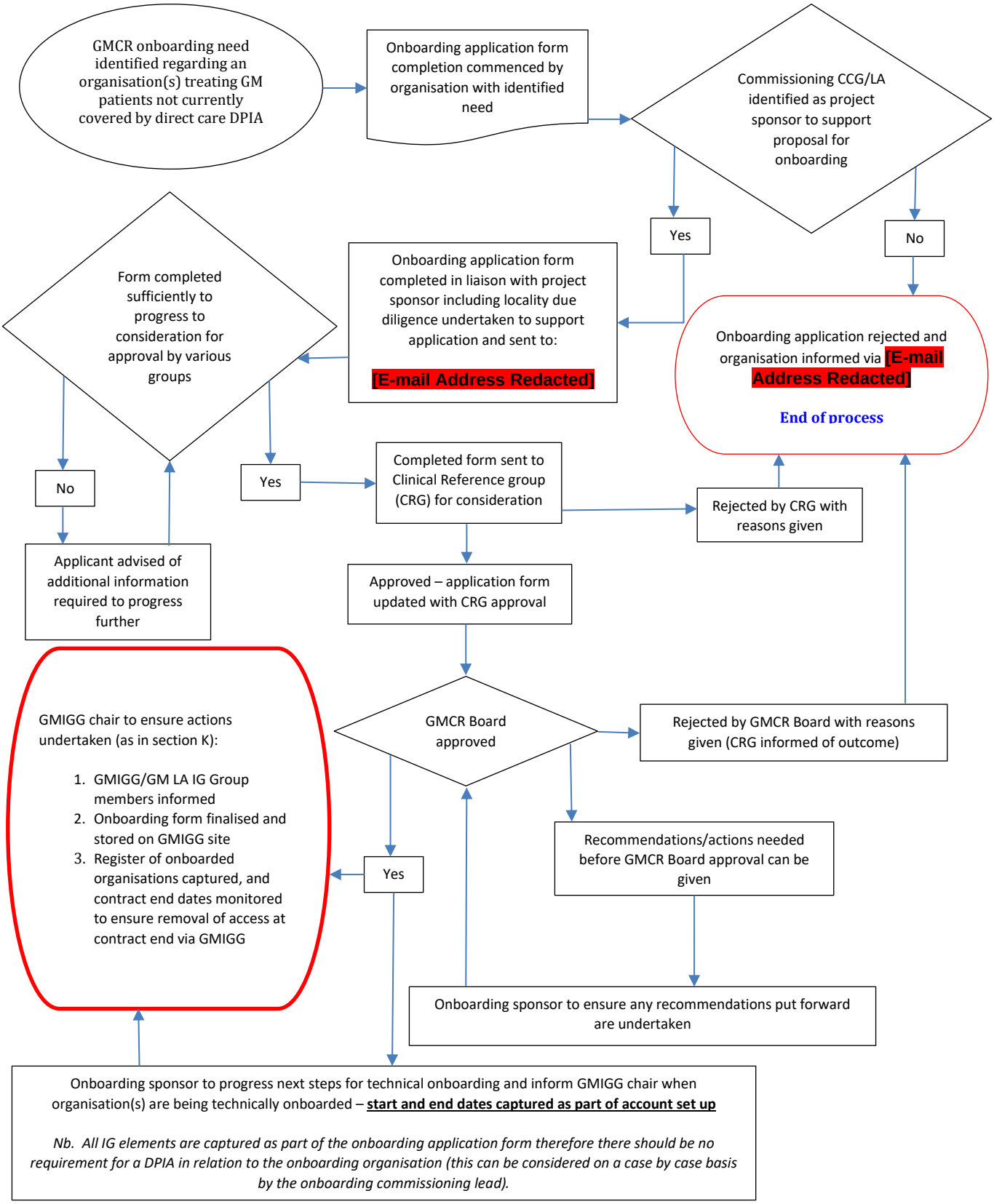
6. Link to privacy notice Click or tap here to enter text.

F: Timeframe for access subject to approval by relevant GM groups	☐ **Urgent given clinical need** ☐ **Under 2 weeks** ☐ **2 – 4 weeks** ☐ **4 weeks and over** **Intended 'Go live' date:** Click or tap to enter a date. **Any additional information to clarify above:** Click or tap here to enter text.
G: Provider/consumer of data/both	☐ Provider ☐ Consumer ☐ Both **Specify clinical/care recording system used:** Click here to enter text.
H: Locality shared care record forum approval: **Date and any recommendations:**	Click or tap to enter a date. Click or tap here to enter text.

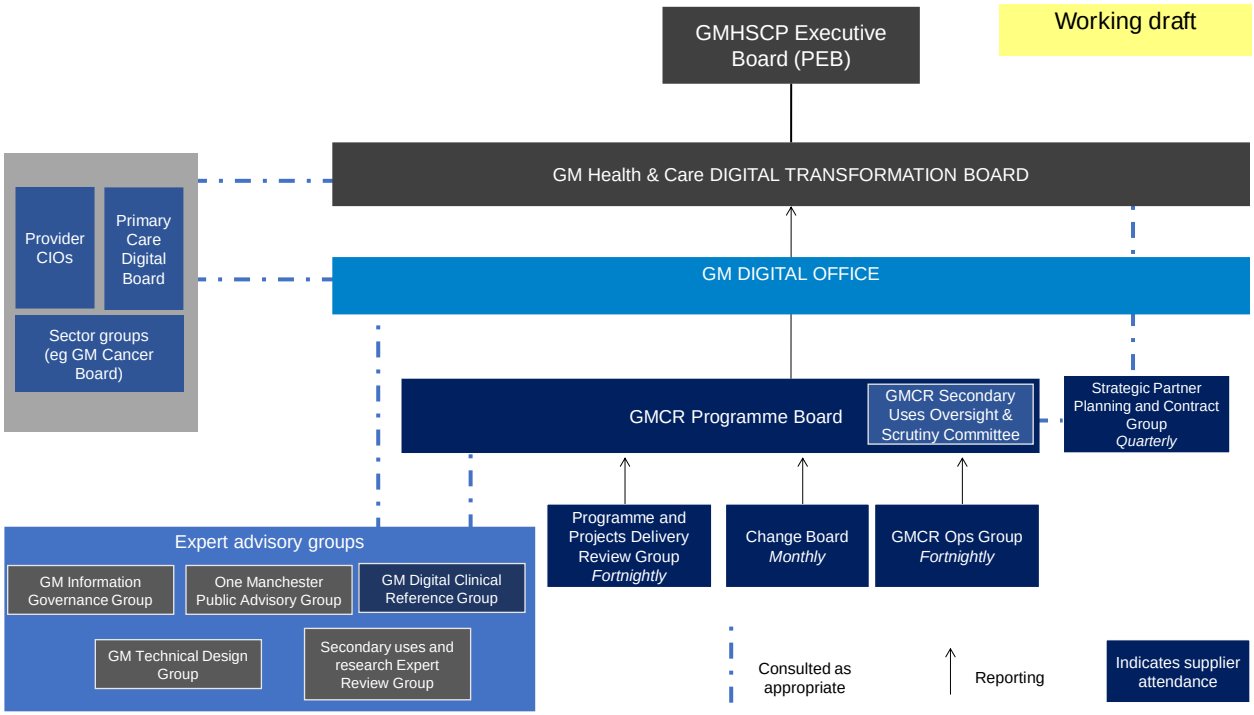
GM APPROVAL	
I: Clinical Reference Group approval (incorporating social care) - Date and any recommendations completed contact: [E-mail Address Redacted]	Click here to enter text Attach any relevant confirmation Date: Click or tap to enter a date.
J: GMCR Board - Date and any recommendation completed **contact:** [E-mail Address Redacted]	Click or tap here to enter text. Attach any relevant confirmation Date: Click or tap to enter a date.
K: GMIGG actions	
Outcome/feedback provided to requesting organisation IG Lead	Specify method: Click or tap here to enter text. Date completed: Click or tap to enter a date.
Public website updated	Date completed: Click or tap to enter a date.
Onboarding organisation(s) sign off data sharing agreement or Joint Controller Agreement as applicable	Date completed: Click or tap to enter a date.
All relevant data controllers informed and date Nb: for social care data the GM Local Authority IG group must be informed	Specify method: Click here to enter text Date completed: Click or tap to enter a date.
Monitoring of contract end date to ensure plan for revoking access at contract end in place or ongoing access if contract extended	Specify outcome: Click or tap here to enter text. Date access to be extended to then reviewed: Click or tap to enter a date. Date access revoked and all organisations informed: Click or tap to enter a date.
GMSS informed for awareness: [E-mail Address Redacted]	Specify method: Click here to enter text. Date completed: Click to enter a date.

Nb: Whilst every endeavour will be taken to expedite requests it is essential that due diligence in place to the satisfaction of all relevant data controllers. Where the request is urgent due to an identified clinical need this will be considered by the Clinical Reference Group (CRG) and the GMCR Board advised of the urgency, clinical justification and any recommendations by the CRG. This will enable the GMCR Board to assess necessity and timeliness.

ONBOARDING PROCESS



Current Governance which is under review as at Jan 2022 in consultation with stakeholders



Appendix D

GMCR DELETION OF DATA PROCESS

[REDACTED – Exempted under Section 43(2) of the Freedom of Information Act (2000) pertaining to Commercially Sensitive Information]

Appendix E

GM Care Record

A report prepared by **[PERSONAL DATA REDACTED – Exempted under Section 40 of the Freedom of Information Act (2000)]**

of V-LEX regarding the GDPR compliance of the contract with Graphnet for the provision of the Greater Manchester Shared Care Records

Version 1.2

21 June 2021

[REDACTED – Exempted under Section 43(2) of the Freedom of Information Act (2000) pertaining to Commercially Sensitive Information]

Annex 2: Graphnet CareCentric Cloud Security Model

[REDACTED – Exempted under Section 43(2) of the Freedom of Information Act (2000) pertaining to Commercially Sensitive Information]

Annex 3: Authority Service Recipients

The Authority Service Recipient Organisations who will benefit from the Services under the terms of this Agreement and will be Licensed to use the Supplier Software in accordance with Schedule 4.1 (*Supplier Solution*) are set out below:

For the avoidance of doubt, any entity listed below also includes their successor body as applicable.

CCGs INCLUDING GPs EXISTING, CARE HOMES AND COMMUNITY PHARMACIES (PDES)	**Licences based on population of 3,119,471**	**Information Providers**	**Information Consumers**
Up to 440 GPs (associated with the CCGs below)	Feed (PDES) / view / SSO	✓	✓
Care Homes	Feed / view / SSO	✓	✓
Community Pharmacies	Feed / view / SSO	✓	✓
NHS BOLTON CCG	Feed (PDES) / view / SSO	✓	✓
NHS BURY CCG	Feed (PDES) / view / SSO	✓	✓
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	Feed (PDES) / view / SSO	✓	✓
NHS MANCHESTER CCG	Feed (PDES) / view / SSO	✓	✓
NHS OLDHAM CCG	Feed (PDES) / view / SSO	✓	✓
NHS SALFORD CCG	Feed (PDES) / view / SSO	✓	✓
NHS STOCKPORT CCG	Feed (PDES) / view / SSO	✓	✓
NHS TAMESIDE AND GLOSSOP CCG	Feed (PDES) / view / SSO	✓	✓
NHS TRAFFORD CCG	Feed (PDES) / view / SSO	✓	✓
NHS WIGAN BOROUGH CCG	Feed (PDES) / view / SSO	✓	✓
COUNCIL (ADULT & CHILDREN)			
Manchester City Council	Feed / view / SSO	✓	✓
The Borough Council of Bolton	Feed / view / SSO	✓	✓
Stockport Metropolitan Borough Council	Feed / view / SSO	✓	✓
Salford City Council	Feed / view / SSO	✓	✓
Trafford Metropolitan Borough Council	Feed / view / SSO	✓	✓
Wigan Metropolitan Borough Council	Feed / view / SSO	✓	✓
Bury Metropolitan Borough Council	Feed / view / SSO	✓	✓
Oldham Metropolitan Borough Council	Feed / view / SSO	✓	✓
Tameside Metropolitan Borough Council	Feed / view / SSO	✓	✓
Rochdale Metropolitan Borough Council	Feed / view / SSO	✓	✓
Greater Manchester Combined Authority (subject to DPIA and approval by data controllers)	view / SSO	✓	✓
ACUTE			
Manchester University NHSFT	Feed / view / SSO	✓	✓
Pennine Acute Hospital NHSFT (to become Northern Care Alliance)	Feed / view / SSO	✓	✓
Tameside and Glossop Integrated Care NHSFT	Feed / view / SSO	✓	✓

Salford Royal NHSFT (to become Northern Care Alliance)	Feed / view / SSO	✓	✓
Stockport NHSFT (Stepping Hill Hospital)	Feed / view / SSO	✓	✓
Bolton NHSFT (Royal Bolton Hospital)	Feed / view / SSO	✓	✓
Wrightington, Wigan & Leigh NHSFT (Royal Albert Edward Infirmary)	Feed / view / SSO	✓	✓
MENTAL HEALTH			
GM Mental Health NHS Foundation Trust	Feed / view / SSO	✓	✓
Pennine Care NHS Foundation Trust	Feed / view / SSO	✓	✓
UNSCHEDULED CARE			
NWAS	Feed / view / SSO	✓	✓
Stockport (Mastercall)	Feed / view / SSO	✓	✓
Manchester (GTD Healthcare)	Feed / view / SSO	✓	✓
Oldham (GTD Healthcare)	Feed / view / SSO	✓	✓
Tameside (GTD Healthcare)	Feed / view / SSO	✓	✓
Bolton (BarDoc)	Feed / view / SSO	✓	✓
Wigan (GP Alliance)	Feed / view / SSO	✓	✓
Bury (BarDoc)	Feed / view / SSO	✓	✓
Heywood, Middleton & Rochdale (BarDoc)	Feed / view / SSO	✓	✓
Salford (Salford GP OOH)	Feed / view / SSO	✓	✓
SPECIALIST			
The Christie NHS Foundation Trust	Feed / view / SSO	✓	✓
COMMUNITY			
Stockport NHSFT (Stepping Hill Hospital)	Feed / view / SSO	✓	✓
Wrightington Wigan and Leigh Community Healthcare NHS Foundation Trust	Feed / view / SSO	✓	✓
Manchester University NHSFT	Feed / view / SSO	✓	✓
Pennine Care NHS Foundation Trust (to become Northern Care Alliance)	Feed / view / SSO	✓	✓
Bolton NHS FT Community Services	Feed / view / URL	✓	✓
HOSPICES			
Springhill Hospice - Bury & HMR	Feed / view / SSO	✓	✓
Bolton Hospice	Feed / view / SSO	✓	✓
St Anns Hospice - Stockport & Manchester	Feed / view / SSO	✓	✓
Wigan Hospice	Feed / view / SSO	✓	✓
Dr Kershaws Hospice - Oldham	Feed / view / SSO	✓	✓
Willow Wood Hospice - Tameside	Feed / view / SSO	✓	✓
Bury Hospice	Feed / view / SSO	✓	✓
GM Health and Social Care Partnership (2nd use) (subject to DPIA and approval by data controllers)	**View**		**v**
Health Innovation Manchester (subject to DPIA and approval by data controllers)	**View**		**v**
Onboarded organisations that have gone through process at Appendix A			
Pennine MSK Partnership Limited (Oldham CCG registered population)	**View**		✓
Liverpool University Hospitals NHS Foundation Trust (Specialist Weight Management Service) commissioned by Wigan Council	**View**		✓

Appendix F

DOUBLE CLICK ON THE BELOW DIAGRAM TO OPEN UP THE POWERPOINT SLIDE

(HIT THE ESC KEY TO STOP THE SLIDE SHOW AND RETURN TO WORD)

Graphnet – GM Architecture Overview Powerpoint

[REDACTED – Exempted under Section 43(2) of the Freedom of Information Act (2000) pertaining to Commercially Sensitive Information]

with thanks and acknowledgement to NHS SOUTH, CENTRAL AND WEST COMMISSIONING SUPPORT UNIT and shared via the Shared healthcare Record (ShCR) regional leads

Legal Gateway Matrix

Description	This document contains a list of some of the relevant legislation that supports the data sharing.
Version	5.0
Last Updated	25/10/2018
Last Updated by	**[PERSONAL DATA REDACTED – Exempted under Section 40 of the Freedom of Information Act (2000)]** – NHS SCW CSU
Related Document	

1. Introduction

Any health and care project that involves information sharing of personal data, needs to have a legal basis, as well as lawful bases for doing so. This is required because each partner organisation is a statutory body, or it provides services for a statutory body, which means that it gets its powers and directions to carry out its functions and deliver services, including sharing the information needed to carry out these functions directly from legislation or a contract with a statutory body.
Section 2 lists the legal gateways (legislation) that may be used by the Partner Organisations, each organisation must decide on which legal gateway they rely on for each function that requires them to share/access data.
Section 3 lists the processing justifications (lawful bases) that may be used by the Partners.
Section 4 lists other applicable legislation.

Please note that the legal gateway information below is directly copied from the corresponding legislation.

2. Legal Gateway Matrix

Legislation	Legal gateway	Organisation
Health and Social Care (Quality & Safety) Act 2015	Section 3 (1),(2)(a)(b): (1) This section applies in relation to information about an individual that is held by a relevant health or adult social care commissioner or provider ("the relevant person"). (2) The relevant person must ensure that the information is disclosed to (a)persons working for the relevant person, and (b)any other relevant health or adult social care commissioner or provider with whom the relevant person communicates about the individual.	All commissioners and providers of health and care services to Adults.
Health & Social Care Act 2012	Section 195: (contains guidance about) specific duties of co-operation, including creating a Health and Wellbeing Board, which must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.	All commissioners and providers of health and care services.
Care Act 2014	Section 1: The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being. Well-being in this Part includes: (b) physical and mental health and emotional well-being; (c) protection from abuse and neglect; (f) social and economic well-being;	Local authorities as commissioners and providers of health and care services to adults, and those commissioned to provide those services.

Legislation	Legal gateway	Organisation
Care Act 2014	Section 3: Local authorities must exercise their functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would — (a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area, (b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or (c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).	Local authorities as commissioners and providers of health and care services to adults, and those commissioned to provide those services.
Care Act 2014	Section 42: Enquiry by local authority (1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)— (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.	Local authorities as commissioners and providers of health and care services to adults, and those commissioned to provide those services.
The Children Act 1989	Section 47(9)(11): Where a local authority are conducting enquiries under this section, it shall be the duty of any person mentioned in subsection (11) to assist them with those enquiries (in particular by providing relevant information and advice). The persons are— (a) any local authority; (d) any clinical commissioning group, Local Health Board , Special Health Authority, National Health Service trust or NHS foundation trust; and (e) any person authorised by the Secretary of State for the purposes of this section.	Local Authorities conducting child protection enquiries and those that have a duty to assist (health bodies).
The Children Act 1989	A local authority may also request help from those listed above in connection with its functions under Part 3 of the Act. Part 3 of the Act, which comprises of Sections 17-30: (allows for local authorities to provide various types of support for children and families). Section 17(5): Every local authority— (a) shall facilitate the provision by others (including in particular voluntary organisations) of services which it is a function of the authority to provide by virtue of this section, or section 18, 20, 22A to 22C, 23B to 23D, 24A or 24B**]**; and (b) may make such arrangements as they see fit for any person to act on their behalf in the provision of any such service.	Local Authorities facilitating services to those identified as "in need" and those that are commissioned to provide the service.
The Children Act 2004	Section 10: Co-operation to improve well-being. (3) The arrangements are to be made with a view to improving the well-being of children in the local authority's area so far as relating to— (a) physical and mental health and emotional well-being; (b) protection from harm and neglect; (e) Social and economic well-being.	Local Authorities and relevant partners that have the remit to improve the well-being of children.

Legislation	Legal gateway	Organisation
	(4) for the purposes of this section each of the following is a relevant partner: • District councils • The police • The probation service • Youth offending teams (YOTs) • Health and Wellbeing Board. • Any clinical commissioning group for an area any part of which falls within the area of the authority	
The Children Act 2004	Section 11: Arrangements to safeguard and promote welfare. The section applies to: (a) a local authority in England; (b) a district council which is not such an authority; (bb) a clinical commissioning group; (d) a Special Health Authority, so far as exercising functions in relation to England, designated by order made by the Secretary of State for the purposes of this section; (f) an NHS trust all or most of whose hospitals, establishments and facilities are situated in England; (g) an NHS foundation trust; (h) the local policing body and chief officer of police for a police area in England; (k) a youth offending team for an area in England; (l) the governor of a prison or secure training centre in England (or, in the case of a contracted out prison or secure training centre, its director);	Local Authorities and relevant partners that have a duty to safeguard and promote welfare of children.
Childcare Act 2006	Section 1: General duties of local authority in relation to well-being of young children (1) an English local authority must— (a) improve the well-being of young children in their area, and (2) in this Act "well-being", in relation to children, means their well-being so far as relating to— (a) physical and mental health and emotional well-being; (b) protection from harm and neglect; (e) social and economic well-being.	Local authorities as commissioners and providers of health and care and services to children, and those commissioned to provide those services.
Childcare Act 2006	Section 4: Duty of local authority and relevant partners to work together (1) For the purposes of this section each of the following is a relevant partner of an English local authority— (za) the "National Health Service Commissioning Board;", and (a) a clinical commissioning group for an area any part of which falls within the area of the local authority; (b) the Secretary of State, in relation to his functions under section 2 of the Employment and Training Act 1973 (c. 50).	Local authorities as commissioners and providers of health and care and services to children, and those commissioned to provide those services.
Children and Families Act 2014	Section 23: Places a duty on health bodies (CCGs, NHS Trust and NHS foundation trust) to bring certain children to local authority's attention, where the health body has formed the opinion that the child has (or probably has) special educational needs or a disability.	Health bodies and local authorities.
Children and Families Act 2014	Section 25: Places a duty on a local authority to exercise its functions with a view to ensuring the integration of educational provision, training provision with health care and social care provision where it thinks that this would – (a) promote the well-being of children or young people in its area who have special education needs or a disability, or (b) improve the quality of special educational provision in its area or outside its area for children it is responsible for who have special educational needs	Local authorities as commissioners and providers of health and care and services to children, and those commissioned to provide those services.

Legislation	Legal gateway	Organisation
Crime and Disorder Act 1998	Section 17: Duty to consider crime and disorder implications. (1) Without prejudice to any other obligation imposed on it, it shall be the duty of each authority to which this section applies to exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent, crime and disorder in its area. (2) This section applies to a local authority, a joint authority, a local policing body, and others.	Local authorities
Digital Economy Act 2017	Section 35 (1)(2)(9)(10)(11)(12): Disclosure of information to improve public service delivery. (1) A specified person may disclose information held by the person in connection with any of the person's functions to another specified person for the purposes of an objective which is a specified objective in relation to each of those persons. (2) In this section "specified person" means a person specified, or of a description specified, in Schedule 4 (9) The first condition is that the objective has as its purpose— (a) the improvement or targeting of a public service provided to individuals or households, or (b) the facilitation of the provision of a benefit (whether or not financial) to individuals or households. (10) The second condition is that the objective has as its purpose the improvement of the well-being of individuals or households. (11) The reference in subsection (10) to the well-being of individuals or households includes— (a) their physical and mental health and emotional well-being, (b) the contribution made by them to society, and (c) their social and economic well-being. (12)The third condition is that the objective has as its purpose the supporting of— (a) the delivery of a specified person's functions, or (b) the administration, monitoring or enforcement of a specified person's functions.	Local authorities as commissioners and providers of health and care and services, and those commissioned to provide those services.
Local Government Act 2000	Section 2 Promotion of well-being. (1) Every local authority are to have power to do anything which they consider is likely to achieve any one or more of the following objects— (b) the promotion or improvement of the social well-being of their area, and	Local Authorities
National Health Service Act 1977	Section 22: Co-operation between health authorities and local authorities. (1) In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales. In this section "NHS body" means— (za) a Strategic Health Authority; (a) a Health Authority; (b) a Special Health Authority; (d) an NHS trust.**]**	Health bodies and local authorities.
National Health Service Act 2006	Section 82: Places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	Health bodies and local authorities as commissioners and providers of health and care and services, and those commissioned to provide those services.

Legislation	Legal gateway	Organisation
Special Education Needs and Disability Regulations 2014	Section 6: Where the local authority secures an EHC needs assessment for a child or young person, it must seek the following advice and information, on the needs of the child or young person, and what provision may be required to meet such needs and the outcomes that are intended to be achieved by the child or young person receiving that provision— (c) medical advice and information from a health care professional identified by the responsible commissioning body; (d) psychological advice and information from an educational psychologist; (e) advice and information in relation to social care; (f)advice and information from any other person the local authority thinks is appropriate; (h) advice and information from any person the child's parent or young person reasonably requests that the local authority seek advice from.	Local authorities as commissioners and providers of health and care and services to children, and those commissioned to provide those services.