Schedule 6 of Appendix 1

Tier 2 - Information Community Agreement

Between signatory agencies involved in the delivery of services for the:

Wolverhampton Better Care Fund Programme Information Sharing agreement – 2018 refresh

Partner	DP Registration Number	Registration Expires
City of Wolverhampton Council	Z5569755	11 July 2019
Black Country Partnership NHS Foundation Trust	Z1663956	26 February 2019
The Royal Wolverhampton NHS Trust	Z8441040	07 March 2019
Wolverhampton Clinical Commissioning Group	ZA024989	29 October 2018
Wolverhampton Voluntary Sector Council	Z9820633	18 March 2019
Wolverhampton Homes	Z9185149	31 August 2019
Compton Care	Z3474886	10 January 2019

Document Control

Version	Date Modified	Author/Modified by	Summary of change
1	14/9/2018	Paul Aldridge	• Added in required new partners and latest DP Registration Numbers per ICO • Added in more specifics around where information needs to be shared and why • Updated and added in some high level process maps to show information sharing in action • Started to add in latest DP Reg Nos • Amended Appendices to reflect current data flowing through Fibonacci and others to reflect current and planned state • Tidy up numbering, spelling etc.
1.2	25.10.19	Andrea Smith	Process for referral of patients into MDT and clarification around consent

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1. Introduction

1.1 This Information Sharing Agreement (ISA) is an agreement between all agencies working together under the remit of The Wolverhampton Better Care Fund (BCF) to ensure the health and well-being of Adults within city.

1.2 The BCF is a transformation incentive which is designed to bring about the integration of health and social care services, launched nationwide in April 2015.

1.3 Working together on the programme are The Royal Wolverhampton NHS Trust, City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Black Country Partnership NHS Trust, Wolverhampton General Practitioners (GPs), Wolverhampton Homes, Wolverhampton Voluntary Sector Council and Compton Care; Primary Care Networks; West Midlands Ambulance Service

1.4 The programme is focusing on the following priorities:

- Reducing emergency admissions to hospital
- Reducing the number of delayed transfers of care from hospital
- Improving the effectiveness of reablement
- Reducing the number of people permanently placed in nursing and residential care
- Improving the experience of people using services
- Ensuring patients access the most appropriate pathway of care for their needs.
- Improving integrated working to increase efficiency in care delivery, reduce duplication and risk

1.5 This Tier- 2 agreement aims to facilitate the lawful and secure sharing of information between partner agencies and designated professionals working to deliver integrated care under the Wolverhampton 3-tier Information Sharing Framework. This document is compliant with the general principles of information sharing set out in Wolverhampton Overarching Information Sharing Protocol and organisations that sign up to this information sharing protocol are therefore bound by the principles of the Tier 1 over-arching protocol and are automatically signed up to it. More information on the framework can be found on at the following link:

http://www.wolverhampton.gov.uk/article/3327/Information-Sharing

1.6 **The absence of a protocol should not prevent sharing information**. If you need to share information outside of the terms of this protocol or with agencies that are not party to this protocol you should follow the guidance as outlined in Section 7, The Information sharing flowchart and golden rules to sharing.

2.0 Background

2.1 Information sharing is the key to improving outcomes for patients/ service users and is essential to enable early intervention and preventative work. In many cases, it is only when information is brought together from a variety of sources, that it is identified that a person is seen to be vulnerable, in need or at risk of harm.

2.2 Following the independent review of how information about patients is shared across the health and care system[1], here on referred to as Caldicott 2, it was found that safe and appropriate sharing in the interests of the individual's **Direct Care** should be the rule, not the exception. This agreement aims to set out the parameters of the sharing that is required between health, social care and other professionals involved in a persons direct care in order to facilitate more effective Direct Care between services, whilst maintaining the control and privacy around Patient/ Service user's data.

2.3 Each organisation party to this agreement is a Data Controller for the data that they collect

and process.Their Data Protection Registration shall reflect this. Where data is shared for a common purpose as defined below in section 3, each participating agency shall be Data controllers in Common working with a patient/ service user for their own purposes. Where two or more organisations are working jointly with patent or service user for a joint outcome, the organisations will be defined as Joint Data Controls for the data processed for these patients and will have joint liability.

3.1 Specific Purposes of Information Sharing under this ISA

There are five defined work streams within the BCF, however this agreement will be focusing on the data sharing required for the primarily for services being designed and implemented through the Adult Community Care Workstream although the data being shared and aspects of the services will have interdependencies and cross overs with work in other workstreams excluding CAMHS as all the data to be shared under this Agreement will be for Adults. Each organisation will be Data Controllers in Common for the purpose of sharing to support the care pathway that each agency will be involved in the delivery for. For each of the categories below, further information of information to be shared can be found in Section 6

3.2 Within these work streams the following purposes for data sharing have been established:

3.2.1 **MDTs.** These currently include Community MDTS, GP Practice Based MDTs, Acute-based MDTs/Huddles, Social Care Huddles and are likely to expand. An MDT is a multi-disciplinary approach that delivers the safest, most effective care for an individual that receives care from multiple organisations and/or services. An MDT can be a physical meeting or a virtual approach that will provide both a proactive and reactive approach to patients/persons in the community that are either currently under services and/or at risk of admission to hospital/nursing home/care home but can be supported appropriately in their own homes using the MDT approach. This may involve the use of the Aristotle Risk Stratification Tool. Each model of MDT will develop individual Standard Operating Procedures that will provide the criteria for presentation and more detailed flow of information.

3.2.2 **Community Co-located Integrated Neighbourhood Teams.** A locality based Co-located multi-disciplinary team (purpose as above in 3.2.1), that facilitates a more timely approach to the care of individuals utilising a real time referral from service to service (both internally and across a range of organisations).

3.2.3 **Specialist Pathway Management - for example Frailty, End of Life, Mental Health Liaison.** Management of individuals with specific clinical conditions that have complex health and social care needs that require a multi-agency approach

3.2.4 **Admission Avoidance.** This will support both proactive and reactive functions. Proactive admission avoidance will involve using information from multiple sources to identify individuals with multiple needs and/or high users of services to prevent avoidable attendance and admission to acute and non-acute health, nursing and residential homes. Reactive admission avoidance is an intervention to those individuals who have contacted or been referred into admission avoidance services to maximise management in their community or in their own home

3.2.5 **Discharge.** Functions and teams that facilitate planned, swift and safe discharge from hospital or community setting. This work involves a multi-agency approach for example but not limited to, Social Care, Housing, Voluntary Sector, Contracted Providers of Care and Health Providers (physical and mental health)

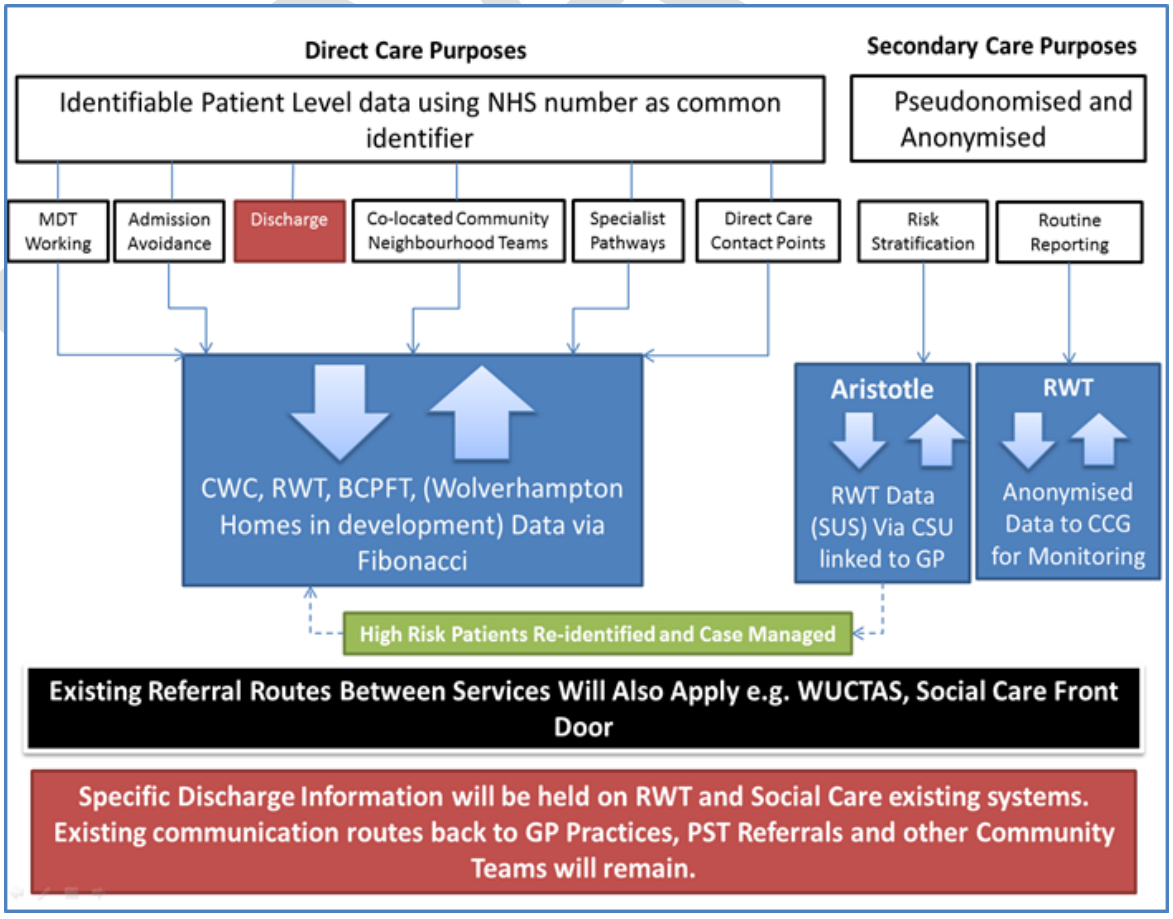
3.2.6 **All direct patient/individual contact points across the Wolverhampton Health and Social Care Economy.** Patients/persons either contact services directly e.g. GP Appointment, Walk in Centre, Urgent Care Centres, Social Care Front Door, A&E Departments or are conveyed and/or referred into services from a variety of sources. All professionals involved in these episodes of Direct Care will all state that having as much

information about the patient/person available as quickly as possible not only facilitates a more rapid, person centred approach but also increased the likelihood of a successful intervention in the care approach – both clinically and from a social perspective. Typical scenarios that will prove vital in direct care cases will include but are not limited to:-

- Knowing that someone has a care package and who the provider is will help swift discharges from emergency care
- Knowing that someone is alcohol dependent will impact on the clinical treatment given in times of crisis
- Understanding a person's social situation will help tailor a more person centred care approach and will help the professional to plan more in line with a person's lifestyle and wishes. The patient/person is more likely to respond to the care.
- Knowing who the key workers are in the person's care will save time in making referrals to front doors and the consequential time delays that are involved with this. The right care can be given more quickly.
- Knowing someone is vulnerable or may pose a risk to lone workers helps prepare professionals with their approach prior to a visit.
- Knowing that someone lives alone, in a tower block with access only via a key safe will help any reactive response in gaining access to the patient/person safely

3.3 Current Data Flows

3.3.1 **Important Note:** At the time of this Agreement Fibonacci is the only IT solution that has the specific feeds from partners required to meet the purpose outlined in 3.2 – however the system solution/software providing the data feeds may change as Wolverhampton develops further technical solutions moving forward. Where 'Fibonacci' is specifically mentioned this does not preclude another system/software from being used but as and when that happens, a refresh of the text and relevant Appendices of this Agreement will be undertaken.



4.0 Key Legislation

(A)Legislation	(B) Duties
Health and Social Care Act 2012	The **Health and Social Care Act 2012** sets out specific obligations for the health system and its relationship with care and support services. It gives a duty to NHS England, clinical commissioning groups, Monitor and Health and Wellbeing Boards to make it easier for health and social care services to work together.
Health Act 1999	**Section 27** of the Health Act replaces section 22 of the NHS Act 1977. Section 27 states that NHS bodies and local authorities shall co- operate with one another (this allows for practitioners to share information) in order to secure the health and welfare of people.
Health and Social Care Act (safety and Quality) Act 2015	—251B Duty to share **information using a common identifier** (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 personll). (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, Under **Schedule 2** of the DPA, either of the following conditions can be met: The processing is necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject. And The processing is necessary to carry out the functions under enactment under the NHS act.

Common Law Duty of Confidentiality	The common law duty of confidentiality applies. This duty applies to identifiable information, and not to aggregated data that is derived from such information, or to information that has been otherwise anonymised. In considering their obligations under the common law of confidence, the Partner Organisations have had particular regard to: • HSCIC Guide to Confidentiality • BMA Confidentiality toolkit • NHS Guide to Confidentiality • Information Commissioner's Data Sharing Code of Practice. • NHS digital IG Toolkit Each agency needs to decide whether the information being shared would breach any duty of confidence in which that was given, under Common Law.
	When data is given in confidence, it is important to explain to the data subject, situations where duty of confidence cannot be maintained or may be overridden.
(C) Data Protection Act 2018 And General Data Protection Regulation (GDPR)	Under **Article 6** of the GDPR, either of the following conditions can be met: a) Consent of the data subject e) Necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. f) Necessary for the purposes of legitimate interests Under **Article 9** the following conditions can be met: 2 (a) Explicit consent of the data subject, unless reliance on consent is prohibited by EU or Member State Law. 2 (c) Necessary to protect the vital interest of a data subject who is physically or legally incapable of giving consent 2 (g) Necessary for reasons of substantial public interest on the basis of Union or Member State Law which is proportionate to the aim pursued and which contains appropriate safeguarding measures. It is also important to ensure that other Data Protection principles are complied with, for example the information being shared is relevant to the purposes of this agreement and is not excessive; information being shared is accurate and up to date; information is kept for no longer than necessary; information shared is kept secure.

5. Information Types

There are three types of information that agencies subject to this agreement may manage and share:

5.1 Personal information

5.1.1 The Data Protection Act 1998 defines ‗personal information' as information relating to a living individual who can be identified either from that information or from that information in conjunction with other information that is in, or is likely to come into, the possession of the data controller.

5.1.2 A person's full name is an obvious likely identifier; but other information such as a customer reference number, address, photograph or CCTV image could also identify them.

5.1.3 The definition of personal information is technology neutral; it does not matter how the information is stored (e.g. on a computer database, paper filing system, portable memory stick, camera or mobile phone).

5.1.4 Where it is necessary for information to be shared, personal information will be shared only on a need-to-know basis.

5.1.5 Any duty of confidentiality will be respected unless there is an overriding 'public interest' to disclose the information and if there is a 'legitimate purpose' to sharing. Where the disclosure would breach client confidentiality the request should be referred to a designated manager - unless exceptional circumstances apply, e.g. where there is a need for urgent medical treatment. Managers should have access to a source of advice and support on information sharing issues (refer to your Information Governance Manager in the first instance or your Caldicott Guardian).

5.1.6 The reasons for breaching client confidentiality must be fully recorded and clearly referenced to the evidence and information on which the decision is based. This must include details of any third parties and details of all the information/evidence they have been given.

5.1.7 Pseudonymised data is classed as personal data where there is a possibility of identification with a key.

5.2 Depersonalised information

5.2.1 Depersonalised information encompasses any information that does not and cannot be used to establish the identity of a living person, having had all identifiers removed.

5.2.2 Partner Organisations accept that there are no legal restrictions on the exchange of depersonalised information, although a duty of confidence may apply in certain circumstances, or a copyright, contractual or other legal restriction may prevent the information being disclosed to Partner Organisations.

5.2.3 Information shared between Partner Organisations should be limited for the purposes of the enquiry. If the purpose of this protocol can be achieved using depersonalised information, then this should be the preferred method used by officers. For example, in assessing crime hotspots geographic information that does not identify living individuals might be used for strategic planning purposes.

5.2.4 Partner Organisations recognise that great care must be taken when depersonalising information and that the Information Commissioner has stated that even a post-code or address can reveal the identity of an individual. Partner Organisations are also aware that it may be possible for an individual's identity to be revealed by comparing several sets of depersonalised data.

5.3.4 Anonymised data is classed as depersonalised data for the purpose of this agreement as it should not like back or enable re identification of the individual. Patients being referenced by NHS number alone are not classed as anonymised.

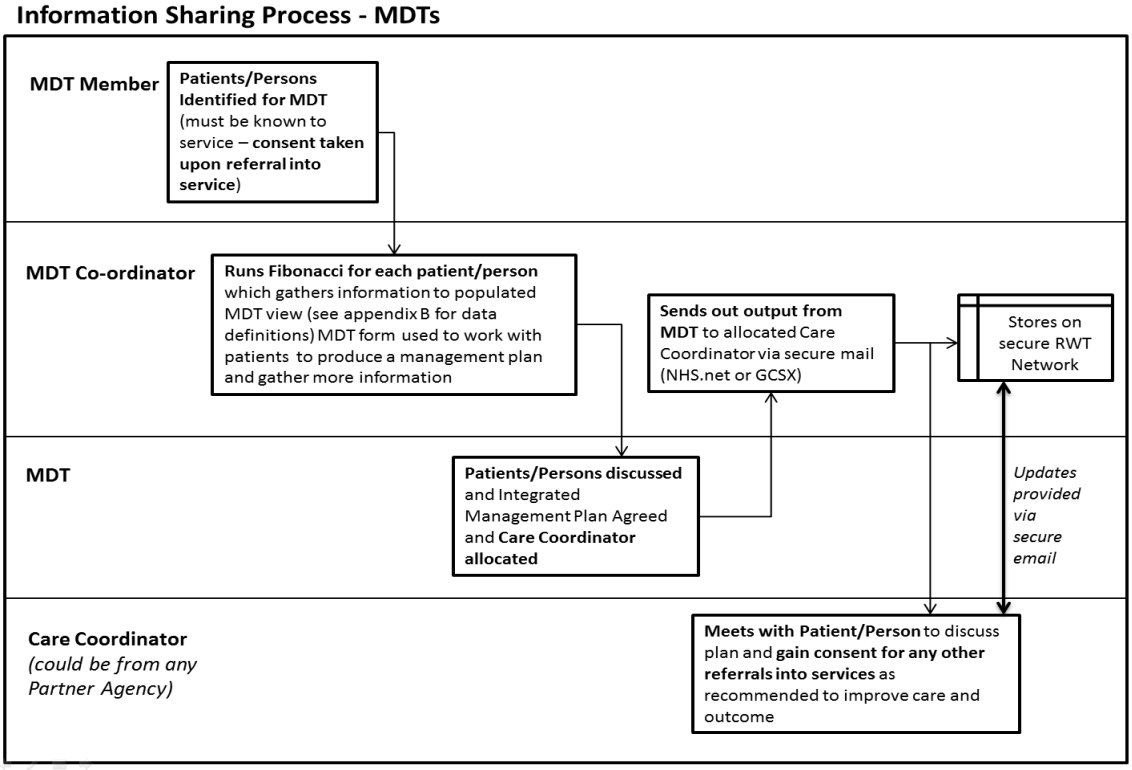
5.3 Non-personal information

5.3.1 Partner Organisations understand that non-personal information is information that does not, nor has ever, referred to individuals. Such information can also consist of plans, policies, guidelines and minutes of meetings. This is information that is generally freely available under the requirements of the Freedom of Information Act, subject to specific exemptions.

6.0 Information Sharing In Practice

6.1 Information sharing for Direct Care - MDT

The staff involved in MDT meetings is described in Appendix G. The process for the MDT meeting is demonstrated in the diagram below:-



Upon decision to refer patients into an MDT the referring professional will obtain consent from the patient, explaining the purpose of the MDT and the people involved.

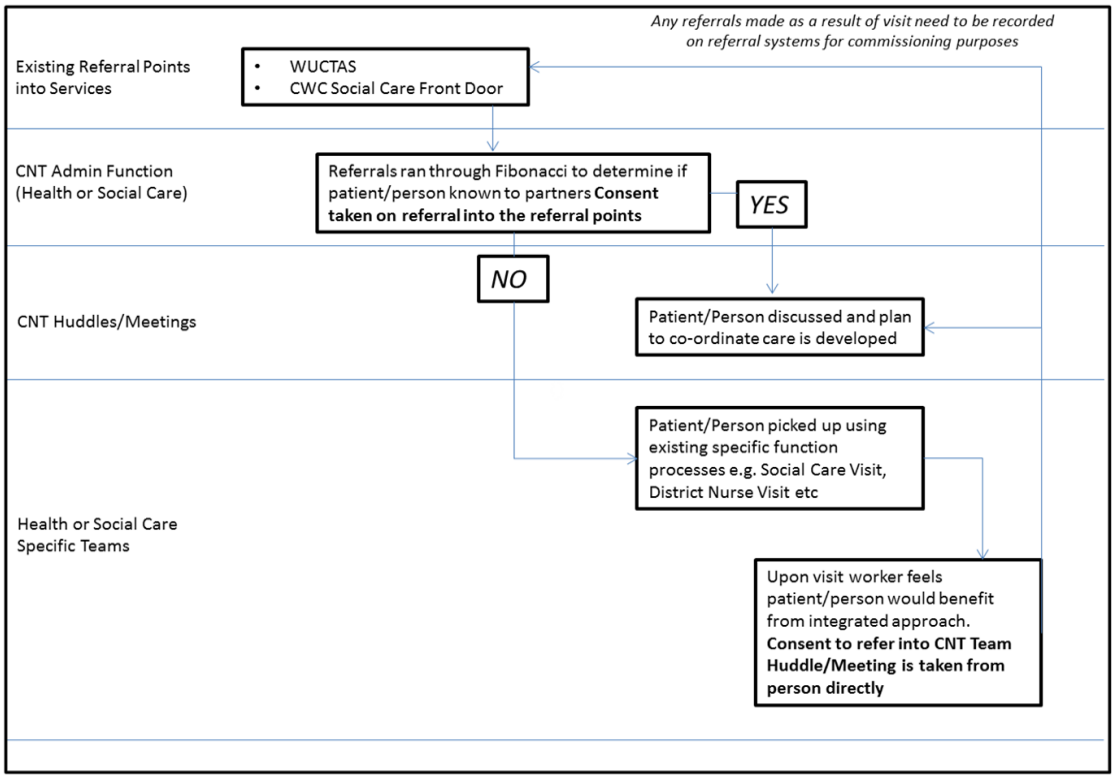
There are instances whereby during an MDT, other cases are introduced into the discussion. In these instances, where prior consent has not been obtained, the discussion will take place anonymously (i.e. “no-name surgery”). Should potential solutions/interventions be identified the professional raising the “patient” shall discuss options with the patient and make the appropriate referrals.

Discussions and outcomes of the MDT are recorded manually by a representative of each organisation present and then recorded on each organisations system (RWT PAS / CWC Carefirst) by that person. As the individual systems are updated the next time that the Fibonacci system retrieves the —view only data it will reveal the updated information. Following discussion at MDT, the individual may be referred to existing services as appropriate, using existing referral pathways and subject to the right consent having been obtained.

6.2 Information sharing for Direct Care – Co-located Integrated Community Neighbourhood Teams

The proposed process for sharing information within co-located teams is shown in the diagram below:-

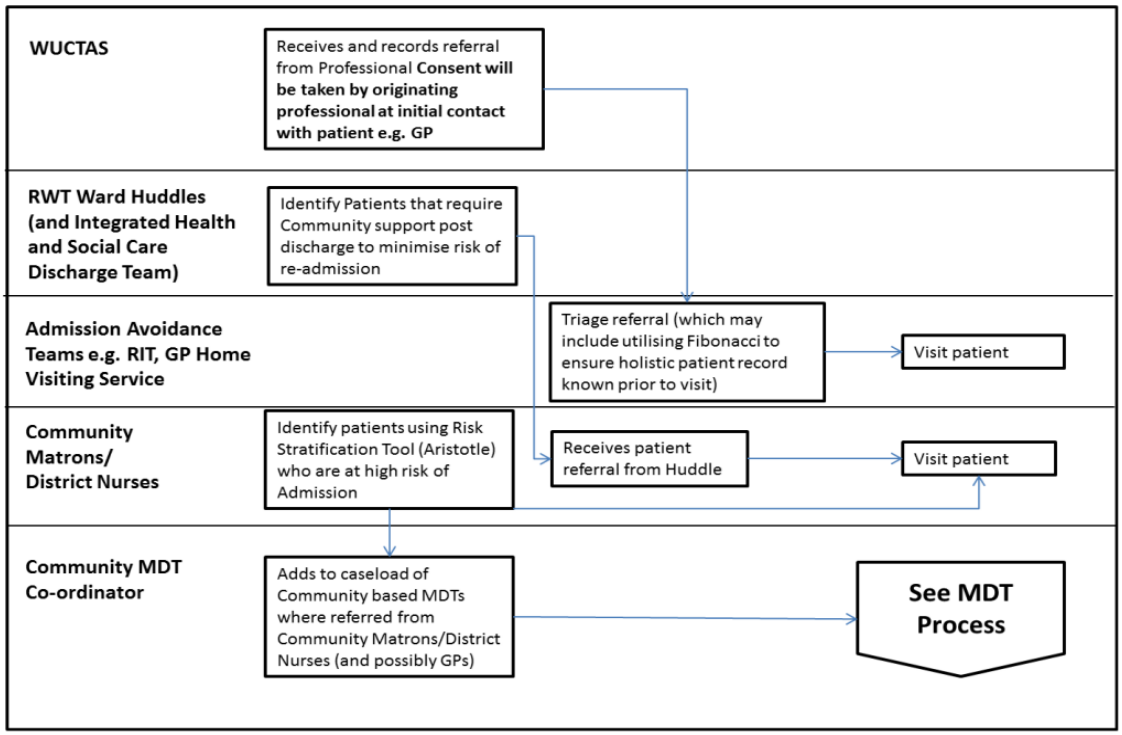
Information Sharing Process – Co-located Integrated Community Neighbourhood Teams



6.3 Information sharing for Direct Care – Admission Avoidance (reactive and proactive)

6.3.1 The high level process for sharing information for admission avoidance purposes is shown in the diagram below

Information Sharing Process – Admission Avoidance



6.4 Sharing information for secondary purposes

6.4.1 **Risk stratification -** risk stratification will be used to match the data from SUS and Graphnet via a tool called Aristotle. The data will be matched through pseudo techniques and an identifiable list will be presented to GPs and Community Matrons to review common patients and case manage where they are high risk.

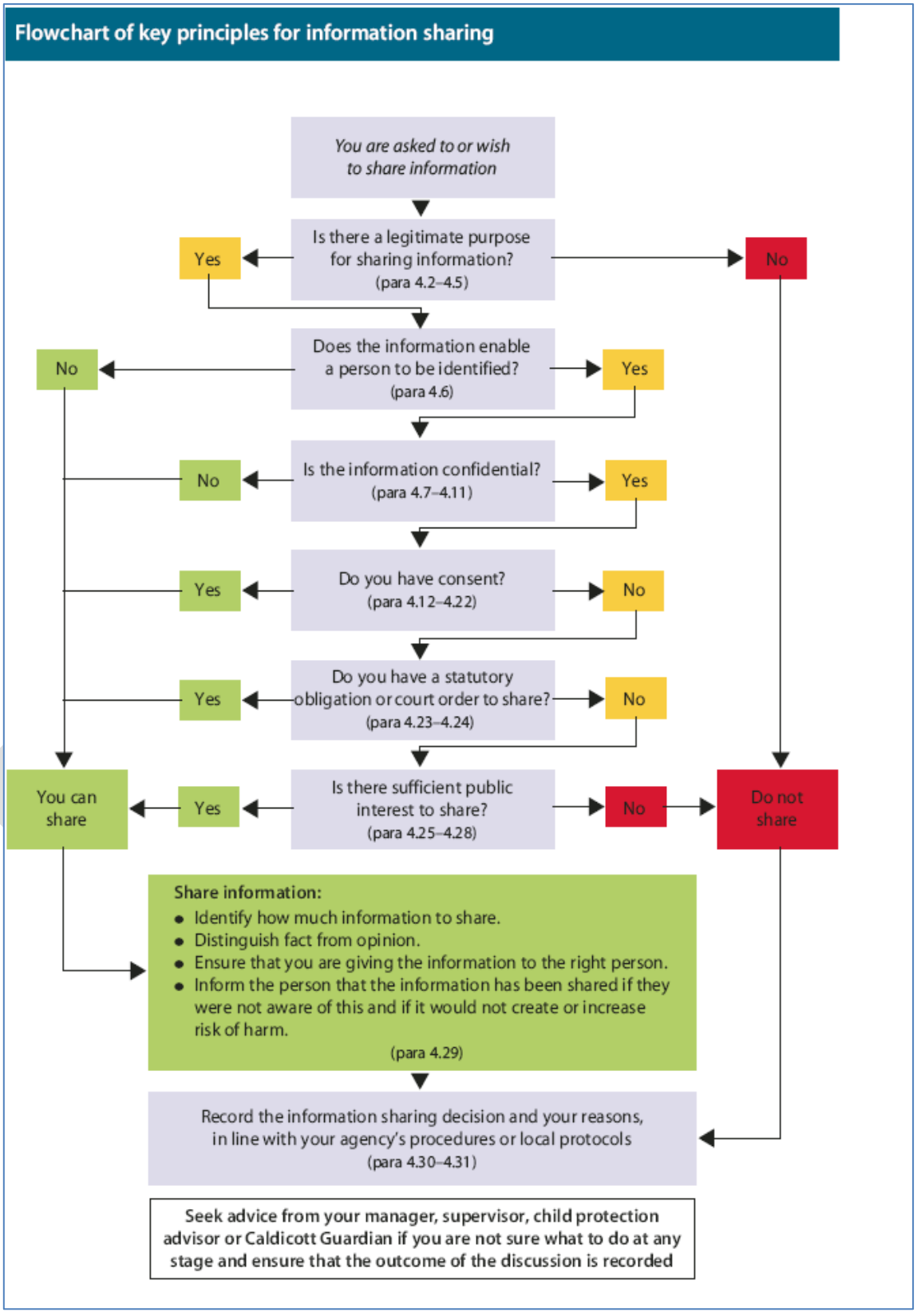
6.4.2 The Aristotle Risk Stratification software uses a series of weightings are used to calculate the % score as below:

- **Recency**: The weighting bandings are grouped by activity within 3,6,12,18,24 months
- **Frequency**: Each piece of activity is weighted by activity type. Emergency Admissions create the largest weighting whereas Outpatient appointments have a low weighting. Non elective (NEL) activity carries a heavier weighting than elective activity.
- **ICD10**: Patients with multiple long term conditions score a higher weighting.

6.4.3 **Routine reports**- RWT anonymised data to CCG for monitoring performance of BCF. All data will be anonymised for monitoring and reporting purposes, and shared by nhs.net to nhs.net email

7.0 Information sharing flow chart for decision making, golden rules to sharing and the Caldicott Principles

7.1 The below information sharing flow chart should be used a basis for decision making for information sharing by all practitioners along with the golden rules to information sharing. This should be used as a basis for training for practitioners.



7.2 It is a requirement that all agencies and staff / practitioners adhere to the Golden Rules for information sharing in all instances of information exchange. These are:

- Confirm the identity of the person you are sharing with
- Obtain consent to share if safe, appropriate and feasible to do so
- Confirm the reason the information is required
- Be fully satisfied that it is necessary to share
- Check with a manager / specialist or seek legal advice if you are unsure
- Don‘t share more information than is necessary
- Inform the recipient if any of the information is potentially inaccurate or unreliable
- Ensure that the information is shared safely and securely
- Be clear with the recipient how the information will be used
- Record what information is shared, when, with whom and why; and if you decide not to share record your reasons

7.3 **Caldicott Principles**

Below are some additional principles that health and social care organisations should use when reviewing its use of client information:

1. Justify the purpose(s) - Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don‘t use personal confidential data unless it is absolutely necessary - Personal confidential data should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. Use the minimum necessary personal confidential data - Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data transferred or accessible as is necessary for a given function to be carried out.

4. Access to personal confidential data should be on a strict need-to-know basis - Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. Everyone with access to personal confidential data should be aware of their responsibilities - Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. Comply with the law - Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. The duty to share information can be as important as the duty to protect patient confidentiality - Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

8. Consent and Fair processing

8.1 Each Partner Organisation shall employ a variety of channels to communicate with its patients regarding information sharing, such as information leaflets, posters, at the point of care, during the patient registration process or when referring into other services. Each Partner Organisation shall have a mechanism in place to deal with patients' requests to have their records excluded either by excluding such records from their data extracts or by flagging them so that the system does not allow the record to be viewed, until such time as the patient opts back in.

8.2 For the purposes listed in Section 3 the following consent model is being adopted for each of the purposes identified.

- **MDT** – where a patient/ service user is known to a relevant agency appropriate consent will be sought at point of access via each agencies existing mechanisms. Where seeking consent is not appropriate (for example an emergency setting or a GP consultation) then implied consent will extend to the relevant agency receiving the information as a continuation of the Direct Care relationship as permitted by statute. Where this information sharing is happening each agency will have this duty to share with relevant agencies stated in their fair processing notices and relevant literature. A link to each agencies privacy notice can be found below:
  - RWT - https://www.royalwolverhampton.nhs.uk/patients-and-visitors/privacy-ico/
  - CWC - http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=3241&p=0
  - BCPFT - http://www.bcpft.nhs.uk/about-us/freedom-of-information/613-how-we-use-your-information?
  - CCG - https://wolverhamptonccg.nhs.uk/about-us/fair-processing-notice-data-protection-act-1998-your-information-and-how-we-use-it
  - Wolverhampton Homes – https://www.wolverhamptonhomes.org.uk/privacy?highlight=WyJwcml2YWN5IiwibW90aWNlIiwibW90aWNlcyIsIm5vdGljZWQiLCInbm90aWNlIiwibW90aWNlYWJsZSIsInByaXZhY3kgbm90aWNlIl0=
  - WVSC - http://www.wolverhamptonvsc.org.uk/wvsc-privacy-notice/
  - Compton Care - https://www.comptoncare.org.uk/privacy-policy/
- **Co-located Integrated Community Neighbourhood Teams** as with the MDT the same consent model and legal basis will extend to the integrated Team
- **Specialist Pathway Management**
- **Admission Avoidance**. For reactive functions to avoid admission patients are referred into Community Health Teams (such as the RITS) via a social care, health or housing professional upon the identification of a clinical need. Therefore the patient is involved in the decision to refer. Proactive admission avoidance functions follows the same consent model as identified for MDTs above

- **All direct patient/individual contact points across the Wolverhampton Health**

and Social Care economy.

- **Risk stratification via Aristotle** – opt out at GP level will be filtered through Aristotle clinical systems using the appropriate national opt out codes.

- **Reporting purposes** – data for reporting purposes will be anonymised and therefore consent is not required.

8.3 A link to the BCF fair processing notice can be found at the following link and each agencies privacy notice will point to the fair processing notice.

http://www.wolverhampton.gov.uk/article/8116/Better-Care-Wolverhampton

In addition to this all agencies will have produced appropriate literature to share with Patients either via the GP or through the entry into to their organisation to raise awareness of how agencies are working together more effectively. Information for patients is currently under development.

9. Information Security

9.1 All agencies signatory to this agreement acknowledge the security requirements of the Data Protection Act 1998 and ensure that the necessary technical and organisational measures to safeguard and secure against unlawful processing, accidental loss or destruction or damage to personal and personal sensitive information.

9.2 Access to information subject to this agreement will be granted to those professionals who —need to know to discharge their duties effectively.

9.3 Each agency will ensure that there are appropriate arrangements in place to ensure that any personal or personal sensitive information, (protected or restricted information), is transferred securely.

- **E-mail** - If information is sent by email between public sector bodies, communisation of protected or restricted information must be sent via a secure email system. Communications between public sector organisations of restricted/ protect information can only be done between the following prefixes (GCSX, PNN, GSI, CJSM, NHS.NET). Agencies that do not have access to the secure public sector network as above must use a secure mail alternative. See appendix E for a list of secure contacts for safeguarding for each organisation.

- **Post** – any information shared via post must have adequate protection.
  Any case files of patient records that need to be shared by post must be done via secure courier.

- **Fax** – sharing via fax should be avoided where possible. Only safe haven fax arrangements should be used to share information via fax. If Fax is being used, it should be as a last resort and this needs to be declared to the receiving agency before utilising.

- **Telephone** – disclosures of information over the telephone should only be conducted where the identity of the recipient is known. All disclosures should be documented and proportionate.

9.4 **System used for data transfer/ collection** – where systems are being utilised for the collection or processing of sensitive personal data the lead agency responsible for the procurement of those systems should assessed the adequacy on behalf of all participating agencies. All system providers should be able to demonstrate compliance with NHS digitals IG toolkit with a valid statement of compliance.

- **Fibonacci** – this system will be used for the MDT as defined in section 3.0 above. The lead agency for this system is the City of Wolverhampton Council who will ensure that a privacy impact assessment has been carried out in relation to the use of this system with the input of participating organisations. The adequacy and security of the system will be monitored in line with the contact between CWC and Fibonacci. The architecture of the system can be found in appendix D and a list of users in appendix E.

- **Aristotle** – the Aristotle system will be used by GP partnerships and Community Matrons at RWT for the purposes of risk stratification. The lead agency for this system is The Wolverhampton Clinical Commissioning group, through their contractual relationship with Midlands and Lancashire CSU. Individual GP practices are responsible for ensuring that the privacy implications of using the system for direct patient care have been assessed. Each practice has indicated that they are content to use the system for the specified purposes and for access to be granted to community matrons as appropriate. The overall adequacy and security of the system will be monitored in line with the contact between Wolverhampton CCG and Midlands and Lancashire CSU.

9.5 **Training** - Each Partner organisation shall ensure that all staff that have access to Patient Confidential Information are appropriately training in line with the recommended standard as per the NHS digital IG Toolkit requirement, and this knowledge should be refreshed on an annual basis. Any system specific training will be coordinated and delivered by the project work streams.

9.6 **User access and audit** - Each Partner organisation shall strictly restrict internal organisational access for each patient record to those personnel/staff who are providing Direct Care to the relevant patient for that record and who are under written obligations to respect and maintain the confidentiality and security of the Patient Confidential Information and have been properly trained to discharge any relevant obligations in accordance with this agreement. Each Partner Organisation shall use user authentication mechanisms to ensure that all instances of access to that the systems listed above and ensure that they are auditable against an individual, including the following information:-

- Job role and name of staff member accessing the system;
- Organisation name;
- What actions were performed; and
- The date and time the information was viewed

9.7 **Right for organisation to inspect** – each agency shall reserve the right to inspect the controls in place by each agency where their data is being shared to ensure compliance with this agreement.

10. Information storage, retention disposal and data quality

10.1 All agencies party to this agreement will ensure that they have in place policies and procedures governing:

- The secure storage of all personal information within their manual and electronic storage systems; Electronic copies of information should only be held on encrypted devices or servers and should not be transferred to portable devices unless such devices are fully encrypted and their use is necessary for the provision of services under this agreement.

- The retention of information held in manual and electronic systems; Information processed under this agreement will only be retained for a minimum period as necessary in relation to the purpose for which it has been provided and then securely destroyed when that period comes to an end.

- Data quality – measures should be put in place to ensure the accuracy of all information that is held and processed during the matching of patients between agencies. A process will be established for identification and auctioning mis-identification of patients, which will be addressed operationally. If NHS numbers are unable to be matched for a patient, the details will not be recorded on an electronic system such as Fibonacci.

- All information will be retained subject to Records Management Code of Practice for Health and Social Care 2016.

10.2 The secure disposal of electronic and manually held information;

- Each agency will ensure that personal and personal sensitive information is securely removed from their systems and that printed documentation is securely destroyed at the end of its retention period.

- Electronic information should be securely destroyed by the physical destruction of the storage media or by the use of electronic shredding software that meets government standards or ISO 27001 to ensure permanent deletion.

- Hard copy information should be destroyed by cross-cut shredding and secure recycling of the paper waste.

11. Breaches of this Agreement

11.1 All agencies who are party to this agreement will have in place appropriate measures to investigate and deal with the inappropriate or unauthorised access to, or use of, personal information whether intentional or inadvertent.

11.2 In the event of personal information that has been shared under this agreement having or may have been compromised, whether accidental or intentional, the organisation making the discovery will without delay:

- Inform the information provider (agency) of the details.
- Inform their local IG Manger, SIRO or Data Protection Officer.
- Take steps to investigate the cause.
- If appropriate, take disciplinary action against the person(s) responsible.
- Take appropriate steps to avoid a repetition.
- Take appropriate steps where possible to mitigate any impact.

11.3 On being notified that an individual's personal information has/have been compromised, the original provider will assess the potential implications for the individual whose information has been compromised and if necessary:

- Notify the individual concerned,
- Advise the individual of their rights,
- Provide the individual with appropriate support.

12. Subject Access and Freedom of Information (FOI)

12.1 Each agency will have in places procedures to respond to subject access requests in line with the Data Protection Act 1998. Where an organisation received a request for information held jointly or in common, they will consult with relevant agencies before any disclosures are made.

12.2 For the purposes of FOI each agency will have in place procedures to respond to FOI requests. Where an agency receives a request or information which is held by or in conjunction with another agency, appropriate consultation will be carried out by the lead agency in line the Section 45 code of practice.

13. Monitoring and Review of this protocol

13.1 This agreement will be reviewed after 6 months and every 12 months thereafter and changes recorded in the version control. It is the responsibility of each agency signatory to the agreement to ensure that they have the latest version of this agreement.

14.0 Disputes

14.1 Any information sharing disputes will go to the agencies information governance officer/ data protection officer in the first instance and where necessary escalated to the Wolverhampton Information Sharing Group (WISG). The organisations Caldicott guardian will be consulted where necessary.

15. Indemnity

15.1 Disclosure of personal information without consent must be justifiable on statutory grounds, or meet the criterion for claiming an exemption under the Data Protection Act. Without such justification, both the agency and the member of staff expose themselves to the risk of prosecution and liability to a compensation order under the Data Protection Act or damages for a breach of the Human Rights Act.

15.2 If the disclosure of information is in contravention of the requirements of the Data Protection Act 1998, the agency who originally breached the requirements of the Data Protection Act 1998, either in requesting or disclosing information, shall indemnify the other agency against liability, cost or expense reasonably incurred.

16. Signatories to Agreement

16.1 We accept that this Information Community Agreement will provide a framework between the signatory organisations for the secure sharing of information within the Wolverhampton Better Care ‗Information Community' in a manner compliant with their statutory and professional responsibilities.

16.2 Signatories undertake to:

- implement and adhere to this ISA in the context of the Wolverhampton Three-Tier Model for Information Sharing.
- ensure that all protocols and procedures established within the organisation and between the organisation and others for the sharing of information are consistent with this ISA;
- establish systems, raise awareness, inform service users, issue specific guidance, and provide training to their staff to ensure compliance with this agreement;
- ensure no restrictions will be placed on sharing information other than those specified in this Agreement, the Overarching Policy, or other relevant service-specific Information Sharing Protocols.

16.3 This agreement is signed by Caldicott Guardian where applicable, on behalf of their organisation.

Organisation	Name	Position	Signature	Date signe
City of Wolverhampton Council				
Black Country Partnership NHS Foundation Trust				
The Royal Wolverhampton NHS Trust				
Wolverhampton Clinical Commissioning Group				
Wolverhampton Voluntary Sector Council				
Wolverhampton Homes				
Compton Care				

Practice Name	National Code	ICO Registration	Caldicott Signature
Thornley Street Surgery	M92028	Z4885899	
Mayfield Medical Centre	M92040	Z6454874	
East Park Medical Practice	M92630	Z6174693	
Drs Taylor & Cam (Tettenhall Road)	M92042	Z131779X	
The Surgery Woden Road	M92013	Z8872317	
Dr Christopher (Mergining with Tudor Medical Centre 1 December)	M92643	Z8084378	
Tudor Medical Centre	M92016	Z6865429	
Dr Fowler	M92014	Z1527222	
Ashfield Road Surgery	M92609	Z114034X	
Fordhouses Medical Centre	M92629	Z2332594	
Probert Road Surgery	M92041	Z7912901	
Keats Grove Surgery	M92019	Z4991552	
Cannock Road Surgery	M92039	Z6509877	
Primrose Lane Clinic	M92004	Z877995X	
Poplars Medical Practice	M92001	Z9050907	
Wolverhampton Doctors Ltd	Y02736	Z3171809	
MGS Medical Practice	M92654	Z9538585	
Prestbury Medical Practice	M92009	Z7372741	
Alfred Squire Medical Practice	M92002	Z6440308	
Drs Bilas & Thomas	M92026	Z476766X	
Ashmore Park Health Centre	M92022	Z6183615	
Church Street Surgery	M92030	Z9618775	
Bilston Urban Village Medical Centre	Y02757	Z4936321	
Ettingshall Medical Centre	Y02735	Z7537489	
Caerleon Surgery	M92027	ZA089739	
Bilston Health Centre (Dr Mudigonda)	M92649	Z8113253	

IH Medical Practice	M92015	Z4914271	
Bilston Health Centre - Dr Sharma's Practice	M92627	ZA009466	
Dr Suranyi (Hill Street)	M92003	Z9436801	
Bradley Medical Centre	M92647	Z6126627	
All Saints and Rosevillas Medical Practice	M92035	Z5489579	
Grove Medical Centre	M92612	Z786534X	
Duncan Street Primary Care Centre	M92012	Z9832797	
Pennfields Medical Centre	Y02636	Z4936321	
Lea Road Medical Practice	M92007	Z6183018	
Penn Surgery	M92043	Z6127730	
Coalway Road Surgery	M92006	Z6539998	
Castlecroft Medical Practice	M92008	Z5712149	
Warstones Health Centre	M92044	Z6557816	
Penn Manor Medical Centre	M92011	Z6802316	
Parkfield Medical Centre	M92024	Z7537489	
Dr Whitehouse	M92640	Z8037233	
The Newbridge Surgery	M92029	Z5088560	
Leicester Street Medical Centre	M92031	Z6052354	
Whitmore Reans Health Centre	M92607	Z7415412	
Lower Green Health Centre	M92010	Z6262216	

Appendix A - Data Definition for Fibonacci – All data below currently feeds directly into Fibonacci from host systems.

Data Dictionary		System data derived from	Reason data item Appendix s needed
Patient Name:		RWT PAS?PAS	To identify patient
NHS Number:		PAS/ Carefirst/BCPFT	To match correct patient
Home Address		PAS	
Temporary Address		PAS	
GP Details		PAS	

Health History Over Past 12 Months			
Risk	Both Start and End Dates are captured	RWT – PAS?	
Outpatient History	Dates and Where	RWT – PAS?	
Inpatient History	Dates and Where	RWT – PAS?	
Referrals	Dates and Specialities	RWT – PAS?	
Number of Attendances at A&E in last 12 months:	Data returned is displayed in quarters to show any trends	**PAS**	**To identify the current state and to monitor if the interventions made by the team are effective i.e. reduction in attendances**
Reason for Attendances:		PatientFirst	
Date of Attendance:		PatientFirst	

Number of Admissions to RWT in the last 12 Months	This data is split into quarters to identify trends	PatientFirst	**To identify the current state and to monitor if the interventions made by the team are effective i.e. reduction in attendances**
Admission Date		RWT PAS?	
Reason for Admission:		PAS	
Community Matron PMP	Specific Data flows are Date, Long Term Conditions, Health Professionals, Specific Problems, Personalised Development Plan and Pathways	RWT PAS?	

Social History			
Is there a Social Care Support Plan in place?	If yes then this will pull through the Start Date, Completed Date and the Outcome of care plan – specifically the commissioned services in place	**CareFirst**	
Name of Allocated Social Worker	Pulls through the worker name and contact details	**CareFirst**	
Social Circumstances	Pulls through the narrative captured from the assessment	**CareFirst**	
Current Open Safeguarding Assessment		**CareFirst**	
Number of Callouts from Telecare:	Information gathered from Jontek Answer link system	CareFirst	
Who does this client live with?		**CareFirst**	
Referrals to OT	Pulls through Start Date only	**CareFirst**	
Who is the main carer/ significant other:	Names of people with the relationship of carer on CareFirst	**CareFirst**	

Have there been any Mental Capacity assessments?	Pulls through date	CareFirst	
Current interventions from MDT:		CareFirst	to enable relevant members of the team to know what interventions are currently being undertaken with patient
Mental Health Data			
Care Co-Ordinator	Name of care co-ordinator	**BCPFT – CareNotes?**	
Alerts	Any alerts that identify risks around the patient will be pulled through	**BCPFT – CareNotes?**	
Allergies		**BCPFT – CareNotes ?**	

Referrals	Specific data flows are Date, Discharge Date, Speciality, Team, Referral Consultant, Setting	**BCPT – CareNotes ?**	
Inpatient Admissions	Specific data flows are Date, Reason, Admitting Consultant, Urgency, Ward and Discharge Date	**BCPT – CareNotes ?**	
Diagnosis	Specific data flows are Date, Category, Code, Description	**BCPT – CareNotes ?**	To enable acute to see where patient has needs that require additional support/ consideration
Future Appointments	Specific data flows are Date, Consultant/Worker, Setting	**BCPT – CareNotes ?**	

Plans in Development to add to data flows			
Housing Data from Wolverhampton Homes	Technical feasibility is underway to look to feed in data such as Housing Conditions, Access Issues and Tenancy Issues	**TBC**	
Primary Care Data from EMIS	Technical Feasibility is underway to look to feed in the data held on the 'Summary' and 'Problems' tabs from EMIS	**EMIS**	
Further RWT Data – Discharge to Assess and Community Teams	Technical feasibility needs to be undertaken in order to consider feeding of the information contained in the D2A Forms. More community health teams are moving to digital records and District Nurse plans and RITs information may be fed in once available.	**RWT PAS?**	
Compton Care	Technical and IG feasibility underway to look at potential of feeding in data held on patients know to Compton Care as part of improvements in palliative and end of life pathways	**Compton Care ?**	

Appendix B - Definitions used within this protocol

A

Aristotle -

B

BCF – Better care Fund Programme. The Better Care Fund (BCF) is a programme spanning both the NHS and local government. It has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with _wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life.

C

Caldicott 2 – A review conducted by the Department of Health on which made recommendations on the how information about patients is shared across the health and care system.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

Caldicott Guardian – A senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-processing/sharing.

CWC – City of Wolverhampton Council

CSU – Clinical Support Unit

D

Data controller - As defined in the Data Protection Act (1998) is the individual or organisation (legal person) who determines the manner and purpose of the processing of personal information, including what information will be processed and how it will be obtained.

Data controller in common – The term in common applies where two or more data controllers share a pool of personal data that they process independently of each other. Each Data Controller remains individually responsible for the processing they have carried out on the personal data.

Data controller (joint) - the term jointly is used where two or more data controllers act together to decide the purpose and manner of any data processing.

Data processor - As defined in the Data Protection Act (1998), is an individual (other than an employee of the Data Controller) or organisation who processes personal information whilst undertaking a business activity or service on behalf of the Data Controller, under contract.

Data Subject – in the context of this agreement this will be the patient/ Service user. The person(s) of whom data is shared about.

Direct Care – Care provided by professionals directly to patients for the benefit of patients

E

F

Fibanacci – IT system (Data processor)

G

Graphnet – GP IT system for Primary Care data

H

I

ISA - Information sharing agreement

J

K

L

M

MDT – Multi Disciplinary team. Multidisciplinary teams consist of staff from several different professional backgrounds who have different areas of expertise

N

O

P

Patient – Person(s) is receipt of service/ care from agencies involved in data sharing

Patient confidential information (PCD) -

Q

R

Risk Stratification – An informed estimate of the probability of a person succumbing to a disease or benefiting from a treatment for that disease

RWT – The Royal Wolverhampton NHS Trust

Rapid Response (RR) -

S

Service user - Person(s) is receipt of service/ care from agencies involved in data sharing

SUS data –

Statement of compliance (SoC) –

Secondary Purposes -

T

U

V

W

X

Y

Z

Appendix C – Consent forms and fair processing posters

Do we need anything here as we have referred to each organisations' Privacy Notice/Policy?

Do we need something BCF specific – or something more wide reaching for Integration in general to cover ICS etc.

Appendix E – List of users for Fibonacci

Local authority user access approved for the following roles:

Role	IG Training received and current? Y/N	Date approval given	Purpose for requiring access
Advanced Social Work Practitioners			To enable participation in MDT and to provide joint planning and care
Community Care Assessors			To enable participation in MDT and to provide joint planning and care
Social Workers			To enable participation in MDT and to provide joint planning and care
Social Care Workers			To enable participation in MDT and to provide joint planning and care
Admin			To enable participation in MDT

The Royal Wolverhampton NHS Trust user access approved for the following roles:

Role	IG Training received and current? Y/N	Date approval given	Purpose for requiring access
Community Matrons			To enable participation in MDT and to provide joint planning and care
District Nurses/Staff Nurses			To enable participation in MDT and to provide joint planning and care
Admin			To enable participation in MDT
Clinical Nurse Specialists			To enable participation in MDT and to provide joint planning and care
Advanced Nurse Practitioners			To enable participation in MDT and to provide joint planning and care
Heads of Service			To enable participation in MDT and to provide joint planning and care
Consultant Geriatrician			To enable participation in MDT and to provide joint planning and care

Other roles given approval:

Role	IG Training received and current? Y/N	Date approval given	Purpose for requiring access

Appendix F – List of Roles to be co-located into Integrated Community Neighbourhood Teams

Role Description	**Organisation**
Senior Social Work Unit Manager	CWC
Social Work Unit Manager	CWC
Social Worker	CWC
CMHT - Social Worker	CWC
Community Care Assessor/CHC Assessor	CWC
Social Care Worker	CWC
Office Manager	CWC
Service Lead/LNM	RWT
District Nurses	RWT
Health Care Assistants	RWT
Community Matrons	RWT
Students	RWT
District Nursing Admin	RWT
Secretaries	RWT
Social Prescriber	WVSC
Housing Assistance	Wolverhampton Homes
?	BCPFT

Appendix G – List of Functions/Roles Participating in Community and Primary Care MDTs. The below list is not exhaustive but will form the core membership.

Function/Role Description	**Organisation**
Social Worker (could be Adults and/or CYP)	CWC
District Nurses	RWT
Community Matrons	RWT
Social Prescriber	WVSC
Housing Assistance	Wolverhampton Homes
Mental Health Practitioner	BCPFT
GP	Primary Care – Various Practices
Practice Nurse	Primary Care – Various Practices
Pharmacist	Primary Care – Various Practices
MDT Coordinator	RWT
Clinical nurse specialist as appropriate i.e. diabetes, palliative care, respiratory	RWT/Compton Care
Consultant Geriatrician	RWT
Advanced Nurse Practitioner	RWT
Paediatrician	RWT

Appendix G – Fibonacci Architecture