

PSA Tracker/Patient Online Service Specification (Version 3.0)

FUNCTIONALITY OVERVIEW

REF #	ITEM	Description	Essential	Desirable
A. SYSTEM LOGIN (CLINICIAN VIEW)				
SSMA01_E	A01. CLINICIAN LOGIN DETAILS	Secure login. Each member of the clinical team to have their own log in details.	X	
SSMA02_D	A02: CLINICIAN LOGIN PASSWORD RESET	Clinicians required to choose own password. Prompted to change it periodically (e.g. every 6 months). Password self reset for forgotten passwords.		X
SSMA03_E	A03. PAGE ENCRYPTION	The system should provide secure, encrypted page for the Clinicians to login.	X	
SSMA04_E	A04. ACCESS RESTRICTIONS	Access to systems and patient information must be restricted to authorised personnel.	X	
B. CLINICIAN HOME SCREEN				
		Description	Essential	Desirable
SSMB01_E	B01. PATIENT LIST	A list of patients registered on the PSA tracker. Displayed as 100 patients per page. List headers [insert data DOB, NHS numbers etc]. Patient list sorted (default) by "PSA test due date" and "action due". Verification status of the NHS number should be stored even if it is not validated. The validation status should come from PDS or the PAS which should store it.	X	
SSMB02_E	B02. PATIENT LIST/COLOUR CODING	Colour coding should be used on the patient list to highlight 1) patients who are due their PSA test 2) Patients who have a PSA test result to view, and 3) patients with an "action due".	X	
SSMB03_E	B03. PATIENT LIST/SEARCH BOX	Search box at the top of the patient list. Clinician can search for patient by typing in any of the following references: [insert references]	X	
SSMB04_E	B04. PATIENT LIST/SORT FUNCTION	Clinician can chose to rank list by any of the following list headers: [insert headers]	X	
SSMB05_E	B05. PATIENT LIST/PATIENT RECORD	Clinician can click on patient on the patient list to "view patient record". See section C.	X	
SSMB06_E	B06. MESSAGES	Clinician can click through to view the messages. See section D.	X	
SSMB07_D	B07. ACTIVITY COUNTER	An information box that includes summary activity data such as "number of PSA reviews", "Number of patients recalled to clinic". This should be customisable for each clinical team, as different Trusts will use require slightly different data.		X
SSMB08_E	B08. ACTIVITY COUNTER / GENERATE REPORT BUTTON	Clinician can click through to view a "generate report" page. See section E.	X	
SSMB09_E	B09. ADD NEW PATIENT	Clinician can click through to view an "add new patient" page.	X	
SSMB10_E	B10. VIEW SUSPENDED PATIENTS	Clinician can click through to view list of "suspended" patients. Clinician can click on patient on the patient list to "view patient record", and should have the option to reinstate the patient to the main patient list (see B01).	X	
SSMB11_E	B11. LOG OUT	Secure log out at the end of the session or time out in case of inactivity for over three minuts, in order to ensure security.	X	
C. PATIENT RECORD (CLINICIAN VIEW)				

SSMC01_E	C01. PATIENT DETAILS / BASIC	Data fields: Patient name, date of birth, address, phone number , email address (optional) and a death indicator (if a patient dies and system does not receive indicator from PAS). Ability to populate these data fields from the PAS or manually input NHS number compliance, hospital number, or unique patient identifier to be entered.	X	
SSMC02_E	C02. PATIENT DETAILS / COMMUNICATION PREFERENCES	Data fields: Is the patient registered in the IT portal - yes / no? Does the patient prefer messages via post or electronic message? Is the patient happy to receive SMS reminders? Is the patient happy to receive email reminders	X	
SSMC03_E	C03. PATIENT DETAILS / GP CONTACT	Data fields: GP name, GP code, GP surgery, Surgery address. Ability to populate these data fields from the PAS or manually input	X	
SSMC04_E	C04. PATIENT DETAILS / CANCER DETAILS	Data fields: GP name, GP code, GP surgery, Surgery address. Ability to populate these data fields from the PAS or manually input.	X	
SSMC05_E	C05. PATIENT DETAILS / TREATMENT	Ability to enter multiple treatment data fields. Select start date of treatment. Finish date of treatment. Treatments from a drop down list. Items should be customisable to local requirements. Suggested data fields [To be determined by clinical team]. O	X	
SSMC06_E	C06. PATIENT DETAILS / COMMENTS BOX	FREE TEXT BOX FOR COMMENTS. SUGGEST 100 WORD LIMIT.	X	
SSMC07_E	C07. MONITORING / PSA HISTORY	On setting up a new patient record, clinician should be able to manually enter several historical PSA results. [date and PSA result]. New PSA results are added to the history automatically as and when they come through.	X	
SSMC08_D	C08. MONITORING / PSA HISTORY /CHART	User to click on "chart" button, and a chart of all PSA results appears (PSA on y axis and date on x axis).		X
SSMC09_E	C09. PSA VALUE	Always reported in ng/ml. Values of <0.1 or <0.01 should be reported as 0.00.	X	
SSMC10_E	C10. MONITORING / PROTOCOL	Data field: drop down list. Items should be customisable to local requirements. Suggested data fields [to be determined by clinical team]]	X	
SSMC11_E	C11. MONITORING / PSA DUE DATE	Data field: shows next PSA due date in DD/MM/YYYY. User should have ability to set and reset this date	X	
SSMC12_D	C12. MONITORING / PSA DUE DATE / SET SMS REMINDER	An SMS reminder is sent to patients (who have consented to this) to remind them that their PSA test is due. Suggest reminder is set two weeks before due date.		X
SSMC13_E	C13. MONITORING / ACTIONS	Once the patient record has been opened, the clinician should be required to select one of the following actions to close the record: PSA OK letter, Recall letter, PSA slightly raised letter, Introduction to Supported Self Management letter, Treatment Summary Record, Audit, admin, no action.	X	
SSMC14_E	C14. MONITORING / ACTIONS / LETTERS	letter. Some of the information in the letters, such as patient name, address should be automatically populated. For each letter to a patient, and additional letter should be generated to be sent to the GP.	X	
SSMC15_E	C15. MONITORING / ACTIONS / TREATMENT SUMMARY RECORDS	If the Treatment Summary Record action is selected, a PDF of the treatment summary record should be generated. (See example treatment summary records). The clinician can then print this record and send it to the patient and/or GP.	X	
SSMC16_D	C16. MONITORING/ASSESSMENT/ASSESSMENT LIST	A list of questionnaire based assessments completed by the patient should be visible. Fields: Date and assessment type. The types of assessment should be pre agreed with the local clinical team. These will vary by locality. Examples of assessments are Holistic needs assessment, EPIC 26, IPSS, SHIM		X
SSMC17_E	C17. MONITORING/ASSESSMENT/ VIEW ASSESSMENT	User should click on an assessment to view it. The view should be a summary output on one screen.	X	

SSMC18_D	C18. MONITORING/ASSESSMENT/NEW ASSESSMENT ALERT	Clinician to receive an email notification when a new assessment is completed (prompting clinician to assessment).		X
SSMC19_E	C19. MONITORING/ASSESSMENT/RED FLAG ALERT	Some of the assessment questions may indicate a serious health problem for the patient. As such, clinical teams should be able to identify these "red flags". When a patient gives a particular response to a red flag question (e.g. "yes" to "rectal bleeding")	X	
SSMC20_D	C20. MONITORING/ ASSESSMENT DUE DATE	The clinician should be able to request that a patient completes an assessment by selecting an assessment from a drop down list, setting a due date.		X
SSMC21_D	C21. MONITORING/ ASSESSMENT DUE DATE / SET SMS REMINDER	An SMS reminder is sent to patients (who have consented to this) to remind them that their assessment is due. Suggest reminder is set two weeks before due date.		X
SSMC22_E	C22. MONITORING / VIEW CARE PLAN / UPDATE CARE PLAN	The care plan can be in a variety of formats, however must contain the following headings: Issue. Action. Due by. Review date. The care plan can be updated by either the clinician or patient. (See example care plan).	X	
SSMC23_D	C23. MONITORING/ NOTES	user should be able to click through to a notes section, and view notes in chronological order. Notes should include the date, the note/comment, and the name of the person who made the entry		X
SSMC24_D	C24. MONITORING/ NOTES/NEW ENTRY	When in the notes section, the user should be able to click on "create new entry". They should then free text in the note. There should also be a free text section that indicates if the note is as a result of a phone conversation.		X
SSMC25_D	C25. MONITORING/ NOTES/ACTIONS	Actions such as "PSA OK letter sent" or "record audited" should be recorded in the notes section.		X
SSMC26_E	C26. GENERATE PDF RECORD / PRINT RECORD	The user should be able to generate a PDF of the following content [insert content] and print or save the PDF.	X	
D. MESSAGING FUNCTION (CLINICIAN VIEW)				
SSMD01_E	D01. MY MESSAGES PAGE / INBOX & SENT ITEMS	INBOX is the default view. User should also be able click through to view sent items. All the key data items to be validated/verified at e	X	
SSMD02_E	D02. MY MESSAGES PAGE / INBOX & SENT ITEMS/SEARCH	Ability to search for messages, or rank messages	X	
SSMD03_D	D03. MY MESSAGES PAGE / ARCHIVE	Ability to archive messages		X
SSMD04_E	D04. NEW MESSAGE ALERT	Clinician to receive an email notification when a new electronic message is received (prompting clinician to check inbox).	X	
SSMD05_E	D05. VIEW MESSAGE / REPLY	Click on message to view. Click reply. Type response. Click send	X	
SSMD06_D	D06. VIEW MESSAGE / PRINT	Click on message to view. Click PRINT MESSAGE		X
SSMD07_E	D07. SEND MESSAGE / ATTACHMENT FUNCTION	Ability to attach documents to messages before sending.	X	
SSMD08_E	D08. SEND NEW MESSAGE	Clinician clicks "new message", searches for recipient in "To:" header. Types message. Clicks send.	X	
SSMD09_E	D09. SEND NEW MESSAGE / ADDRESS BOOK	This function allows the clinician to search for the recipient. Clinician should be able to verify the recipient by name, date of birth and NHS number (There may be two or more patients with the same name using the system).	X	
SSMD10_D	D10. SEND NEW MESSAGE / ADDRESS BOOK	A further identifier is normally required as patients with same name and DOB may reside at the same address sometimes. So in addition to NHS number, this identifier should be entered and also the status of the NHS number verification to be stored.	X	
SSMD11_D	D11. SEND NEW MESSAGE / BCC MAILIST	Clinician can create a mailing list to enable them to send messages (in BCC form) to groups of patients.		X
E. CREATE NEW PATIENT RECORD (CLINICIAN VIEW)/DELETE PATIENT RECORD (CLINICIAN VIEW)				

SSME01_E	E01. ADD NEW PATIENT	The add new patient page will require clinicians to add in: Patient name, patient date of birth, NHS number and patient email address (if available), and mobile phone number (if available). A new patient record will be added to the list. The clinician will fill enter the new patient record to complete remaining details (see section C). All the key data items to be validated/verified at entry.	X	
SSME02_E	E02. ADD NEW PATIENT / GENERATE PATIENT LOGIN	The clinician should be able to generate patient log in details for patients who wish to use the patient system. Log in details should also be sent to the patient in a secure manner (e.g. username by SMS and password by email)	X	
SSME03_E	E03. DELETE PATIENT RECORD	Secure process in place to minimise the risk of patient records being deleted accidentally	X	
F. AUDIT, REPORTING AND TRACIBILITY (CLINICIAN VIEW)				
SSMF01_E	F01. REPORTING / PROVIDER GENERATED	The customer should be able to request reports from the IT provider, that detail any recorded activity on all the data items that are stored. For example number of PSA reviews, number of patients on the system, datasets of patients on the system etc. The customer should have the option of standard common reports. It would be ideal to provide an option to export all data into their own reporting tool.	X	
SSMF02_D	F02. REPORTING / SELF SERVICE	The customer should be able to generate reports from the IT system. User selects "generate report " button on home page, enters date range, and then selects from list items to include in the report. For example number of PSA reviews, number of patients on the system, datasets of patients on the system etc.		X
SSMF03_E	F03. METADATA QUERIES	The customer should have the option to raise queries. For example, when investigating a clinical incident a provider may wish to know who carried out various actions on the system.	X	
SSMF04_E	F04. ELECTRONIC SIGNATURES	An electronic signature (whether visible on the screen or not) should be recorded for all information added/deleted/reviewed or changed).	X	
SSMF05_E	F05. CRITICAL FIELD CHANGE	When a critical field is changed, such as the PSA result, the system should prompt the user that it is a key field and if he is sure he wants to make a change. The system should capture the identity of the person who rendered the change along with a reason for change.	x	
SSMF06_E	F06. TRACEABILITY	Access must be controlled by secret passwords (or secure credentials) and be traceable to an individual.	X	
SSMF07_E	F07. BUSINESS JUSTIFICATION	Access must be justified on business requirements.	X	
SSMF08_E	F08. AUDIT	Ability to audit the use of access and trace the abuse of access.	X	
G. SYSTEM LOGIN / INITIAL SYSTEM LOGIN (PATIENT VIEW)				
SSMG01_E	G01. INITIAL LOGIN	One step login. Patient can login using username and password	X	
SSMG02_E	G02. PAGE ENCRYPTION	The system should provide secure, encrypted page for the Patients to login.	X	
SSMG03_D	G03. INITIAL LOGIN / PASSWORD RESET	On initial login - patient prompted to change password		X
SSMG04_E	G03. LOG OUT	Secure log out as well as logout in case of inactivity for over three minutes.		
H. PATIENT HOME SCREEN				
SSMH01_E	H01. PATIENT HOME SCREEN / CONTENT	Welcome page with welcome/introductory text. Tabs or click through icons for the for the following: "My messages", "My assessments", " My care plan", " My PSA results", "Information resources"	X	
I. MY PSA RESULTS				
SSMI01_E	I01. PSA HISTORY	All PSA results, expressed in ng/ml - listed by date. Most recent first.	X	
SSMI02_D	I02. PSA HISTORY / CHART	User to click on "chart"button, and a chart of all PSA results appears (PSA on y axis and date on x axis).		X

SSMI03_E	I03. PSA DUE DATE	PSA due date to be specified on this screen	X	
J. MESSAGING FUNCTION (PATIENT VIEW)				
SSMJ01_E	J01. MY MESSAGES PAGE / INBOX & SENT ITEMS	INBOX is the default view. User should also be able click through to view sent items.	X	
SSMJ02_E	J02. MY MESSAGES PAGE / INBOX & SENT ITEMS/SEARCH	Ability to search for messages, or rank messages	X	
SSMJ03_D	J03. MY MESSAGES PAGE / DELETE	Ability to delete messages		X
SSMJ04_E	J04. NEW MESSAGE ALERT	Patient to receive an email notification when a new electronic message is received (prompting patient to check inbox).	X	
SSMJ05_E	J05. VIEW MESSAGE / REPLY	Click on message to view. Click reply. Type response. Click send	X	
SSMJ06_E	J06. SEND MESSAGE / ATTACHMENT FUNCTION	Ability to attach documents to messages before sending.	X	
SSMJ07_E	J07. SEND NEW MESSAGE	Patient clicks "new message". Only option to message clinical team. (N.B. Patient cannot message individuals). Types message. Clicks send.	X	
SSMJ08_D	J08. VIEW MESSAGE / PRINT	Click on message to view. Click PRINT MESSAGE		X
K. MY ASSESSMENTS (PATIENT VIEW)				
SSMK01_D	K01. ASSESSMENT DUE	The patient should be able to see on the assessment page what assessments he is due to complete and by when.		X
SSMK02_E	K02. COMPLETE ASSESSMENT / SELECTING ASSESSMENTS	The patient should click on an assigned assessment (SSMK01_E) to complete a questionnaire assessment. Patient should be able to complete an assessment, even when this assessment has not been assigned by the clinical team. He should be able to select from a list of assessments.	X	
SSMK03_E	K03. COMPLETE ASSESSMENT / SAVE OR SUBMIT	When the patient completed an assessment he should have the option to save it or submit it (to the clinical team). He should also have the option to save the assessment part way through and return to it at a later time.	X	
SSMK04_D	K04. COMPLETE ASSESSMENT / UNCOMPLETED ASSESSMENT EMAIL/SMS REMINDER	If a patient has started a questionnaire, but not submitted it - an email SMS reminder should be sent to him after a defined period of time.		X
SSMK05_E	K05. ASSESSMENT / LOGIC BRANCHING	Assessment questionnaires should be able to incorporate logic branching.	X	
SSMK06_E	K06. VIEW COMPLETED ASSESSMENTS	The patient should be able to see a list of their completed assessments and click through to view each assessment.	X	
SSMK07_E	K07. GENERATE PDF / PRINT ASSESSMENT	Patients should be able to generate a PDF or print out of their assessment.	X	
L. MY CARE PLAN (PATIENT VIEW)				
SSML01_E	L01. VIEW/EDIT CARE PLAN	The care plan can be in a variety of formats, however must contain the following headings: Issue. Action. Due by. Review date. The care plan can be updated by either the clinician or patient. (See example care plan).	X	
SSML03_E	L02. PRINT CARE PLAN	Patients should be able to generate a PDF or print out of their care plan.	X	
M. PATIENT INFORMATION (PATIENT VIEW)				
SSMM01_E	M01. WEB PAGE LAYOUT AND MEDIA	Information organised under headings. Web links, videos, downloadable files (PDS, podcast, video content)	X	
SSMM02_E	M02. WEB PAGE LAYOUT / EXPANDABLE HEADINGS	The information section may contain a high volume of links to resources. Ideally the information should be organised under headings that can be expanded or collapsed to view/hide information.		X
SSMM03_E	M03. LOCAL CONTENT MANAGEMENT	Clinical team to be able to manage the content.		X
N. VALIDATION & AUTHENTICATION				
SSMN01_E	N01. PATIENT AUTHENTICATION	The system should validate the patient's credentials and authenticate	X	
O. DATA TRANSMISSION				

SSMO01_E	001. TRANSMISSION OF PATIENT AND CLINICAL DATA	Patient and Clinical data to be sent via secure HTTPS via web.	X																																																																																																				
P. DATA STORAGE																																																																																																							
SSMP01_E	P01. DATA STORAGE	Data should be encrypted and stored as per NHS Information Governance guidelines.	X																																																																																																				
Q. ACCESS RIGHTS																																																																																																							
SSMQ01_E	Q01. ROLE BASED ACCESS RIGHTS	The system should provide different levels of access permissions for different user roles. The roles and access should be clearly defined.	X																																																																																																				
R. SYSTEM ADMINISTRATION																																																																																																							
SSMR01_E	R01. SETUP ROLES AND ACCESS	The system administration should be able to configure patients, clinicians and other administrators to the system.	X																																																																																																				
S. INTERFACE SPECIFICATIONS																																																																																																							
SSMS01_E	S01. CODING STANDARDS	HL7 and FHIR (Fast Healthcare Interoperability Resources) standards are to be used.	X																																																																																																				
		For communication with external systems, we will use HL7 version 2 using the Minimal Lower Layer Protocol (MLLP). Standard HL7 MLLP framing characters will be used as listed in Table 1.																																																																																																					
		DescriptionCharacter Start of Message<OB> End of Message<1C> Message termination<OD> Table 1 - HL7 MLLP Framing Characters																																																																																																					
SSMS02_E	S02. MESSAGING PROTOCOL		X																																																																																																				
SSMS03_E	S03. HOST AND TRANSPORT CONFIGURATION	Messages will be passed over TCP/IP. Acknowledgements will be transmitted over the same socket as the message was sent/received on.	X																																																																																																				
		When a new patient is registered, a query message will be sent to the respective trust so that the patient can be associated to health record in a local data store. That data store can then be used to determine whether to send information on to the UHS TIE as and when it becomes available.																																																																																																					
SSMS03_D	S04. PATIENT IDENTIFICATION	The same mechanism could be used to retrieve existing information for the patient, such as appointments already booked, and send them through as an initial broadcast of information.		X																																																																																																			
		The use of most message types is optional and depends on the functionality and data visibility each trust expects for their patients. Others are conditional depending upon other data types. A brief description of the segments used for each message type are given below:																																																																																																					
		<table><tr><th colspan="3">HL7 Event</th><th colspan="8">HL7 Segments</th></tr><tr><th>Name</th><th>Opt</th><th>Code</th><th>MSH</th><th>EVN</th><th>PID</th><th>NK1</th><th>PV1</th><th>MRG</th><th>OBR</th><th>OBX</th></tr><tr><td>Add an Outpatient Attendance</td><td>O</td><td>ADT^A01</td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr><tr><td>Add an Outpatient Appointment</td><td>O</td><td>ADT^A05</td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr><tr><td>Update an Appointment/Attendance</td><td>C</td><td>ADT^A08</td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr><tr><td>Cancel/Delete an Appointment/Attendance</td><td>C</td><td>ADT^A11</td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr><tr><td>Update Patient Information</td><td>R</td><td>ADT^A31</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td><td></td><td></td><td></td></tr><tr><td>Merge Patient Information</td><td>R</td><td>ADT^A34</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td></tr><tr><td>Laboratory Result</td><td>O</td><td>ORU^R01</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td><td>✓</td><td>✓</td></tr></table>	HL7 Event			HL7 Segments								Name	Opt	Code	MSH	EVN	PID	NK1	PV1	MRG	OBR	OBX	Add an Outpatient Attendance	O	ADT^A01	✓	✓	✓		✓				Add an Outpatient Appointment	O	ADT^A05	✓	✓	✓		✓				Update an Appointment/Attendance	C	ADT^A08	✓	✓	✓		✓				Cancel/Delete an Appointment/Attendance	C	ADT^A11	✓	✓	✓		✓				Update Patient Information	R	ADT^A31	✓	✓	✓	✓					Merge Patient Information	R	ADT^A34	✓	✓	✓	✓		✓			Laboratory Result	O	ORU^R01	✓		✓				✓	✓		
HL7 Event			HL7 Segments																																																																																																				
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SSMS03_D	S05. MESSAGE DEFINITIONS			X																																																																																																			

SSMS06_D	S06. OTHER INTERFACES	Interfaces with other cancer databases like Somerset Cancer registry, National cancer registration service, Cancer Research UK desirable.		X
T. USER INTERFACE				
SSMT01_E	T01. USER INTERFACE DESIGN	The design of user interfaces for the system should be compliant with the Common User Interface (CUI) standards and guidance which include increasing patient safety, clinical take-up of health IT and reducing training costs.	X	
SSMT02_E	T02. SNOWMED CT	The design to be compliant with SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a standardized, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information.	X	
SSMT03_E	T03. USER INTERFACE GUIDANCE	Design to adhere to NHS User Interface Guidance with further clinical safety risk assessments undertaken during implementation. In particular the design must cater to the following sections: Patient identification and information Entry and Display, Medications management (where applicable), Clinical Noting and Terminology, Handover, Consistent navigation, Abbreviations and acronyms, and Decision Support.	X	
U. INFORMATION GOVERNANCE				
SSMU01_E	U01. INFORMATION GOVERNANCE	The system must adhere to NHS Information Governance and cover confidentiality in standards of practice, IG toolkit, IG statement of compliance of services including N3, Information Security safeguards and guidelines for protecting patient data, NHS codes of practice and legal obligations, IGA and National Data Guardian.	X	