# NHS North Central London Data Access Group (DAGr) Data Access Request Form V0.02 (April 2024)

In order to access data regarding patients, the controllers need to instruct use for identifiable data, or review it and agree its suitability for de-identified data covered under the Section 251 authorisation. The data controllers have jointly agreed to delegate this to the DAGr, and this form provides a request to that group

Please complete this form and submit it to [**nclicb.dagr@nhs.net**](mailto:nclicb.dagr@nhs.net) where it will be initially reviewed before being passed to the group.

V0.01

02 November 2023

V0.02

9th April 2024: to add guidance and screening questions including ICS Partner (Controller) internal approval.

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| **Guidance** |
| **The NCL ICS HealtheIntent data platform is dependent on NCL ICS Partners approving a Data Sharing Agreement to support Direct Care and Secondary Uses of data. Partners to the agreement are**   1. **NCL GPs** 2. **NCL NHS Trusts** 3. **NCL Local Authorities and** 4. **NCL Integrated Care Board (ICB)**   **Only Partners to the agreement can request access to the platform and use of personal identifiers or record level, potential identifiers.** |

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| **Partner Pre-application Screening Questions** | |
| **Name of your NCL ICS Partner organisation** | <please provide> |
| **Applicant Name:** | <please provide> |
| **Applicant’s Caldicott Guardian:** | <please provide> |
| **Caldicott Guardian Approval:** | <please provide> |

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| **Partner Project Application Details** |

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| **Project / Work Stream Name** | <please provide> | |
| **Project / Work Stream Lead**  **(Who is leading the project or implementation)** | Name | <please provide> |
| Designation | <please provide> |
| Email | <please provide> |
| **Information Asset Owner**  **(Who will be responsible for the data that is stored / created)** | Name | <please provide> |
| Designation | <please provide> |
| Email | <please provide> |
| **Overview:**  **(Summary of the project/work stream. Make sure you include details about how the cohort is split if there are multiple teams)** | <please provide> | |
| **Level of Data:**  **(Please delete as appropriate. Note that patient level data MUST be for direct care purposes)** | Patient Level / Aggregate by Practice / Aggregate by PCN / Aggregate by Borough / NCL Wide (Delete as appropriate) | |
| **Data Required:**  **(Please provide details of each data item you require. Where aggregate, please state upon which data items aggregation is done e.g. clinical codes, age bands, etc.)** | <please provide> | |
| **Implementation Date:** | <please provide> | |

| **Q** | **Category** | **Screening question** | **Yes/No**  **(please include details)** |
| --- | --- | --- | --- |
| 0.1 | Purpose | Is the project for DIRECT CARE purposes? If so, proceed at [**question 1.0**](#DirectCare); if it is for any other purpose, please proceed at [**question 2.0**](#OtherPurposes)**.**  Please see the [Glossary](#_Glossary) for the definition of Direct Care. |  |
| 1.0 | Purpose | Is the project performing health checks, waiting list triage or national screening to ensure patients receive best care? |  |
| 1.2 | Process | The project consists of contacting patients to make appointments, assess status and arrange care? This includes reviewing waiting lists to see if other facilities can be offered |  |
| 1.3 | Systems | The project uses EXISTING patient record systems – no new systems are created? |  |
| 1.4 | Expectations | The patient is initially contacted by phone, email or text message according to their registered preferences ONLY? |  |
| 1.5 | Expectations | The initial contact is done ONLY by an organisation or person that has a “legitimate relationship” with the patent? That is:   1. The contact is from persons working under the **supervision** of the General Practitioner to whom the patient is registered. 2. The contact is from persons working under the **supervision** of an acute facility clinician (or a group of clinicians e.g. cardiology) who has the patient on their waiting list or has had a direct contact with the patient within the last 12 months. 3. The contact is from social workers who have the patient on their lists and there is a MDT of which health and social care are a part relating to the patient. 4. A single project may use more than one contact method. For example, where patients are being called because they fit into certain clinical criteria, but may or may not have had recent acute contact, so some will be contacted by the acute facility and some by GP, so that all contacts are covered by one of a or be. |  |
| 1.6 | Special risks | Are there “special risks” relating to the group as a whole?  *For example, a recall of SMI patients, or patients receiving ART for HIV would have special risks due to additional vulnerabilities – hence the answer would be “Yes”.*  *Note that there may be patients in a cohort with such risks (e.g. a call for age 50-74 people with lung cancer risk would certainly include such patients), but the special risks would only apply if the whole cohort had a particular risk* |  |
| 1.7 | END | This completes the direct care questions. Please submit the form as noted above. |  |
| 2.0 | **Other Purposes** | Is patient-identifiable data visible in any of the OUTPUTS of the processing? E.g. Reports, drill-down tables. |  |
| 2.1 | **Excluded purposes** | Is the output being used for any of:   * Research? * Calculation of payments? * Performance management of staff, commissioned services or contracts? * Auditing of delivery of services?   Note: These purposes are outside our Section 251 permission, but may still be allowable under other routes. |  |
| 2.2 | **Restricted identification** | Are numbers in each category less than 5 redacted as “less than 5”? Are totals removed where sums less than five are in the total set? If you require detail below this please explain why. |  |
| 2.3 | **Opt-outs** | Are patients who have objected either via our local objection to HealtheIntent / HIE, the provider opt-outs or the National Data Opt-Out excluded from the reports? If not, why, and what is the legal basis for doing so? |  |
| 2.5. | **Unsharable Codes** | Are any of the Legally Unsharable Clinical Codes, also known as Legally Restricted patient confidential data used? |  |
| 2.5 | **Potential Discriminatory Codes** | Are any of   * Race? * Ethnicity? * Religion? * Nationality?   Used in the processing? If Yes, provide full details of reason it is required. |  |

## Glossary

| **Term** | **Definition** |
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| Direct Care | 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. It includes 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. |
| Legally Unsharable Clinical Codes | These are codes, mostly associated with sexual health, that have additional legal restrictions on their use. These are documented at:  <https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance> |
| Local Audit | Review of the impacts of direct care activities, involving the organisations delivering the care AND the clinical teams involved. The audit must be carried out by these teams or those under their direct instruction. |
| National Screening | Any screening activity listed on <https://www.gov.uk/topic/population-screening-programmes>. These have been approved by the UK National Screening Committee. |