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1. Purpose

As part of QDT’s work a call for Expression of Interest (EOI) was sent out to all the QIPP workstreams to ask local QIPP teams to identify specific digital challenges that they would like to work with QDT in overcoming. Out of the 14 teams that submitted an EOI 7 identified the need for data sharing agreement guidance as a key enabler to their local QIPP activities. QDT therefore in response decided to carry out an investigation of data sharing issues within the specific area of Risk Stratification as this area is both a key QIPP LTC principle and was also identified by many of the EOI LTC teams as present or planned in their technology roadmaps.

The benefit of this investigation to QDT is to get a better understanding of current barriers so any future DH efforts around data sharing agreement guidance can be focused effectively.

The benefit of this investigation to LTC QIPP is to enable sharing of case studies or approach taken by local teams who have successfully implemented risk stratification data sharing agreements already.

This document reports the findings of the investigation along with recommended guidance.

1.1. Scope

For any technology solution to be implemented within a healthcare setting, a wide range of areas need to be considered. This document is not intended to cover every aspect of the delivery of a solution. The below diagram gives a general overview of some of the areas you may need to consider – the areas that are addressed (at least in part) in this document are shown in green:
1.1.1. Out of Scope
This guidance will NOT develop any new data sharing agreement templates or guidance, rather the aim is to clearly identify and document the issues facing the local teams, and put forward a checklist of best practice guidance to follow.

1.2. Intended Audience
This guidance is intended to be read by Project Managers, and Information Governance leads in health and social care provider and commissioner organisations who are engaged in planning, design, implementation and operation of risk stratification solutions.

1.3. Document Conventions
In order to aid clarity, a number of conventions have been followed in this document:

- Where additional sources of information are referenced in the text, a reference number will be provided linking it with the appropriate entry in the referenced section at the end of this document – e.g. [Ref: 1].
2. Background

Quality, Innovation, Productivity and Prevention (QIPP) is a large scale transformational programme within the NHS, involving all NHS staff, clinicians, patients and the voluntary sector [Ref: 1]. It will improve the quality of care the NHS delivers whilst making up to £20 billion of efficiency savings by 2014-15, which will be reinvested in frontline care.

At a regional and local level Strategic Health Authorities have been developing integrated QIPP plans that are supported by national QIPP workstreams which are producing tools and programmes to help local change leaders in successful implementation.

2.1. Long Term Conditions

The Long Term Conditions (LTC) workstream, lead by Sir John Oldham, seeks to improve clinical outcomes and experience for patients with long term conditions in England by focusing on improving the quality and productivity of services for these patients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn, slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their own conditions. The workstream seeks to reduce unscheduled hospital admissions by 20%, reduce length of stay by 25% and maximise the number of people controlling their own health through the use of supported care planning. The workstream aims to replicate this performance nationally by 2013/14.

One of the three key principles of the QIPP LTC workstream is the adoption of Risk Stratification (also known as Risk Profiling) to ensure that commissioners understand the needs of their population and manage those at risk. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised.

2.2. QIPP Digital Technology Team

QIPP Digital Technology has been established as a function under the QIPP programme to assist QIPP national workstreams and local teams in exploiting digital technology in order to accelerate delivery of their QIPP priorities [Ref: 2].

The function focuses on helping to overcome digital challenges and barriers, to accelerate delivery, to spread initiatives and to maximise the potential value from technology enabled healthcare delivery.
A core principle of this operating model is to ensure that any work conducted or national enablers provided, have direct traceability back to key business drivers, and that work is only undertaken where there is a local ‘pull’ for national assistance.

2.3. Approach for the Development of this Guidance
Engage with EOI LTC local teams to understand what mechanisms and processes they had to put in place to allow data to be shared for risk stratification, and what issues they faced getting agreements in place.

Then engage with DH IG Policy team to provide support in the review of the barriers identified and recommendations for next steps.

Produce a report outlining:

- Findings from discussions with local teams
- Summary of issues/barriers to sharing of data
- Potentially provide pointers to existing resources and standards
- Guidance on how to implement data sharing agreements
3. Summary

Risk Stratification requires the sharing of data between different health care organisations and also between health and social care. This will include patient identifiable data. In order to process personal data lawfully, the purpose of the risk prediction and stratification activity should be clearly identified from the onset and the stages of gathering, linking and analysing the data should only occur:

1. With the explicit consent of all those individuals where it is necessary to process personal data, e.g. where the intention is to identify an individual’s care needs to offer intervention, or;

2. By using pseudonymised data e.g. where the purpose is for service planning in general.

Input data used to calculate risk scores for individual patients will be shared and linked from different sources such as primary care, acute care and community care. The resultant output data of calculated risk scores for individual patients will then be shared with the relevant health care and social care professionals to inform patient care planning.

One of the barriers to such data sharing is that Information Governance concerns need to be addressed to ensure the legitimacy of data sharing and that suitable precautions are taken to ensure its security. This is the responsibility of each participating organisation who act separately as a Data Controller under the terms of the Data Protection Act 1998 for the personal data they hold, and as Data Controllers in common when sharing that personal data with others for the purpose of Risk Stratification activities.

This document reports on an investigation of data sharing issues of NHS organisations who have an operational Risk Stratification system. It did not identify any deficiencies or gaps in existing Information Governance standards or guidance for data sharing when applied to Risk Stratification. The organisations interviewed identified nine common activity areas for successful data sharing:

1. Identify a sponsor
2. Establish a project team or stakeholder group
3. Map the data flows
4. Agree a `legitimate` purpose for sharing data
5. Obtain stakeholder agreement
6. Draft a data sharing agreement
7. Formally sign the agreement
8. Management of the agreement
9. Produce communications material and inform stakeholders

This document presents the findings of the investigation and details a set of recommendations with associated check lists that organisations can use to help deliver successful data sharing projects.

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1 Data Controllers must establish grounds under Schedule 2, Data Protection Act (1998), and possibly Schedule 3, to legitimise processing information that identifies patients.
4. Findings

Six organizations agreed to participate in the investigation and were interviewed in a two week period between the 25th of January 2012 and the 7th of February 2012.

The organisations interviewed represented:

- 1 Mental Health Trust
- 5 Primary Care Trust Clusters

In total eleven individuals from these six organisations participated in the interviews.

The initial analysis of the interview records identified nine common activity areas within data sharing. Eight of them can be placed in a sequence that can be used as a basis for a data sharing project plan:

1. Identify a sponsor
2. Establish a project team or stakeholder group
3. Map the data flows
4. Agree a legitimate purpose for sharing data
5. Obtain stakeholder agreement
6. Draft a data sharing agreement
7. Formally sign the agreement
8. Management of the agreement

The ninth is an activity that runs in parallel with all the others:

9. Produce communications material, and make sure key stakeholders are communicated with and kept up to date with what’s happening

4.1. Identify a Sponsor

The majority of organisations spoken to, highlighted the benefits of having an individual (or group) to sponsor a data sharing project (four of the six interviewed). A sponsor has the effect of driving an information sharing project, providing direction, leadership and convincing peers of its value, particularly if he/she is a clinician (the majority of organisations had clinicians leading the project).

4.2. Establish a Project Team or Stakeholder Group

Only one organisation we spoke to had not formed a project board or local group to coordinate data sharing work. Most were able to point to the considerable value of a group comprising representatives from Clinical, Information Governance and ICT backgrounds. As the implementation project turns to ‘business as usual’ the need for a permanent team is preferable to manage data sharing going forwards. Administrative and management tasks are not insignificant, particularly as more organisations are drawn into the data sharing agreement.
4.3. Map the Data Flows

Health organisations must map data flows, where data comes from and where it goes to. The Caldicott Principles also require that data mapping is carried out, as well as the IG Toolkit \(^2\), and also when organisations carry out a Privacy Impact Assessment. Where information is shared with another organisation the data mapping becomes absolutely essential for reasons set out below.

The data mapping exercise should Identify:

1. **Data sources** - Without knowing exactly what data it is that you wish to share with partner organisations you cannot hope to deal with Information Governance issues later in the project.

2. **Potential (or realised) risks and issues** - i.e.; patient consent to sharing their information. Two organisations interviewed had specific measures in place to record patients’ preferences regarding their agreement to share information amongst partner organisations. Maintaining a record of patients consent is not mandatory, but as a record of how you justified your reasons for handling their data it is helpful. IG risks are minimised by using pseudonymised (or anonymised) data in preference to clearly identifiable patient data. Organisations interviewed were divided on this issue with three using pseudonymised data and three using data in the clear. Either way this is typical of an IG risk to be identified and controlled as part of the data mapping exercise.

3. **Organisations involved** - Mapping the ‘flow’ of data as it traverses an information system means creating a model showing information assets, including organisations involved and identifying where the role of Data Controller applies.

Responses to the investigation varied when organisations were asked who is involved in information sharing for Risk Stratification. Only two organisations included Private Sector and Charitable organisations in their data sharing agreements, and another one included Local Authority Social Services. A frequently quoted reason for not involving non-NHS bodies is because they do not use the NHS number to identify patients. The NHS number is important in risk stratification as it is used as a common identifier to link data together from different data sources\(^3\).

4.4. Agree a Purpose for Sharing Data

In the context of Risk Stratification the ‘purpose’ or reason for sharing information was generally quoted as patient assessment\(^4\). However, purposes may be many and varied, but must always be identified, agreed and recorded

\(^2\) IG Toolkit; an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards.

\(^3\) NIGB have published guidance on the NHS Number and use of it in this context.

\(^4\) NIGB have published advice on the functions of “Risk Stratification” and “Assessments”
to justify the exercise. By law\(^5\) organisations must have a legitimate and justifiable purpose for using personal information and this will feature strongly in a documented information sharing agreement. Once agreed the purpose does not normally change, however several organisations interviewed said representations had been made to them to use the data for a purpose different from the original, requiring the development and implementation of a process for managing change (see 4.8 “Management of the Agreement”).

4.5. **Obtain Stakeholder Agreement**

The benefits of convening a Board or Stakeholder Group become apparent when the time comes to obtain agreement amongst the various parties involved. All the organisations interviewed have information sharing agreements with the exception of one organisation, and significantly that same organisation does not have an effective Project Board or Stakeholder Group. Personal information (patient identifiable data) must not be shared with organisations that do not agree to the terms and conditions of the information sharing agreement.

4.6. **Draft a Data Sharing Agreement**

A documented data sharing agreement is an efficient way to manage an organisation’s commitment to the process, and is recommended by the Information Commissioners Office. It basically sets out what data it is that you propose to share, the organisations involved in the sharing, the purpose (or reason) for sharing data and the measures taken to ensure data is shared securely and confidentially. This will normally include reference to adherence with IGSoC where the N3 network is being used to share data, see: [http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/igsoc](http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/igsoc)

It should however be noted that having an Information Sharing Agreement in place does not give rise to sharing without consideration to the legal requirements that still need to be met.

One organisation interviewed had an electronic, on-line agreement, with the benefit of being able to add, amend or otherwise affect its terms and conditions quickly and easily (with the agreement of all the signatories). There are no IG reasons why agreements cannot be electronic. Others (five) said their agreements are manageable (i.e. changes can be made to the information sharing purpose, organisations involved or additional disclosures), but the process can be protracted and resource intensive.

Five organisations said their documented agreement consists of two components; (i) an over-arching agreement to cover the generic issues, and (ii) a ‘system specific information sharing agreement’ (SSISA) tailored to issues pertinent to a particular system or sharing purpose.

Two organisations said they use a third party data processor and they are included in the data processing agreement. I.e.; a contracted supplier

provides data warehousing, storage and maintenance, as agreed and documented by the data sharing group.

4.7. Formally Sign the Agreement
The written data sharing agreement is effectively a contract and must be signed by all the parties involved. Publishing it (on-line) is normal practice and contributes to organisations compliance with the fair processing requirements of the Data Protection Act, and disclosure of information under the Freedom of Information Act.

4.8. Management of the Agreement
An agreement is likely to consist of three basic components (below). Any of the components have the potential to change in certain circumstances and should in any case be revisited and updated regularly, creating an administrative overhead for NHS organisations;

(i) The purpose - see section 4 (above) - all organisations interviewed said their agreements are drafted with one legitimising purpose. However, at some point an organisation will inevitably ask if information about patients can be used for a slightly different purpose, requiring organisations to consider the impact on patients and what they consented to or acknowledged was the original reason for their data being used. Changes such as this cannot be made in isolation, it must be agreed by all the signatories for it to be lawful, thereby creating an administrative process to obtain necessary permissions, amend the agreement, circulate it for approval and publish an amended version.

(ii) Information security requirements - organisations contributing data must be assured it will be protected whilst in transit and stored on their behalf. Such assurances will feature as part of the agreement and any updates must again be communicated to signatories, and possibly made subject to agreement if necessary.

(iii) Listed parties to the agreement - see also 3 (iii) above - all organisations interviewed spoke of the need to add organisations to the agreement as it expands, and a corresponding requirement for change control procedures.

4.9. Produce Communications Material and Inform Stakeholders
By far the most significant issue spoken about by organisations during interviews was the effectiveness of their communications material, as a means of demonstrating benefits and raising awareness of data sharing amongst patients, but also to inform and reassure stakeholders of the legitimacy of data sharing and precautions taken to ensure its security. Being able to quote tangible benefits or case studies is a good way of engaging with stakeholders.

Instances were also quoted of communications being used to gain views and reassurances from Local Medical Committee’s (LMC) and National Information Governance Board (NIGB).
A range of exemplar communications material can be found at Appendix C, with sample agreements, patient consent forms, patient information leaflets and other material.

4.10. National Information Governance Board (NIGB)

It is not necessary to consult with NIGB as a means of obtaining any kind of approval for individual data sharing agreements. It may be necessary to apply under Section 251 of the NHS Act (2006) for approval to use personal information when no other lawful basis exists (i.e. it is impossible to secure consent and impractical to use pseudonymised / anonymised data).

NIGB offer advice and guidance and are currently drafting new guidance on the use of data for predictive modelling and risk stratification which should be published in the near future. By law relevant bodies are required to have regard to any guidance published by the NIGB\(^6\).

However the major review into the confidentiality and the sharing of health and social care information, lead by Dame Fiona Caldicott NIGB Chair, may delay this.

4.11. Working with Non-NHS Organisations

Research found that whilst certain organisations include Private Sector and Charitable organisations in their data sharing agreements, and another one included Local Authority Social Services, their involvement is limited to the provision of raw data to contribute to Risk Stratification analysis. The research found no output of data pseudonymised or otherwise to non-NHS organisations but it is acknowledged that disclosure to non-NHS organisations remains an aspiration.

\(^6\) Health and Social Care Act 2008 section 250A(7)
5. **Recommendations**

The investigation did not identify any deficiencies or gaps in existing Information Governance standards or guidance (see Appendix B) for data sharing when applied to Risk Stratification.

**Recommendation 1**

*Existing Information Governance guidance is adequate and there is NO requirement to develop any new data sharing agreement templates or guidance. See Appendix D – Links to resources on Data Sharing*

The investigation found that there was a general consensus of what the activities should be around implementing data sharing agreements, and what was considered best practice for each activity. The consensus focused on a nine point model with a check list of best practice for each point.

**Recommendation 2**

*Identify a Sponsor*

- When starting a data sharing project identify a sponsor.
- The sponsor should be a clinical professional.
- The sponsor should have both professional and organisational credibility and status.
- Where the data sharing project will include health and social care data, consider having two joint sponsors one from health care and one from social care.

**Recommendation 3**

*Establish a Project Team or Stakeholder Group*

- Have health care representation including representation from any local health care professional bodies such as LMC.
- Have social care representation if social care data will be shared.
- Have clinical safety representation (Clinical Safety Officer)
- Include a Senior Information Risk Owner (SIRO)
- Have IG representation including representation from any cross-organisational or cross-sector local IG groups, forums or committees.
- Have ICT representation including representation from any cross-organisational local ICT groups, forums or committees.
- Have clear Terms of Reference.

**Recommendation 4**

*Map the Data Flows*

- Identify the organisations that will be the data sources.
- Identify the organisations that will act as intermediaries.
- Identify the organisations that will be data users (and therefore ‘Data Controllers’ for DPA purposes).
- Identify the data assets involved; this should include all the individual data items for each data asset.
- Formally document the full data flow – normally a diagram with attached explanatory text.
- Identify potential (or realised) risks and issues for the documented data flow.
For each risk or issue provide a proposed mitigation and/or exemption.
Add the risks, issues, mitigations and exemptions as part of the data flow documentation.
Seek Caldicott Guardian approval for proposed data flows.

**Recommendation 5**

*Agree a Purpose for Sharing Data*  
*See Appendix D – Links to resources on Data Sharing*

- Identify the purpose for sharing data – be as exact and specific as possible.
- Identify the organisations and the groups or job roles within the organisations that will use the shared data.
- Define any time, locational, organisational or information processing system constraints that will restrict access to the shared data.
- Consider undertaking a Privacy Impact Assessment as a means of identifying and managing issues affecting individuals’ privacy (IG Toolkit standard 210 requires this).
- Document the purpose for sharing data.

**Recommendation 6**

*Obtain Stakeholder Agreement*

- Get the project team or stakeholder group to approve the documented data flow and the documented purpose for sharing data.
- Iterate data flow and purpose for sharing data if required to obtain stakeholder agreement.

**Recommendation 7**

*Draft a Data Sharing Agreement*  
*See Appendix C – Copy Exemplar Data Sharing Agreements*

- Where possible make use/reference to any existing over-arching data sharing agreement that covers generic issues.
- Create a System Specific Information Sharing Agreement (SSISA).
- Get the project team or stakeholder group to approve the data sharing agreement.
- Publish the approved data sharing agreement in electronic form on organisation web sites.

**Recommendation 8**

*Formally Sign the Agreement*

- Maintain a list of all organisations that need to sign the data sharing agreement.
- Get all organisations on the list to formally sign the data sharing agreement.
- Caldicott Guardians are likely signatories for NHS organisations.
- Where formally signing is of a paper copy of the agreement, scan and securely store the signed paper copy.
- Where formally signing is via an online electronic form, securely store the transaction.
- Annotate the organisation list to show who has formally signed the agreement.
**Recommendation 9**  
**Management of the Agreement**

- If the purpose of the data sharing changes you must:  
  - Agree the new purpose for sharing data  
  - If the original purpose relied on patient consent then further consent must be obtained to cover the extended use.  
  - Obtain stakeholder agreement again.  
  - Draft a new data sharing agreement.  
  - Get all organisations to formally sign the new agreement.  

- If the listed parties to the agreement changes you must:  
  - Get new organisations to formally sign the agreement.  
  - Revoke signed agreements for organisations that withdraw from the agreement.

**Recommendation 10**  
**Produce Communications Material and Inform Stakeholders (See Appendix D – Links to resources on Data Sharing)**

- For all stages of a data sharing project produce clear and concise communications material.  
- Tailor communications material to intended audience; for example patient, GP Practice and NHS Trust.  
- Be proactive in using communications material to engage with all stakeholders to inform and reassure them of the legitimacy of data sharing and precautions taken to ensure its security.

This final recommendation, “Produce Communications Material and Inform Stakeholders”, is the most important point in the whole process. It is considered essential to the success of an information sharing project to communicate with key stakeholders – influential GPs as well as LMCs – right from the beginning of the process as this will reassure them, as well as ensuring their concerns and issues are considered in the design of the processes right from the very start.
6. References
These resources will provide additional information, and are referenced in the relevant sections in this document.

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7. Appendix A - Research Methodology

From the submitted EOIs local teams were identified as candidates for interview on the basis that they had a Risk Stratification system operational and therefore by implication must have addressed data sharing agreement issues.

A short information sheet (see Appendix B) was produced that explained the purpose of the investigation, what participation from the EOI LTC local team was being requested and an outline of the questions that would be asked.

This information sheet was emailed to all the primary contacts for the candidate teams asking for their agreement to participate. Those that responded positively were then asked to identify all the relevant participants within their team who should be interviewed.

For each team that agreed, a telephone conference was scheduled. Each interview was limited to a maximum of one hour.

Each interview followed the same protocol:

- Introduction of interviewers
- Introduction of participants
- A short introduction was given by an interviewer that reiterated the purpose of the investigation and the format of the interview
- An interviewer asked each question and then invited the participants to answer
- The interviewers and participants engaged in a discussion of the answers given to aid elaboration and clarity where needed
- An interviewer recorded notes about the answers
- Participants were given the opportunity to raise and discuss any other issues that did not fall within the structured questions

After the interview, the recorded notes were transcribed to an interview record and then reviewed by the interviewers.

Any additional elaboration or clarity deemed necessary by the review was followed up by emailing appropriate interview participants with specific questions. The answers to these specific questions were added to the interview record.

The resultant interview records were first analysed to identify common activities within data sharing as described by the interviewed organisations. These were then placed into a sequence that may be used as the basis for a project plan for organisations embarking on data sharing projects. Best practice was then gathered from the organisations interviewed for each of the activity areas and was assessed for compliance with relevant IG standards and guidance.
## 8. Appendix B - Interview Information Sheet

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<th>Investigation of Data Sharing Issues Within Risk Stratification Request for Participation</th>
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<td><strong>Background</strong></td>
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<tr>
<td>Out of the 14 teams that submitted an EOI (Expression of Interest), 7 identified the need for data sharing agreement guidance as a key enabler to their local QIPP activities. In response the QIPP Digital Technology team is carrying out an investigation of data sharing issues within the specific area of Risk Stratification as this area is both a key QIPP LTC (Long Term Care) driver and was also identified by many of the EOI LTC teams as present or planned in their technology roadmaps.</td>
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<tr>
<td><strong>What we plan to produce</strong></td>
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<tr>
<td>The output from this investigation will be a report outlining; findings from discussions with local teams, summary of issues/barriers to sharing of data and suggested next steps. The report will NOT develop any new data sharing agreement templates or guidance, rather the aim is to clearly identify and document the issues facing the local teams with a view to subsequent actions to help resolve issues identified.</td>
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<tr>
<td><strong>When?</strong></td>
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<tr>
<td>We will publish the investigation report covering the above points by the end of March 2012.</td>
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<tr>
<td><strong>What we need from you</strong></td>
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<tr>
<td>As a local QIPP team who has submitted an EOI and has been identified as having an operational Risk Stratification system, we would like to invite you to participate in the investigation.</td>
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<tr>
<td><strong>If you agree to participate we will ask you to identify relevant people within your organisation who can be interviewed in Jan 2012.</strong> We will then arrange a telephone conference of no more than 1 hour with ourselves and the people you have identified to discuss:</td>
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<tr>
<td>• What data is shared?</td>
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<tr>
<td>• What organisations are involved in the data sharing?</td>
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<tr>
<td>• What approach have you taken to getting data sharing agreements?</td>
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<tr>
<td>• What data sharing successes have been realised?</td>
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<tr>
<td>• What issues or blockages have been identified as contributing to the failure of data sharing?</td>
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<tr>
<td>We may subsequently need to email some participants to clarify or elaborate points raised in the interview. We will then document the interview and ask you to review and approve before including it in the written report. The subsequent report will be made available to all QIPP local teams as well as the NHS in general.</td>
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**Please respond with your agreement to participate, and contacts for the above by Friday 20th January**
9. Appendix C – Examples of Communications Material

Inter-organisational general protocol for sharing information - from Outer North East London NHS. 
Contains organisational policy details relating to information sharing, as well as information for service users and information for citizens.

[PDF]
Information_Sharing_Protocol.pdf

SSISA agreement – from Outer North East London NHS. 
This provides details regarding specific information sharing exercises not covered in the generic measures described above.

[PDF]
SSISA_AGREEMENT.pdf
10. Appendix D – IG Resources and Standards

**Legal Material**

Links in this sub-section are to material of a legal nature, providing advice and guidance on organisations statutory obligations regarding information sharing.

Information Commissioner’s Office - Data Sharing Code of Practice.  


Information Commissioners Office – Privacy Impact Assessment Handbook  

**Policy**

Links in this sub-section are to policy documents and exemplar material gathered during the course of the research, considered to be examples of good practice and provided (with agreement) for the benefit of other organisations.

Kent Children’s Trust - The Kent and Medway Three Tier Model for Information Sharing.  
[http://www.kenttrustweb.org.uk/Policy/ig_home.cfm](http://www.kenttrustweb.org.uk/Policy/ig_home.cfm)

NHS - Information Governance Toolkit Knowledge Base.  
[https://nww.igt.connectingforhealth.nhs.uk/KnowledgeBase.aspx?tk=409164355982355&Inv=8&cb=1f3405ee-2033-4b4c-8bd2-a7af931aab4e&sViewOrgType=0&sDesc=View+Entire+Knowledge+Base](https://nww.igt.connectingforhealth.nhs.uk/KnowledgeBase.aspx?tk=409164355982355&Inv=8&cb=1f3405ee-2033-4b4c-8bd2-a7af931aab4e&sViewOrgType=0&sDesc=View+Entire+Knowledge+Base)


**Guidance**

Links in this sub-section are to guidance material published by other Government organisations but worthy of consideration as the basis for projects in the NHS.


http://media.education.gov.uk/assets/files/pdf/i/information%20sharing%20%20%20case%20examples.pdf