Independent Group Advising on the Release of Data (IGARD)

Minutes of meeting held via videoconference 30 June 2022

IGARD MEMBERS IN ATTENDANCE:	
Name:	**Position:**
Paul Affleck	Specialist Ethics Member (Acting Chair)
Prof. Nicola Fear	Specialist Academic Member
Dr. Robert French	Specialist Academic / Statistician Member
Dr. Imran Khan	Specialist GP Member (Acting Vice Chair: item 3.5 only)
Dr. Maurice Smith	Specialist GP Member
Jenny Westaway	Lay Member
IGARD MEMBERS NOT IN ATTENDANCE:	
Maria Clark	Lay Member
Kirsty Irvine	IGARD Chair
Dr. Geoffrey Schrecker	Specialist GP Member / IGARD Deputy Chair
NHS DIGITAL STAFF IN ATTENDANCE:	
Name:	**Team:**
Michael Ball	Data Services for Commissioners (DSfC)
Garry Coleman	Associate Director / Senior Information Risk Owner (SIRO) (**Observer:** item 3.1)
Dave Cronin	Data Access Request Service (DARS) (**SAT Observer**: item 3.5)
Duncan Easton	Data Access Request Services (DARS) (**SAT Observer**: Items 3.1 & 3.2)
Chloe James	Data Services for Commissioners (DSfC) (**Observer**: Item 3.4)
Nicola Jennings	Data Access Request Services (DARS) (**Observer**: items 3.5)
Dr. Jonathan Osborn	Deputy Caldicott Guardian (Item 1 & 3.1 (part))
Anna Weaver	Data Access Request Service (DARS)
Vicki Williams	IGARD Secretariat
***SAT** – Senior Approval Team (DARS)	

1	**Declaration of interests:** Paul Affleck noted professional links to the University of Leeds [NIC-155843-0MQMK-v4.17] but noted no specific connection with the application or staff involved and it was agreed that this was not a conflict of interest, however it was agreed that Dr Imran Khan would chair this particular item. Prof Nicola Fear noted a professional link to the applicant [NIC-155843-0MQMK-v4.17 University of Leeds] but noted no specific connections with the application or staff involved and it was agreed that this was not a conflict of interest. Dr Rob French noted a professional link to the applicant [NIC-155843-0MQMK-v4.17 University of Leeds] but noted no specific connections with the application or staff involved and it was agreed that this was not a conflict of interest. Dr Maurice Smith noted a professional link with Cheshire & Merseyside ICS & NHS Liverpool CCG [CIPHA cited in NIC-361618-Y2W1Y-v0.2 NHS Surrey Heartlands CCG & Surrey County Council] and would not be part of the discussion. It was agreed that Maurice would not remain in the room for the discussion of that application. **Review of previous minutes and actions:** The minutes of the 23rd June 2022 IGARD meeting were reviewed and subject to a number of minor amendments were agreed as an accurate record the meeting **Out of committee recommendations:** An out of committee report was received (see Appendix A).
2	**Briefing Notes**
2.1	*There were no briefing papers submitted for review.*
3	**Data Applications**
3.1	<u>NHS Kent & Medway Integrated Care Board (ICB): DSfC Kent & Medway ICB – Comms, RS & IV (Presenter: Michael Ball) NIC-615960-G7W1L-v0.3</u> **Application:** This was a new first of type application for the newly formed Integrated Care Body (ICB) for the purpose of commissioning, risk stratification and invoice validation and is a request for: pseudonymised commissioning datasets, identifiable risk stratification datasets and identifiable invoice validation datasets. The application is based on an ICB template, which in turn is based on the standard CCG template, with all changes agreed by NHS Digital's Senior Information Risk Owner (SIRO). Sub-licencing to members of the ICB is part of the application. Pseudonymised record-level commissioning data can only be shared by the Data Controller with substantive organisations who are part of the ICB's Integrated Care System (ICS), which includes Trusts, GPs, Local Authorities and other health care providers who will contribute to commissioning decisions. **Discussion:** IGARD noted that NIC-362255-K5D1H NHS Kent & Medway CCG had been noted in the out of committee (OOC) report under "*Optum Health Solutions UK Ltd Class Action*" on the 1st July 2021. IGARD noted that there appeared to be no evidence of a previous Data Access Advisory Group (IGARD's predecessor) or IGARD review of the CCG application.

	There was a lengthy discussion with regard the dissolution of CCGs and the formation of the new ICB entities from the 1st July 2022, and IGARD asked that terminology such as "*merger*" be removed from the application and updated to clearly articulate the legislative framework and timeframes. This will be particularly important where ICBs cover different geographical areas to predecessor CCGs. IGARD also asked that reference to "*CCG*" be removed from throughout the application and replaced with "*ICB*". IGARD noted that an Executive Management Team (EMT) briefing paper had been presented to the BAU meeting of IGARD on the 30th September 2021 where IGARD had provided a number of high level comments and noted that since this was a living document that it should be updated and returned to IGARD once the Health & Social Care Bill 2021 passed into law. IGARD requested that this briefing paper be updated and returned to IGARD as soon as possible. IGARD suggested that the ICB's legal responsibilities be clearly articulated in section 5 (Purpose / Methods / Outputs), in that the ICB can identify cohorts of patients for service providers to provide the most appropriate care, but the ICB **cannot** provide direct care. In addition, section 5 should clearly articulate that the re-identification of individuals and the re-identification of cohorts are different processes and should be recognised as such. IGARD had raised in advance of the meeting that the Data Security and Protection Toolkit (DSPT) had been submitted by NHS Kent & Medway CCG for 2021/22 and the standards met as at 31st March 2022. IGARD asked that section 5 clearly articulate that the DSPT for the year 2021/22 was submitted by the CCG and that the ICB would submit a DSPT for 2022/23 onwards and in line with the agreed submission timetable. In addition, IGARD suggested that section 6 (Special Conditions) be updated and included narrative that the DSPT submission for the year 2021/22 was by the CCG and from 2022/23 the DSPT would be submitted by the ICB. IGARD had raised in advance of the meeting that the re-identification for direct care might be used as a way of performing risk stratification without the National Data Opt-Outs (NDO) being applied to the source data; that it was unclear why separate flows of data were needed for risk stratification; and if it was accurate to state that identifying individuals where re-identification was required, is an unintended but inevitable secondary result of commissioning. IGARD asked that section 5 be updated to clarify why separate flows of data were needed for risk stratification. In addition, that the sentence that starts "*commissioners can then prepare plans for patients who may require high levels of care*" in section 5(a) (Objective for Processing) be updated to "*commissioners can then prepare plans for cohorts of patients who may require high levels of care".* IGARD also suggested that the word "underlying" be removed from the sentence in section 5(a) that currently read "*Health Needs Assessment – identification of **underlying** disease…*". IGARD requested that the paragraph in section 5(a) with regard to demand management be updated to ensure that it is not conflated with commissioning. IGARD also suggested that the word "*unintended*" be removed from the sentence in 5(a) that read "*an **unintended** but inevitable second result…*", since it was necessary for care of patients. IGARD also suggested that the word *"**mortality**" be removed* from the sentence in section 5(a) *"support the health, **mortality** or care needs of the total local population.*

	IGARD suggested that the sentence "*reports and dashboard to show the outcome of clinical interventions including patient outcomes and cost savings*" in section 5(c) be updated to "…*including patient outcomes* ***and modelled transactional*** *cost savings*…". IGARD had raised in advance of the meeting that the application stated that the commissioning dataset were pseudonymised by the DSCRO but that "*local patient identifiers*" were included "*for the purpose of challenging data submissions with providers*", and queried if these were direct identifiers. IGARD noted a risk area to NHS Digital in that the local patient identification numbers are akin to NHS numbers (they are intended as direct identifiers not as pseudonyms). This raised the risk that the disseminated data is not actually pseudonymous. In advance of the meeting IGARD had noted in section 5 of the application that "*As data is disseminated via DSCRO, the held category is inaccurate as DARS does not know which files have been released. Instead, a DSCRO release register will be made available on a public facing website".* NHS Digital confirmed that this would not be a separate register to the existing NHS Digital data uses register, but instead would feed information about DSCRO disseminations into the existing register. NHS Digital also confirmed that having discussed with the DSCRO, they were expecting the new information to published in the NHS Digital Data Uses Register in the next couple of months. IGARD noted that the information would be made available on the NHS Digital public facing website giving greater detail than was previously available and recommended this happened quickly to give public transparency, and within three months at the latest. IGARD noted the large number of storage and processing locations in section 2 (Locations), and noting this may cause difficulty for NHS Digital in respect of auditing, suggested that NHS Digital worked with the applicant to review and consider if the locations could be consolidated and in line with the NHS Digital DARS Standard for Processing and Storage Locations. In additional section 5(a) should be updated to provide a statement that the applicant has minimised the number of storage and processing locations to prevent excessive processing. IGARD also noted the inclusion of a number of technical phrases and words within sections 5(a) and 5(b) (Processing Activities), such as "*backing data*", and asked that this public facing section, which forms NHS Digital's data uses register, was amended throughout, to ensure technical terms were explained in a manner suitable for a lay audience. IGARD noted that the Health Research Authority Confidentiality Advisory Group (HRA CAG) s251 approval had expanded to include date of birth and suggested that the application was updated throughout to note the s251 expansion. IGARD noted reference in section 5 to "*section 1c*" in the sentence "*Data processors must be listed in* ***section 1c*** *of this data sharing agreement*…" and noted that since section 1c is not publicly available via the NHS Digital's data uses register that this reference be removed from section 5. In addition, and noting section 1(c) is not published in the release register, IGARD suggested that the Data Processors be listed in section 5(b) for transparency. Noting the NHS Digital DARS standard for sub licencing and onward sharing, IGARD suggested that a special condition be inserted in section 6 that there was a formal oversight process in place for sub licencing applications, which was in line with NHS Digital's guidance and published DARS Standard. IGARD suggested that section 5(d) (Benefits) be updated to remove reference to "*it will*…", and instead use a form of words such as "*it is hoped*…". In advance of the meeting, and in line with the NHS Digital's DARS Standard for Expected Measurable Benefits, IGARD had raised a number of queries including:

	IGARD noted that the sentence in section 5(d) that started "*improved quality of services through reduced emergency readmissions…*" should be updated to "*reduce emergency readmissions, especially avoidable emergency admissions by improving quality of services*". IGARD also noted that the sentence in section 5(d) "*improved planning by better patient flows*…" should be updated to "*Improved planning by better understanding patient flows through the healthcare system, thus allowing commissioners to identify priorities and identify commissioning plans to address these (it is expected that pathways would be designed by service providers within the ICS with input from appropriate stakeholders including patient and public representation)".* IGARD also noted that the sentence in section 5(d*)* "*insight to understand the numerous factors that play a role in the outcome for both datasets…"* should be updated to include narrative with regard to which datasets were being referred to, for example births and death date. IGARD also suggested that the sentence in section 5(d) "*allows a reduction in premature death and hospital admissions*" should be updated to add more detail such as "*Allows clinicians with direct care responsibilities to improve quality of care for patients identified. This may reduce the risk of unwanted emergency hospital admission, premature complications of disease and of premature death".* In respect of the privacy notice and in line with NHS Digital's DARS Standard for Transparency (fair processing), IGARD wished to draw the applicant's attention to the statement in section 4, that a UK General Data Protection Regulation (UK GDPR) compliant, publicly accessible transparency notice was maintained throughout the life of the agreement and to the sub-licensing special condition that both the ICB and any sub-licensees must update their notices to inform the public about data sharing. **Outcome**: recommendation to approve subject to the following condition 1. In respect of terminology around the initialisms CCG / ICB a. To update the application throughout to remove reference to "*CCG*" and replace with "*ICB*", and b. To remove reference to "*merger*" to clearly articulate the legislative framework, timeframes, the dissolution of CCGs and the formation of the new ICB entities, and c. To clearly articulate the ICB's legal responsibility in section 5 that the ICB can identify cohorts of patients for service providers to provide the most appropriate care, but the ICB cannot provide direct care, and d. To be clear in section 5 that the re-identification of individuals and cohorts are different processes and recognised as such. e. To update section 5 to be clear that the DSPT for the year 2021/2022 was submitted by the CCG, and that the ICB will submit a DSPT for the year 2022/23 onwards, and f. To update section 6 to ensure that the DSPT covers the relevant bodies and is in line with point (c) above. The following amendment were requested: 1. In respect of storage and processing locations and in line with NHS Digital's DARS Standard for processing and storage locations: a. IGARD noted the large number of storage and processing locations, and, noting this may cause difficulty for NHS Digital in respect of auditing, suggested that

NHS Digital worked with the applicant to review and consider if the locations could be consolidated, and

b. To update section 5(a) to provide a statement that the applicant minimise the number of storage and processing locations to prevent excessive processing.

2. To remove from section 5(a) "*unintended*" from the sentence "*an **unintended** but inevitable second result*…", since it is necessary for care of patients.
3. In respect of risk stratification in section 5(a):
    a. To clarify in section 5 why separate data flows of data are needed for risk stratification, and
    b. To amend in section 5(a) "*commissioners can then prepare plans for patients who may require high levels of care*" to "*commissioners can then prepare plans for cohorts of patients who may require high levels of care",* and
    c. To amend in section 5(a) "*to ensure the right services are available for individuals when and where they need them*…" to "…*to inform the commissioning or appropriate services for that population's health needs*…", and
    d. to remove in section 5(a) "*underlying*" from the sentence "*Health Needs Assessment – identification of **underlying** disease…*", and
    e. to update the paragraph with regard to demand management to ensure it is not conflated with commissioning.
4. To update section 5(c) "*reports and dashboard to show the outcome of clinical interventions including patient outcomes and cost savings*" to "…*including patient outcomes **and modelled transactional** cost savings*…".
5. IGARD noted a number of technical terms in section 5(a) and 5(b), and asked that this public facing section, which forms NHS Digital's data uses register, was amended throughout, to ensure technical terms are explained in a manner suitable for a lay audience, for example "*backing data*".
6. In respect of the benefits in section 5(d) in line with the NHS Digital's DARS Standard for Expected Measurable Benefits:
    a. To update section 5(d) to use a form of wording such as "*it is hoped* …", rather than "*it will…*", and
    b. To amend the sentence that starts "*improved quality of services through reduced emergency readmissions…*" to "*reduce emergency readmissions, especially avoidable emergency admissions by improving quality of services*.", and
    c. To amend the sentence that starts "*improved planning by better patient flows*…" to "*Improved planning by better understanding patient flows through the healthcare system, thus allowing commissioners to identify priorities and identify commissioning plans to address these (pathways would be designed by service providers within the ICS with input from appropriate stakeholders including patient and public representation).", and*
    d. To amend the sentence "*insight to understand the numerous factors that play a role in the outcome for both datasets…"* to include narrative with regard to which datasets, for example births and death date, and
    e. To amend the sentence that starts "*allows a reduction in premature death and hospital admissions*" to add more detail such as "*Allows clinicians with direct care responsibilities to improve quality of care for patients identified. This may reduce the risk of unwanted emergency hospital admission, premature complications of disease and of premature death".*

	7. To remove *"**mortality**"* from the sentence in section 5(a) *"support the health, **mortality** or care needs of the total local population.* 8. To update the application throughout to note the s251 approval has expanded to include date of birth. 9. In respect of the Data Processors: a. To remove "*section 1c*" from the sentence "*Data processors must be listed in **section 1c** of this data sharing agreement*…" since section 1c is not publicly available via the NHS Digital's data uses register, and b. To state all Data Processors must be described in section 5b. 10. To insert a special condition in section 6 that there is a formal oversight process in place for sub licencing applications, which is in line with NHS Digital's guidance and the NHS Digital DARS standard for sub licencing and onward sharing. The following advice was given: 1. IGARD noted that information about data dissemination by DSCROs would be made available on the NHS Digital public facing website giving greater detail than was previously available. IGARD recommended this happened quickly to give public transparency and within three months at the latest. 2. In respect of the privacy notice and in line with NHS Digital's DARS Standard for Transparency (fair processing), IGARD wished to draw to the applicant's attention to the statement in section 4, that a UK GDPR compliant, publicly accessible transparency notice is maintained throughout the life of the agreement, and that this should be within 3 months of signing the DSA and to the sub-licensing special condition that both the ICB and any sub-licensees must update their notices to inform the public about data sharing. **Risk Area:** The commissioner will receive local patient identification numbers but does not have a list of which patients they belong to, so they are being treated as pseudonyms. However, local patient identification numbers are akin to NHS numbers (they are intended as direct identifiers not as pseudonyms). This raises the risk that the disseminated data is not actually pseudonymous. **Separate to this application:** As noted at the 30th September 2021 meeting, NHS Digital to provide the briefing paper which has been updated in line with current Government legislation approved under the Health & Social Care Bill to the next available meeting of IGARD. It was agreed the condition would be approved out of committee (OOC) by IGARD members.
3.2	NHS Surrey Heartlands CCG & Surrey County Council: CIPHA – COVID (Presenter: Michael Ball) NIC-361618-Y2W1Y-v0.2 **Application:** This is a new application to receive identifiable Acute-local Provider Flows, Adult Social Care, Ambulance-Local Provider Flows, Children & Young People Health and Civil Registration (Births). The data is considered confidential as the Data Processor (Graphnet Health Ltd) hold a mapping table to revert the pseudonymised data back to the NHS number for direct care purposes. The purpose of the application is to support a set of COVID-19 related population health analytics, designed to inform both population level planning for COVID-19 recovery and to support the targeting of direct care to vulnerable populations across the Surrey Heartlands Integrated Care System (ICS) partnership areas.

	The dissemination of the data is under Regulation 3(1) of the Health Service (Control of Patient Information) Regulations 2002 (COPI): NHS Digital noted that, as outlined in section 1 (Abstract), the applicant had breached a current data sharing agreement (DSA) by sending non-suppressed data to PPL Consultants. **Discussion:** IGARD noted that aspects of this application had been previously seen by the IGARD – NHS Digital COVID-19 Response meeting on the 26th October 2021. IGARD noted the information in section 1 (Abstract) and supporting document (Breach investigation report) in respect of the breach of a current DSA and the sharing of 58 records without small number suppression to PPL Consultants. IGARD thanked NHS Digital for providing a copy of the Breach Report as a supporting document, however suggested that this was also shared with NHS Digital's Caldicott Guardian, if not already done so. IGARD queried if Graphnet had equivalent, robust re-identification processes in place and that NHS Digital should provide written satisfactory confirmation that they had a robust system in place which was comparable with the DSCRO's re-identification processes. In addition, IGARD asked that the applicant confirm how the Common Law Duty of Confidentiality (CLDoC) was being met for identifiable datasets Graphnet received directly from providers, which is subsequently linked to the data from NHS Digital. IGARD suggested that NHS Digital consider a full audit of Graphnet Health Ltd in respect of **all** data usage under **all** live DSAs with NHS Digital, where Graphnet was recorded as a Data Processor, to ensure it was in line with the specific purposes of the data flows and the legal basis put forward for each data flow. In addition, IGARD suggested that the audit review to ensure the appropriate contracts are in place, to fulfil Regulation 7(2) of COPI. IGARD noted that the applicant was relying on Regulation 3(1) COPI. Noting that IGARD had **not** been provided with the Privacy Transparency & Ethics (PTE) legal advice to DARS, which was subject to legal privilege, IGARD asked that NHS Digital PTE directorate confirm in writing to IGARD that Regulation 3(1) COPI was an appropriate legal basis for the flow of confidential data under this DSA. IGARD also requested sight of written confirmation that NHS Digital's Caldicott Guardian has been sighted on all relevant documentation relating to this application and had been able to proffer an opinion. IGARD asked that any pertinent legal basis documentation was uploaded to NHS Digital's customer relationship management (CRM) system for future reference. Finally, IGARD suggested that section 5 should include an outline of the approval procedures in place for the legal gateway of Regulation 3(1) COPI, for example, but not limited to, appropriate oversight. There was a discussion with regard the dissolution of CCGs and the formation of the new ICB entities from the 1st July 2022, and IGARD asked that reference to "*CCG*" be removed from throughout the application and replaced with "*ICB*". IGARD queried if there would be automated decision making or profiling and asked how any relevant UK General Data Protection Regulation (UK GDPR) requirements were being addressed and suggested that section 5 (Purpose / Methods / Outputs) of the application should be updated to clarify if automated decision making and / or profiling was taking place. IGARD noted that the application stated that "*The dashboards will make use of algorithms to highlight cohorts of patients but these are pseudonymised so does not constitute as profiling or automated decision making. If patients are re-identified for the purpose of direct care, this will be a decision made by a health care professional on a case by case basis*" and in advance of

	the meeting had queried the relationship between the algorithm to create a cohort and the decision making by a health and care professional. Noting the NHS Digital response that a decision not to offer care would not significantly affect any individual, IGARD noted if an algorithm was used to identify individuals who might be offered direct care as a result, other members of the population could be excluded, and suggested that the applicant carried out a Data Protection Impact Assessment (DPIA), including an assessment of whether automated decision making and / or profiling would take place. IGARD asked that any pertinent documentation was uploaded to NHS Digital's customer relationship management (CRM) system for future reference. In addition, IGARD noted that should automated decision making and / or profiling be taking place, that the applicant must ensure that appropriate transparency materials were available to patients and the public, in line with NHS Digital's DARS Standard for transparency (fair processing) and Article 22 of UK GDPR. IGARD noted reference within the application to a number of non-COVID-19 related purposes and noting the purpose of this application was to support a set of COVID-19 related population health analytics and targeting of direct care to vulnerable populations across the Surrey Heartlands Integrated Care System (ICS) partnership areas, suggested that all reference to purposes other than COVID-19 be removed. In addition, section 5(b) (Processing Activities) should be updated to be clear that the re-identification of patients must be relevant to COVID-19 purposes only. IGARD noted that the COVID-19 purpose could be interpreted in an overly broad way and that this was a risk to NHS Digital. IGARD noted the large number of storage and processing locations in section 2 (Locations), and noting this may cause difficulty for NHS Digital in respect of auditing, suggested that NHS Digital worked with the applicant to review and consider if the locations could be consolidated and in line with the NHS Digital DARS Standard for Processing and Storage Locations. In addition, section 5(a) should be updated to provide a statement that the applicant has minimised the number of storage and processing locations to prevent excessive processing, and that the current paragraph in section 5(a) under locations be removed. Noting the large volume of data and number of datasets requested in section 3(b) (Additional Data Access Requested) of the application, IGARD asked that the application be updated throughout and in line with the NHS Digital DARS standard for data minimisation, for example, only requesting data that correlate to the purposes outlined in section 5. IGARD suggested that section 5(d) (Benefits) be updated to remove reference to "*it will*…", and instead use a form of words such as "*it is hoped*…". IGARD also noted the inclusion of a number of technical phrases and words within sections 5(d), such as "*place based*", and asked that this public facing section, which forms NHS Digital's data uses register, was amended throughout, to ensure technical terms were explained in a manner suitable for a lay audience and in line with the NHS Digital's DARS Standard for Expected Measurable Benefits. IGARD advised that they would wish to review this application when it comes up for renewal, extension or amendment and that this application would not be suitable for NHS Digital's Precedent route, including the SIRO Precedent, due to the suggested audit. IGARD noted that the applicant had written to IGARD on the 13th April 2022 and that this had been provided to IGARD as part of the application pack as a supporting document at today's meeting. IGARD noted that if an applicant writes to IGARD via NHS Digital, this must be provided to IGARD at the time of receipt by NHS Digital and not delayed to be part of the

	application pack or not provided to IGARD at all, since it was for the IGARD Secretariat Team and IGARD Chair to evaluate such communications and decide whether a response is required or to wait for the application. **Outcome:** IGARD were unable to make a recommendation as not all the necessary information was available in order for IGARD to make a full assessment. 1. In respect of reliance on Regulation 3(1) of The Health Service (Control of Patient Information) Regulations 2002 (COPI): a. NHS Digital PTE to confirm that Reg 3(1) is an appropriate legal basis for the flow of confidential data under this DSA, and b. To confirm that NHS Digital's Caldicott Guardian has been sighted and been able to proffer an opinion, and c. To upload the written PTE confirmation to NHS Digital's CRM system, and d. To provide in section 5 an outline of the approval procedures in place for this legal gateway, for example, but not limited to, appropriate oversight. 2. To update the application throughout to remove reference to "*CCG*" and replace with "*ICB*". 3. In respect of Graphnet: a. NHS Digital to provide satisfactory written confirmation that Graphnet have robust re-identification processes in place, comparable to the DSCRO's re-identification processes. b. The applicant to confirm how the CLDoC is being met for identifiable datasets Graphnet receive directly from providers, which is subsequently linked to the data from NHS Digital. 4. In respect of storage and processing locations and in line with NHS Digital's DARS Standard for processing and storage locations: a. IGARD noted the large number of storage and processing locations, and, noting this may cause difficulty for NHS Digital in respect of auditing, suggested that NHS Digital worked with the applicant to review and consider if the locations could be consolidated, and b. To update section 5(a) to provide a statement that the applicant minimise the number of storage and processing locations to prevent excessive processing, and c. To remove from section 5(a) the paragraph with regard to "*locations*" and replace with narrative as outlined in point (b) above. 5. In respect of data minimisation: a. To update the application throughout in line with NHS Digital DARS standard for data minimisation; and b. To provide a justification for the large volume of data and number of datasets requested. 6. In respect of automated decision making and profiling: a. To confirm if a DPIA has been carried out to determine if there is profiling and/or automated decision making, and b. To update section 5 to clarify if profiling and/or automated decision making is taking place and, if it is, how the relevant UK GDPR requirements are being met, and c. To upload any pertinent documentation to NHS Digital's CRM system for future reference. 7. In respect of the COVID-19 purposes:

	a. To remove references from throughout the application to any purposes other than COVID-19 purposes, and b. To update section 5(b) to be clear that the re-identification must be relevant to COVID-19 purposes only. 8. In respect of the benefits in section 5(d) in line with the NHS Digital's DARS Standard for Expected Measurable Benefits: a. To clarify what is meant by the term "*place based*", and b. To update section 5(d) to use a form of wording such as "*it is hoped* …", rather than "*it will*…". The following advice was given: 1. IGARD noted that should profiling and/or automated decision making be taking place, that the applicant must ensure that appropriate transparency materials were available to patients and the public, in line with NHS Digital's DARS Standard for transparency (fair processing) and Article 22 of UK GDPR. 2. IGARD noted the Breach Report provided as a supporting document and suggested that this was shared with NHS Digital's Caldicott Guardian, if not already done so. 3. In respect of a request to audit: a. IGARD suggested that NHS Digital carry out a full audit of Graphnet Health Ltd in respect of all data usage under all live DSAs with NHS Digital where Graphnet is recorded as a processor to ensure it is in line with the specific purposes of the data flows and the legal basis put forward for each data flow. b. IGARD suggested an audit review to ensure the appropriate contracts are in place, to fulfil Regulation 7(2) of COPI. 4. IGARD advised that they would wish to review this application when it comes up for renewal, extension or amendment, due to the suggested audit. 5. IGARD suggested that this application would not be suitable for NHS Digital's Precedent route, including the SIRO Precedent, due to the DSA and the suggested audit. **ACTION for NHS Digital:** IGARD noted that the applicant had written to IGARD and that this had been provided to IGARD as part of the application pack. IGARD noted that if an applicant writes to IGARD via NHS Digital, this must be provided to IGARD at the time of receipt by NHS Digital and not delayed to be part of the application pack or not provided to IGARD at all, since it was for the IGARD Secretariat Team and IGARD Chair to evaluate the letter and decide whether a response was required or to wait for the application. **Risk area:** IGARD noted that the COVID-19 purpose could be interpreted in an overly broad way.
3.3	Ambulance Dataset class action for CCGs (Presenter: Michael Ball) NIC-616051-B2J1R **Application:** This was a new class action application for all Clinical Commissioning Groups (CCGs) in England with delegated commissioning responsibilities to receive pseudonymised Ambulance data sets. NHS Digital has the legal obligation to establish and operate informatics systems for the collection or analysis of information, and to exercise systems delivery functions under Direction. The Ambulance data set is required to monitor the impact and clinical outcomes of the ambulance services, as well as the impact on reducing hospital admissions. It will also

	contribute to the evaluation of the programme and drive future policy decisions in terms of further roll out Currently CCGs have access to a form of Ambulance Data through local provider flows. Having access to a nationally consistent data set will help to reduce burden on providers submitting data and allow a more nationally consistent view on Ambulance Services. Patient level data is required specifically to monitor the impact and clinical outcomes of Ambulance services and the impact on reducing hospital admissions. It will also contribute to the evaluation of the programme and drive future policy decisions in terms of further roll out. **Discussion:** IGARD noted that a briefing paper had previously been presented at the IGARD business as usual (BAU) meetings on the 7th January 2021, 4th February 2021 and finalised on the 26th May 2022. IGARD noted in advance of the meeting that under "*legal basis for processing*" that the "*data required for the purpose of risk stratification is identifiable*" and asked if this had been included in error. NHS Digital confirmed that this was as error and that the application would be updated to be clear that the data will only be used for commissioning purposes. IGARD were supportive of the amendment. There was a discussion with regard the dissolution of CCGs and the formation of the new ICB entities from the 1st July 2022, and IGARD asked that reference to "*CCG*" be removed from throughout the application and replaced with "*ICB*". Noting that this was a class action application, and that text would be replicated across a number of ICB applications, the template should be updated to clearly articulate in sections 5(a) (Objective for Processing) and 5(b) (Processing Activities) what the ICB landscape was and to provide clarity with regard to the geographical areas (for example, but not limited to, Merseyside) and place based services (for example, but not limited to, Liverpool). The application should also be updated throughout to accurately reflect that the data would be processed by the place based systems within the ICB, this was particularly relevant for those ICB's across a larger geographical footprint. IGARD asked that the word "*reducing*" be removed from the sentence in 5(a) "*impact on **reducing** hospital admissions*", since it was not known if there will be a reduction until the benefits were realised. Noting that the briefing paper had not mentioned "*assessing ambulatory care*", IGARD suggested that reference to this be removed from section 5(d). **Outcome:** recommendation to approve the class action The following amendments were requested 1. In respect of CCG / ICB narrative: a. To update the application throughout to remove reference to "*CCG*" and replace with "*ICB*" b. To update the application throughout to accurately reflect that the data will be processed by place based systems within the ICB c. To clearly articulate in the templated application (section 5a / 5b) the ICB landscape and to provide clarity with regard to geographical areas (for example Merseyside) and place based services (for example Liverpool). 2. To remove reference to "*data required for the purpose of risk stratification is identifiable*" since this is a commissioning application.

	3. To amend section 5(a) to remove "*reducing*" from the sentence "*impact on **reducing** hospital admissions*" 4. To amend section 5(d) to remove reference to "*assessing ambulatory care*"
3.4	<u>NHS Continuing Health Care (CHC) Data class action for CCGs (Presenter: Michael Ball) NIC-616053-Y9D0B</u> **Application:** This was a new class action application for all Clinical Commissioning Groups (CCGs) in England with delegated commissioning responsibilities to receive NHS Continuing Health Care (CHC) data. The NHS Continuing Healthcare (NHS CHC) data set is a patient level, output based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent, and comparable person-based information for people (over the age of 18 years) accessing NHS CHC services and NHS-funded Nursing Care located in England. NHS CHC means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing. The collection of data relates to 5 core tables (Master Patient Index, Referral, Assessment and Outcome, Care Package and Review), each submitted on a monthly basis by responsible commissioners directly to NHS Digital via a secure data landing portal. This new, monthly data set is designed to address the limitations of the current NHS CHC activity collection, which is quarterly and aggregated. Patient level data is to be sourced from NHS CHC commissioning organisations; the legal commissioning bodies for CHC services will initially be CCGs then, from 1 July 2022, Integrated Care Boards (ICBs) will replace CCGs. The intention is to capture data at the level of the former CCG locations that can then be aggregated to ICB level as necessary. **Discussion:** IGARD noted that briefing paper had previously been presented at the IGARD business as usual (BAU) meetings on the 24th March 2022 and finalised on the 16th June 2022. IGARD noted in advance of the meeting that under "*legal basis for processing*" that the "*data required for the purpose of risk stratification is identifiable*" and asked if this had been included in error. NHS Digital confirmed that this was as error and that the application would be updated to be clear that the data will only be used for commissioning purposes. IGARD were supportive of the amendment. There was a discussion with regard to the dissolution of CCGs and the formation of the new ICB entities from the 1st July 2022, and IGARD asked that reference to "*CCG*" be removed from throughout the application and replaced with "*ICB*". Noting that this was a class action application, and that text would be replicated across a number of ICB applications, the template should be updated to clearly articulate in sections 5(a) (Objective for Processing) and 5(b) (Processing Activities) what the ICB landscape was and to provide clarity with regard to the geographical areas (for example, but not limited to, Merseyside) and place based services (for example, but not limited to, Liverpool). The application should also be updated throughout to accurately reflect that the data would be processed by the place based systems within the ICB, this was particularly relevant for those ICBs across a larger geographical footprint. Noting that this was a class action application, and that text would be replicated across a number of ICB applications, the template should be updated to clearly articulate in section 5

	(Purpose / Methods / Outputs) why children and young people aged 18 and under were not included in the NHS continuing health care dataset. **Outcome:** recommendation to approve The following amendments were requested. 1. In respect of CCG / ICB narrative: a. To update the application throughout to remove reference to "*CCG*" and replace with "*ICB*" b. To update the application throughout to accurately reflect that the data will be processed by place based systems within the ICB c. To clearly articulate in the templated application (section 5a / 5b) the ICB landscape and to provide clarity with regard to geographical areas (for example Merseyside) and place based services (for example Liverpool). 2. To remove reference to "*data required for the purpose of risk stratification is identifiable*" since this is a commissioning application. 3. To include a justification in section 5 as to why children and young people aged 18 or under are not included in the NHS Continuing Health Care dataset.
3.5	University of Leeds: comparison of healthcare access for the general population in Yorkshire under the age of 65 to a population who were diagnosed with childhood or young adult cancer (Presenter: Anna Weaver) NIC-155843-0MQMK-v4.17 **Application:** This was a renewal and extension to an existing data sharing agreement (DSA) which expired on the 31st March 2022. It was also an amendment application to include **1)** pseudonymised record level Hospital Episode Statistics (HES) and mental health data, **2)** Microsoft as a cloud storage location, **3)** to remove Iron Mountain as a storage location, and **4)** to remove the University of York as a storage location. In conjunction with a separate application (NIC-11809-H1Y3W) for HES and mental data for a specific cohort, the Yorkshire Specialist Register of Cancer in Children & Young People (YSRCCYP), this application supports an epidemiology and health services research programme. **Discussion:** IGARD noted that the application and relevant supporting documents had previously been presented at the IGARD business as usual (BAU) meeting on the 13th April 2017 as part of a group of 2 connected applications (NIC-11809-H1Y3W). IGARD noted that NIC-11809-H1Y3W had also been previously presented at the IGARD BAU meeting on the 13th April 2017 and 23rd April 2020. IGARD noted that the data requested in section 3(b) (Additional Data Access Requested) did not correlate with the objectives outlined in section 5(a) (Objective for Processing) and although the applicant had confirmed in advance of the meeting that the data requested under this application would be used for all the objectives outlined in section 5(a), IGARD suggested that the application be updated, since it appeared some of the objectives listed in this DSA were in fact objectives associated with the connected application: NIC-11809-H1Y3W University of Leeds. In line with NHS Digital DARS standard for data minimisation, IGARD suggested that the application was updated to include the steps taken to ensure that the minimum amount of data possible was being requested to create the comparison group, noting that the comparison group would involve anyone in the Yorkshire and Humber area who was aged less than 65.

	IGARD queried the geographical area, since the application consistently referenced "Yorkshire" however the YSRCCYP covered the Yorkshire & Humber Strategic Health Authority (SHA) and noting that "Yorkshire & the Humber*" is one of the nine official regions of England, asked that narrative in section 5(a) be clarified as to whether the application is referencing "Yorkshire" or "Yorkshire & the Humber", noting that they were not interchangeable terms. *Yorkshire & Humber region contains: North Yorkshire, West Yorkshire, South Yorkshire, East Riding of Yorkshire, North Lincolnshire and Northeast Lincolnshire Dependent on the clarification of the geographical area, IGARD asked that the estimated size of the comparison cohort be included in section 5(a) for transparency. IGARD also suggested that sections 3(b) and 5(b) (Processing Activities) should be updated to articulate how the cohort will be built by NHS Digital, alongside a definition and that section 5(a) should be updated from "*patients have been collected since 1974*…" to "*collected from 1974 onwards*…". In advance of the meeting, IGARD had queried section 5(b) which stated "*The HES and mental health data are not added into the YSRCCYP research database. The two datasets are stored separately but contain common unique study IDs enabling data to be linked at record level*." and NHS Digital had confirmed that this was referring to storing the HES and mental health data separately to the YSRCCYP dataset "*Where required for specific research, relevant data are extracted from the respective databases, linked and analysed by the YSRCCYP research team, the data are never linked within the YSRCCYP research database*." However, IGARD noted that it referred to linkage between the data to be supplied under this DSA and the YSRCCYP research database, and also stated that "*The pseudonymised HES and Mental Health extracts will not be linked to the cohort data supplied by NHS Digital or to the YSRCCYP database.*" IGARD therefore suggested that section 5(b) should be updated to be clear that there would be **no** linkage at record level permitted under this DSA with the identifiable cohort in NIC-11809-H1Y3W, and to amend the terminology throughout section 5 (Purpose / Methods / Outputs) that "*linkage*" was in fact a "*comparison*", if that was the case. IGARD noted reference to "*common unique study ID*" in section 5(a) and asked that clarification be provided that the study ID was not related to the cohort under this DSA and that it was also not included as part of the pseudonymised cohort. IGARD also queried if the unique HES ID was different across the two DSAs and asked that an unequivocal statement was made in section 5(a) that the unique HES ID was **not** the same across both DSAs and that linkage **cannot** be made at record level. IGARD noted that applicant had requested the consultant code but queried why the site code could not be used, since IGARD were unclear what the consultant code gave in addition to the site code. IGARD asked that clarification as to whether the site of treatment could be used as an alternative to the consultant code (which is identifiable to the consultant via the publicly available General Medical Council (GMC) register). IGARD noted that a number of statements throughout the application appeared to be only relevant to the connected application: NIC-11809-H1Y3W and IGARD asked that the application was updated throughout to remove reference to the legal basis being s251; to remove reference to "*the data will be kept indefinitely*" and to remove reference to "*identifiable data*" since these were not relevant to this application. IGARD noted reference to risk stratification models in section 5(c) (Specific Outputs Expected) and that this appeared to apply to NIC-11809-H1Y3W and suggested that the reference be removed, or if relevant to this DSA, to provide a justification for their inclusion. In addition, that

	narrative also be included about how these risk stratification models will be open and published, noting the narrative in section 5(c) stated that the models "…*will be devised by the YSRCCYP research team and disseminated to clinicians in the Yorkshire & Humber region via the Y&H* children's and young people's cancer network*…" which suggested they were not being released. IGARD also asked that section 5(c) clearly reflect what research goals would be achieved, since those in the cohort were no longer children and young people and it may be beneficial to alert them to other health outcomes which may benefit their long-term health in general. *Y&H – Yorkshire & Humber IGARD noted reference in section 3(a) (Data Access Already Given) that Hospital Episode Statistics Admitted Patient Care data was classed as "*pseudo/anonymous*" and asked that narrative be included in section 3(a) to make clear that the previous dissemination of data was aggregated with small numbers unsuppressed. IGARD queried the current funding arrangements for the study, since it was not clear in the application or supporting documents provided and asked that section 8(b) (Funding Sources) was updated to outline who the funder(s) of the study were. In addition, IGARD asked that a brief summary of the funding arrangements was outlined in section 5(c) (Specific Outputs Expected), since this forms NHS Digital's data uses register. IGARD also asked that any pertinent funding documentation was uploaded to NHS Digital's CRM system for future reference. IGARD noted reference in section 1 (Abstract) to "*type 2 patient objections*" and asked that this be removed and updated to National Data Opt-outs (NDO), if applicable. IGARD noted that a sentence in section 5(a) seemed to be missing crucial information and asked that the sentence "*including the national systemic anti-cancer*" be updated such as "…*therapy data set*". IGARD noted that any references to books or journals should be correctly cited (Harvard referencing) in section 5 or a web link provided so that the books or journals can be easily found, noting that section 5 forms NHS Digital's data uses register. IGARD queried the content within section 5(d) (Benefits), and noted that some of the information provided were outputs and asked that these were moved to correctly sit in section 5(c); in line with NHS Digital's DARS Standard for Expected Measurable Benefits. IGARD suggested that section 5(d) be updated to remove reference to "*it will*…", and instead use a form of words such as "*it is hoped*…". IGARD suggested that because a number of the benefits appeared to cover both this DSA NIC-155843-0MQMK-v4.17 and NIC-11809-H1Y3W, that the benefit be prefaced to clearly articulate that they were benefits across both DSAs, which outlined the need for comparison to allow research to take place. IGARD noted the paragraph in section 5(d)(ii) (Expected Measurable Benefits) which started "*improved patient care*" should be updated to ensure the language reflects this cohort and **not** the wider population. IGARD also asked that section 5(d) make clear the difference between the identifying an individual patient who would benefit from direct care interventions and the cohorts of patients who are of interest to commissioners for planning, for example.

	Unless a clear accrued benefit can be articulated in section 5(d)(ii), IGARD suggested that reference to "*their GPs' will also be informed of the results of the risk stratification via the hospital consultant team*" be removed. IGARD suggested that the sentence in section 5(d)(ii) "*clinicians to help better manage their clinical populations*" be amended to reflect that "*clinicians treating cohorts of patients under their care…".* IGARD noted reference in section 5(d)(ii) to "*South Asians as they are more likely to present with cancer due to genetic risk factors.*", however since this was not reflected in the outputs of the application or study protocol suggested that it be removed. If it was a realisable benefit, then IGARD noted that this study was not looking at that particular output. IGARD noted a number of technical terms in section 5, and asked that this public facing section, that forms NHS Digital's data uses register, was amended throughout, to ensure acronyms be defined upon first use, for example, *"PPM"*. IGARD also queried in section 5 what was meant by the term "*patient care pathway*" and suggested that the term was further explained for a lay audience. IGARD noted that the application outlined providing presentation of results to the public and participants but was silent on any more public and patient involvement and engagement (PPIE) and suggested that the applicant involve relevant public and patient representatives / groups for the lifecycle of the project if not already happening, and that the applicant should endeavour to include a brief update in section 5 (Purpose / Methods / Outputs) since this forms NHS Digital's data uses register, on renewal, amendment or extension. **Outcome:** recommendation to approve subject to the following condition 1. In respect of data minimisation: a. To update the application throughout in line with NHS Digital DARS standard for data minimisation, and b. To outline the steps taken to ensure the minimum amount of data possible is used to create the comparison group, and c. To clarify the geographical area (Yorkshire or Yorkshire & Humber) in section 5(a), and d. To provide an estimated size of the comparison cohort in section 5(a), dependent on the clarification of point (c) above. The following amendments were requested: 1. To update the application throughout to remove reference to the legal basis being s251, since this is only relevant to NIC-11809-H1Y3W. 2. In respect of the objectives a. To clearly articulate the objectives for processing NHS Digital data for the cohort under this application, and b. To remove any duplication of objectives only applicable to NIC-11809-H1Y3W. 3. To update the application to remove reference to "*type 2 objections*" and update to "*NDO*", if applicable. 4. In respect of the term "*linkage*": a. To update section 5(b) to be clear that there will be no linkage at record level permitted under this agreement with the identifiable cohort in NIC-11809-H1Y3W, and b. To amend terminology throughout section 5 that "*linkage*" is in fact a "*comparison*", if that is the case, and

	c. To amend the application throughout to make clear that there will be no linkage of identifiable data to that held by NIC-11809-H1Y3W 5. To update section 3(a) to make clear that previous dissemination of data was aggregated with small numbers unsuppressed. 6. In respect of the cohort: a. To update section 3(b) and 5(b) to articulate how the cohort will be built by NHS Digital with a definition, and b. To amend section 5(a) "*patients have been collected since 1974*…" to "*collected from 1974 onwards*…" 7. In respect of funding: a. To update section 5(c) and 8(b) outlining who the funders are, and b. To upload any pertinent funding documentation to NHS Digital's CRM system for future reference. 8. To amend the application to ensure acronyms are defined upon first use, for example "*PPM*". 9. IGARD noted a number of technical terms in section 5(b), and asked that this public facing section, that forms NHS Digital's data uses register, was amended throughout, to ensure technical terms are explained in a manner suitable for a lay audience, for example "*patient care pathway*". 10. To update the sentence in 5(a) "*including the national systemic anti-cancer*" since it seemed to be missing crucial information such as "…*therapy data sets*". 11. IGARD noted that any reference to books or journals should be correctly cited (Harvard referencing) in section 5 or a web link provided, noting that section 5 forms NHS Digital's data uses register. 12. To clarify whether the site of treatment can be used as an alternative to the consultant code (which is identifiable to the consultant via the publicly available GMC register). 13. To remove reference to "*the data will be kept indefinitely*" since that is not relevant to this application, but to NIC-11809-H1Y3W. 14. To remove reference to "*identifiable data*" since that is not relevant to this application, but to NIC-11809-H1Y3W. 15. In respect of the Study ID: a. To clarify that the study ID is not related to the cohort under this application, and b. To clarify that it is not included as part of the pseudonymised cohort, and c. That the unique HES ID is not the same across both DSA's and that linkage cannot be made at record level. 16. In respect of risk stratification: a. To remove reference to risk stratification models since this applies to NIC-11809-H1Y3W, OR b. If relevant to this application to provide a justification for their inclusion, and c. to provide narrative how those models will be open and published, and d. to reflect what research goals will be achieved. 17. In respect of the benefits in section 5(d) in line with the NHS Digital's DARS Standard for Expected Measurable Benefits: a. To remove any specific outputs from section 5(d) (iii) and move to section 5(c), and b. To preface the benefits in this DSA are benefits across both applications (this application NIC-155843-0MQMK-v4.17 and NIC-11809-H1Y3W) which outlines the need for a comparison to allow research to take place, and

	c. To update the paragraph beginning "*improved patient care*" to ensure the language reflects this cohort and not the wider population, and d. To make clear the difference between the identifying an individual patient who would benefit from direct care interventions and cohorts of patients who are of interest to commissioners for planning, for example, and e. To update section 5(d) to use a form of wording such as "*it is hoped* …", rather than "*it will…*", and f. To remove reference to "*their GPs' will also be informed of the results of the risk stratification via the hospital consultant team*" unless a clear accrued benefit can be articulated, and g. To amend "*clinicians to help better manage their clinical populations*" to reflect that "*clinicians treating cohorts of patients under their care…", and* h. To remove reference to "*South Asians as they are more likely to present with cancer due to genetic risk factors.*" as a benefit, since this is not reflected in the outputs of the application, study protocol and if it is a realisable benefit, then this study is not looking at that particular output. The following advice was given: 1. IGARD suggested that, if not already happening, the applicant involve relevant public and patient groups for the lifecycle of the project in line with HRA guidance on Public Involvement. It was agreed the conditions would be approved out of committee (OOC) by IGARD members.
4 **4.1**	<u>Applications progressed via NHS Digital's Precedent route, including the SIRO Precedent</u> Applications that have been progressed via NHS Digital's Precedent route, including the SIRO Precedent, and NHS Digital have notified IGARD in writing (via the Secretariat). <u>NIC-448252-L2R6Q-v3.4 NHS England (No Presenter)</u> The purpose of the application was to enable the AMR programme to understand the impact that the COVID-19 pandemic has had on the utilisation of antimicrobial agents and associated resistance changes versus patterns pre-pandemic, taking into account the indications that there have been significant changes in primary prescribing patterns, in order to inform the key actions to ensure effective antimicrobial stewardship and appropriateness of clinical prescribing going forward as the country starts to come out of the pandemic. IGARD noted that this application was last reviewed at the IGARD business as usual meeting on the 16th June 2022 where IGARD had been supportive of the application but unable to make a formal recommendation as there was not a quorum of members available (potential conflict on the part of the GP Specialist member present). IGARD noted and thanked NHS Digital for the written update and supported the next iteration of the DSA being brought to a future IGARD BAU meeting, however noted that section 1 (Abstract) in response to the request by IGARD to remove the conditions from section 6 (special conditions) that had been inserted at the request of PAG had stated "*this has not been done due to this needing to be discussed with PAG*". IGARD noted that they had met with the PAG Deputy Chair on the 23rd June 2022 and that the outputs were disseminated to NHS Digital. The PAG Deputy Chair had been clear that PAG feedback should not directly population section 6 without a requisite rationale. IGARD suggested that the application summary be updated in line with the current agreed narrative between the PAG Deputy Chair, IGARD and NHS Digital.

5	Oversight & Assurance IGARD noted that they do not scrutinise every application for data, however they are charged with providing oversight and assurance of certain data releases which have been reviewed and approved solely by NHS Digital. Due to the volume and complexity of applications at today's meeting, IGARD were unable to review any Data Access Request Service (DARS) applications as part of their oversight and assurance role. IGARD Members noted that they had not yet been updated on the issues raised at the 27th May 2021 IGARD business as usual (BAU) meeting with regard to previous comments made on the IG COVID-19 release registers March 2020 to May 2021. IGARD noted that in addition, they had not been updated on the issues raised on the IG COVID-19 release registers June 2021 to April 2022. IGARD noted that the NHS Digital webpage excel spreadsheet had now been updated for the period March 2020 to April 2022: NHS Digital Data Uses Register - NHS Digital. IGARD noted that the IG COVID-19 Release Register May 2022 had been circulated and reviewed out of committee by members, discussed in-meeting and agreed the comments that would be shared with the Privacy, Transparency and Ethics Directorate.
6	COVID-19 update *No items discussed.*
7 **7.1**	AOB: IGARD Meeting Quoracy IGARD noted that following consideration by IGARD members, it had been agreed with NHS Digital that from the 26th March 2020 IGARD business as usual (BAU) meeting in-meeting quoracy may be temporarily reduced to three members (from four members), which must include a Chair and at least two specialist members. This was to ensure business continuity in the event that COVID-19 impacted on members ability to dial-in to meetings (due to COVID-19 illness or caring for a household member with COVID-19) and to support those IGARD members who had other roles linked to the COVID-19 response. Noting the recent recruitment and that membership had now increased to 9 members, it was agreed that this requirement was no longer required and that quoracy would revert to pre-pandemic and in line with the published IGARD Terms of Reference and Standard Operating Procedures which was 4 members including a Chair and at least 2 specialist members. IGARD noted that the pandemic was far from over, and that this will be reviewed as and when required. This related to COVID-19 only and asked that the next formal update in IGARD minutes would be the end of December 2022. There was no further business raised, the Acting Chair of the meeting thanked members and NHS Digital colleagues for their time and closed the meeting.

Appendix A

Independent Group Advising on Releases of Data (IGARD): Out of committee report 24/06/22

These applications were previously recommended for approval with conditions by IGARD, and since the previous Out of Committee Report the conditions have been agreed as met out of committee.

NIC Reference	Applicant	IGARD meeting date	Recommendation conditions as set at IGARD meeting	IGARD minutes stated that conditions should be agreed by:	Conditions agreed as being met in the updated application by:	Notes of out of committee review (inc. any changes)
NIC-625841-T2V6N-v0.4	Cancer Research UIK	19/05/22	1. In respect of the Data Processor and in line with NHS Digital DARS Standard for Data Processors: a) To provide written confirmation why the University of Oxford, are not considered a joint Data Processor; noting the activities outlined in the protocol of the Big Data Institute at the University of Oxford; or, b) To update the application throughout to reflect the University of Oxford as a joint Data Processor, and as borne out of the facts; or, c) To update section 5(a) to confirm that the University of Oxford do not undertake any data processing activities. a) To provide written confirmation in section 5 as to why the University of Oxford are not considered a joint Data Controller, in line with NHS Digital's DARS Standard for Data Controllers, and as borne out of the facts.	IGARD Chair	Acting Chair (due to absence of IGARD Chair & IGARD Deputy Chair)	None

NIC-332870-B6Z4R-v0.10	London School of Hygiene and Tropical Medicine (LSHTM)	03/03/22	1. In respect of data minimisation: a) To update the application throughout in line with NHS Digital DARS standard for data minimisation; and b) To outline the steps taken to ensure the minimum amount of data possible is used to create the comparison group; To ensure that any data not required is destroyed and that the applicant has provided a data destruction certificate.	IGARD Members	Quorum of IGARD members at the IGARD BAU meeting on the 23/06/2022.	None

In addition, a number of applications were processed by NHS Digital following the Precedents approval route. IGARD carries out oversight of such approvals and further details of this process can be found in the Oversight and Assurance Report.

In addition, a number of applications were approved under class action addition of:

Liaison Financial Service and Cloud storage:

- None

Optum Health Solutions UK Limited Class Actions:

- None

Graphnet Class Actions:

- None