Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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9(2)(a) [redacted]

[redacted]

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RE Official information request CDHB 10507

I refer to your email dated 14 December 2020, requesting the following information under the Official Information Act from Canterbury DHB regarding data sharing at DHBs and PHOs. Specifically:

1. Do you have a privacy officer and at what level of DHB leadership do they sit?

Canterbury DHB has a shared privacy officer with West Coast DHB. This is a senior leadership position.

2. Do you have a chief data officer and if so, what is their responsibility in the organisation?

Canterbury DHB has a Chief Digital Officer, which as part of their role involves ensuring patient management systems have the appropriate technical security relating to access to patient identifiable data (e.g. passwords, firewalls, etc), their role also requires ensuring that for DHB staff that have access to systems containing patent identifiable data that before access is granted they sign a form agreeing to abide by the policy of the DHB around access and release of data.

Canterbury DHB also has a Decision Support team that provides data at different levels of detail, including patient identifiable, for reporting, audit, analysis and research purposes. To establish what information requestors are entitled to see a purpose use matrix is consulted and appropriate approvals are sought.

3. How do you gain patient consent for data sharing - ie via a consent form? (please provide a copy of the form or statement that explains how patient data is shared)

A variety of forms are used in various clinical settings that include collection of patient consent as appropriate to the nature of service being provided. Statement on our policies on the gaining of patient consents, including data capture and sharing, is jointly covered by the Canterbury DHB's Informed Consent Policy (copy attached as **Appendix 1**) and Release of Patient Information Policy.

Other supporting DHB policy, national guidelines and legislation relevant to the Canterbury DHB in regard to the capture, holding and sharing of information to individual persons include:

- **Guidelines for Informed Consent of Children**
- **Health Information Privacy Code 2020**
- **On the Record - A Practical Guide to Health Information Privacy**
- **Privacy Act 2020**
- **Official Information Act (OIA) 1982**
- **Health Act 1956**
- **Health and Disability Standards 2008**

Depending of the level and purpose of the information patient consent may not be gained if you are sharing information due to safety concerns, for example: under provisions of the Family Violence Act. The Ministry of Health has produced guidance in this regard in their publication Information Sharing Guidance for Health Professionals from 1 July 2019 Wellington: Ministry of Health. **https://www.health.govt.nz/system/files/documents/publications/health-professional-guidance-information-sharing-from-1-july-2019.pdf**

Further, we share information with a patient's other health providers/caregivers under section 22F Health Act 1956. This would generally involve a discussion with the patient, or if they lack capacity, appropriate others.

4. For what purposes are you sharing patient identifiable health information within the DHB?

a. Clinical care
b. Analytics
c. Quality improvement
d. Planning
e. Research

Data that identifies individuals is primarily shared between directly inter-related health care services for the purposes of clinical care for the individual patients concerned. This includes clinical care interactions with patient identifiable information commonly shared as National Health Identifiers (NHI) through administrative and national data collections. Information relating to individual persons may also be shared with other agencies involved in the care and/or protection of those people as outlined in the answer to Question 5 below.

All staff and contractors who work within the DHB are subject to strict confidentiality clauses as part of their employment engagement with respect to all and any patient information that they may view or hear and/or have to share or work with as part of their daily work within our health services. Any breaches of this confidence that may occur in relation to patient information are subject to being dealt with accordingly as an employment matter or as otherwise befits the nature and scope of the breach.

With the exception of information mandatorily supplied to national data collections held by the Ministry of Health, no individual patient identifiable data is released externally to any other agencies for the specific purposes of analytics, quality improvement, planning or research outside of established policy.

Where internal planning, analytics, quality improvement work, surveys, or research is undertaken, any resultant data or reporting is only released with anonymised information, such that individual persons cannot be identified.

5. ***Do you share patient identifiable information outside of the DHB and if so, with what other entities? Ie other DHBs, PHOs, GPs, NGOs, social services. If so, what agreements do you have in place to support this?***

Contractual Agreements are in operation with service providers and government agencies where data sharing of relevant identifiable individual patient health information is required, including agencies such as ACC, Oranga Tamariki, Tamariki Ora, Police, other DHBs, General Practices, Ministry of Social Development, and to third party NGOs as outlined in the answer to Question 8 below.

See answer to point 3 above regarding the sharing of data with other agencies. Please also refer to Section 22F of the 1956 Health Act which outlines the mandate to share information between healthcare providers who are providing diagnostic and other health care to the same patients. This may be found at the following website address:
https://www.legislation.govt.nz/act/public/1956/0065/latest/DLM306662.html

6. ***Do you share any personal data directly with patients? (appointment and discharge letters/ emails to patients should not be included in this definition of 'sharing personal data')***

a. If yes, what data do you share and via what method?

Yes. The release of Health information, current or historic, to patients is available via this link to CDHB website:
https://www.cdhb.health.nz/wp-content/uploads/8ae1e609-release-of-health-information-form.pdf

7. ***Do you plan to let consumers access and contribute to their own health information online, via something like a patient portal, in the future?***

a. If so: when do you plan to implement and what info will be shared first?

Canterbury and West Coast DHBs plan to implement a consumer engagement solution that will allow patients to better manage their own care. We are still in the preliminary stages of investigation.

8. ***How does your organisation govern data sharing?***

There is no specific governance group, but there is a recently formed Privacy Governance Group which will promote the DHB's compliance with the Information Privacy Principles, including principles 10-12, which relate to sharing of information.

As per question 5 above, please refer to Section 22F of the 1956 Health Act which outlines the mandate to share information between healthcare providers who are providing diagnostic and other health care to the same patients. Governance of data sharing across agencies is otherwise provided through a formal agreement with specific purpose of intent of use of information, timeframe and roles, and a limitation of the data shared with and between vendors, health service providers and other Government agencies if not cover by the provision of legislation. Examples of this include view of near real time data of St John Ambulance or Health Line services of patients accessing our Emergency Department services.

In 2014 there were a series of workshops across the Canterbury Health System to develop a framework for sharing data, and in particular to agree when it is permissible to share identifiable data.

One of the outcomes of those workshops was the development of an agreed Purpose/Use matrix which provides examples of when it is appropriate to provide identifiable data (Patient or Provider dependant on the purpose for which the request relates). **Note** the importance that it is the purpose for which the data is to be used, not the role that the requestor has. This requires consideration of the purpose on each occasion a request to share data is made, rather than defaulting to the role of the requestor.

A copy of the Canterbury Information Use & Management Use & Management Group (IUMG) Healthsafe Purpose-Use Matrix is attached as **Appendix 2.**

In general, we operate on the principle of sharing the least-identifiable data at all times when we receive requests for data.

I trust this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

Informed Consent

Purpose

To ensure CDHB and WCDHB follow an approach to informed consent which:

- is patient-centred and supports people to make an informed and voluntary choice about their care; and
- complies with relevant legal, ethical and professional standards regarding informed consent.

Policy

Informed consent is part of all clinical service and must be obtained from a patient before any treatment is provided, except where:

- specific legislation allows the treatment to be provided without consent;
- the common law allows services to be provided without consent (for example, in an emergency); or
- the patient is incompetent.

The informed consent process involves four elements including:

- checking to ensure the person is **competent** to make the decision to undergo or refuse the proposed treatment;
- effective communication;
- providing the person with **sufficient information** to enable to them to make an informed decision about the proposed treatment; and
- the person giving consent **voluntarily.**

Informed consent is not the act of filling out a form, but rather a process of exchange of information so that an informed decision can be made by that person.

Competence

Every person is presumed competent unless there are reasonable grounds for believing that the person is not competent.

The person must be capable of understanding the essential nature of their condition along with the treatment proposed, its intended benefits, risks and possible side effects.

A competent person has the right to refuse treatment or services, even if it is not in their best interests, results in significant harm, or even death.

Medication, intellectual disability, mental illness, the influence of alcohol or other substances or physical injuries all may affect the informed consent process, and may amount to reasonable grounds for believing the person is not competent. In each case reasoning outlining why the person is not considered competent must be documented.

A decision which seems unwise to others is not reasonable grounds for believing the person is incompetent.

Information about Capacity, and assessing Capacity, can be found on Hospital HealthPathways under *'Legal and Ethical'*.

Treatment of an incompetent person

Except in case of emergency, if the patient is rendered temporarily incompetent, the planned health care procedure should be delayed until the patient is able to provide informed consent. See pages 5 and 6 regarding treatment of an incompetent patient.

Competence and children

The health professional must assess competence of a child as with an adult. Capacity includes the ability to understand and to make a decision in relation to the particular treatment. The assessment and the child's decision must be documented in the clinical notes.

Children 16 years and over: Under the Care of Children Act 2004, a child who is 16 years or over, or is or has been married, in a civil union, or living in a de facto relationship can consent, assuming he or she is competent, to any medical procedure (including blood donation and surgical and dental procedures). Consent to medical treatment and procedures expressly includes the right to refuse consent.

Children under 16 years: It is generally agreed that children under 16 years of age can consent to their own treatment if they are competent to make a decision about the particular treatment.

Incompetent children: If a child is incompetent to make an informed choice and give informed consent, services may be provided:

- With the consent of the child's legal representative; or
- In an emergency, to save the child's life or prevent serious risk to his or her health;
- Without consent, provided the treatment is in the child's best interests and the requirements set out in Right 7 (4) of the Code have been satisfied.

Effective communication

Information is to be provided in a form, language and manner that enables the person to understand the information provided to them. Where necessary and reasonably practicable, this must involve arranging for an independent interpreter to be present in person or by phone. Interpretation by family members or other personal support persons should not be relied upon. This is because the lack of independence creates an inherent risk to the accurate exchange of information.

The Booking and Requesting Interpreters procedure gives information on the limited circumstances when family, friends and untrained staff members can interpret.

The environment must be one in which the person and the provider of the health and disability services feels that they are able to communicate openly, honestly, and effectively.

Sufficient information

Every person has the right to information that a reasonable person, in that person's circumstances, would expect to receive, including:

- An explanation of their condition;
- An explanation of the options available, including an assessment of the expected risks, side effects, benefits and cost of each option (including no treatment);
- The estimated duration for the service
- The possibility of additional treatments or procedures that can be anticipated,
- Any proposed participation in teaching or research, including whether the research requires and has received ethical approval;
- Any other information required by legal, professional, ethical and other relevant standards;
- The results of tests; and
- The results of procedures.

Other relevant information may include private treatment options, the option of a second opinion, implications of existing advance directives, issues related to the use of blood products, issues related to body parts, precautions following the procedure, recovery and planned follow-up.

In many situations, a patient would expect to be informed of which clinician will be performing or leading their treatment. For example, in some cases a patient will consent to a procedure at a pre-admission clinic but enter a pooled waiting list for a theatre booking with the next available surgeon. In this situation, the patient should be informed of the process for allocating theatre bookings and advised who their surgeon will be prior to their procedure.

The discussion should include an opportunity for the individual to ask questions and have their questions answered.

The discussion must take place with a person who is suitably qualified and experienced and has sufficient knowledge of the individual's condition and the proposed services.

Voluntary choice

The individual must be allowed to make a decision (either to accept or decline healthcare services) freely, without any form of coercion or constraint.

Documentation of consent

Consent (oral or written), must always be recorded in the patient's clinical notes. If written consent is required, it must be obtained using one of the forms associated with this policy or another form which has been approved as an exception by the legal team and the Chief Medical Officer.

Written consent

Consent must be obtained in writing if:

- General anaesthetic or conscious sedation is to be used;
- There is a significant risk of adverse effects;

- The patient is to participate in any research;
- The procedure is experimental.

Recordings and imaging

Where recordings and imaging are made as part of patient treatment or management, informed consent is required.

These recordings and imaging may only be used for education and research purposes if appropriate consent is given *(see Agreement to Clinical Imaging form).*

Refusal or withdrawal of consent

Every competent patient has the right to refuse service and withdraw consent for service for any reason (including religious beliefs).

- This decision must be respected (noting the few exceptions regarding decisions on behalf of children and incompetent persons).
- The person should be informed of the implications their refusal may have on their clinical outcome.
- The best standard of care and support possible in the circumstances is to be offered to that patient.
- No undue influence or pressure is to be brought to bear on that patient.

Appropriate members of the clinical team must be informed of the decision.

The following should be documented in the patient's clinical notes;

- A full account of what happened (including date and time);
- What the patient was told, his or her response;
- Whether any relatives or witnesses were present;
- An assessment of the patient's competence.

It may sometimes be appropriate, if the risks are unusually high, to ask the patient to provide a written acknowledgment of their refusal and their acceptance of the risks involved. This record is not to be framed as a waiver of responsibility or liability by CDHB or WCDHB. CDHB and WCDHB remain responsible for the quality of care we provide and our actions.

When this decision is made by one or more people on behalf of a child or incompetent person, there may be provision for the decision to be legally challenged. For example, a person holding an enduring power of attorney for an incompetent adult cannot refuse treatment intended to save the person's life or prevent serious damage to their health. When situations such as this occur, advice should be sought from the Clinical Director / Corporate / Legal.

How long is the consent valid for?

The validity of consent is variable. If any of the following situations are fulfilled the patient's consent should be considered invalid and retaken:

- The nature of the procedure changes

- There is progression of the condition
- Change in the health status of the individual (prognosis)
- Change in the individual's competence
- Change in the expected outcome or side effects
- Change in treatment options
- Elapse of more than 3 months between consent and the beginning of the treatment.

Advance directives

Every person has the right to use an advance directive under Right 7 (5) of the Code of Rights.

An advance directive is made by the person, while they are competent, about a possible future health care service that is intended to be used only when the person is incompetent. An advance directive can be made orally or in writing but for clear communication and evidentiary purposes a written advance directive is preferred.

A valid advance directive is binding on health professionals and should be followed unless there are reasonable grounds for believing it is not valid.

An advance directive is valid when the person:

- Was competent;
- Anticipated and intended his or her decision to apply to the prevailing circumstances;
- Had been sufficiently informed to make the decision; and
- Reached their decision without undue influence or coercion.

Persons legally entitled to give consent on a person's behalf

A welfare guardian or an Enduring Power of Attorney (EPOA) for personal care and welfare can consent on behalf of an incompetent adult.

- They cannot refuse treatment intended to save a person's life or prevent serious damage to a person's health.
- An EPOA is activated when a health practitioner has certified that the patient is mentally incapable. This "activation" must occur before an attorney can act in respect of a "significant matter".
- An EPOA for property cannot consent to personal care or treatment decisions.

A person cannot consent on behalf of an incompetent adult simply because they are that person's next of kin, a member of their family or a close friend.

Treatment without consent under Right 7(4)

Where a person is not competent to make an informed choice and give informed consent, and no person who is legally entitled to consent on the patient's behalf is available (and it may not be an emergency), right 7(4) allows a health professional to administer treatment without consent where:

- It is in the best interests of the person;
- Reasonable steps have been taken to ascertain the views of the person; and

Either:

a) If the person's views have been ascertained, and having regard to those views, the health professional believes, on reasonable grounds, that the provision of services is consistent with the informed choice the patient would make if he or she were competent; or

b) If the patient's views have not been ascertained, the health professional takes into account the views of other suitable persons who are interested in the welfare of the patient and available to advise the health professional. The suitable persons are not being asked to give informed consent. Rather it is a matter of taking their views into account in deciding whether the proposed treatment is in the patient's best interests and the patient would have consented.

Treatment without consent where permitted by legislation

Some specific legislation overrides an individual's right to refuse treatment. This includes:

- *The Mental Health (Compulsory Assessment and Treatment)* Act 1992, where statutory criteria are met for treatment of mental disorder.
- *The Substance Addiction (Compulsory Assessment and Treatment)* Act 2017, where a court has ordered detention for the treatment of alcohol or drug dependence.
- *The Health Act 1956* provides for compulsory treatment in specified circumstances, e.g. some Infectious Diseases.

Students and teaching

Informed consent must be gained for the presence or involvement of students or other staff who do not have a direct role in the treatment team during the health care procedure. The reasons for the presence or involvement must be explained to the patient.

The clinician is expected to exclude any students during the discussion to allow the patient to make a decision without undue pressure (real or perceived).

Additional treatments or procedures

If an unexpected event occurs and the person has not given their prior informed consent to any additional treatments, no further treatment can be undertaken without first pausing to obtain consent, unless those treatments are required in an emergency situation or immediately for the preservation of life.

Applicability

Applies to all CDHB or WCDHB staff (permanent or casual/temporary), including contractors, visiting health professionals and students working in any CDHB or WCDHB facility and to all organisations providing services and treatment on behalf of CDHB or WCDHB.

Roles and Responsibilities

Obtaining consent

The registered health professional who is responsible for the service/treatment being proposed has duty of care to enable an informed choice to be made about that treatment before any treatment begins.

This responsibility may be delegated provided that delegated person is suitably qualified and experienced and has sufficient knowledge of the individual's circumstances, condition and the proposed service/treatment.

Legal advice

The legal team is responsible for advising on informed consent when requested.

The legal team will oversee legal obligations and potential concerns and complaints relating to consent for CDHB and WCDHB.

Training

Education on informed consent is professionally and clinically based. CDHB and WCDHB's informed consent processes and divisional practice will be included as part of clinical staff induction and ongoing training within their department as required.

Governance

Divisional quality teams monitor informed consent processes through customer feedback and regular reporting processes, escalating concerns to clinical governance committees when necessary.

Clinical governance committees will ensure that compliance with this policy is monitored. The focus of monitoring is to verify that the:

- Informed consent process occurs.
- A written consent is obtained when appropriate.
- Consent and the discussions between the health professional and person are recorded in the clinical notes.

Policy measurement

Incidents and complaints relating to poor compliance with the policy are reported using the Incident Management Reporting System.

Patient experience feedback will provide data about informed consent.

Area or topic specific audit will occur as per local audit schedules.

Associated material (inclusive)

Related documents

- Agreement to Treatment form
- Request for Treatment form
- Treatment without consent form
- Agreement to Clinical Imaging Form
- General photography/ Video Filming consent
- Electronic Interpreter Booking form
- Interpreter Services Patient Information

Legislation and standards

- Code of Health and Disability Services Consumers' Rights 1996 Rights 5, 6 and 7.
- Health and Disability Services Standard 2008: 1.10
- Medical Council of New Zealand Statement on information, choice of treatment and informed consent, March 2011

Contents

Appendix 2

CANTERBURY INFORMATION USE & MANAGEMENT GROUP (IUMG)
HEALTHSAFE PURPOSE-USE MATRIX

		Purpose	Direct Patient Care	Clinical Audit	Service Management	Monitoring and Resource Allocation	Planning & Service Development	Academic Research
		Nature	Clinical Interaction	Clinical Interaction	Service Interaction	Service Interaction	Programme Interaction	Academic Interaction
		Used By	Clinician (responsible for patient care) Clinical Leader/ Director Clinical Coders	Clinician Clinical Leader/ Director Clinical Pathway Auditor Clinical Quality Auditor	Clinician Clinical Leader/ Director Practice Manager Product Manager/ Owner Service Manager	Alliance & Workstreams Operations Manager PHOs Planning & Funding	Alliance & Workstreams Community Public Health PHOs Planning & Funding	Case By Case
		Used For	Clinical Care	Quality Summary Feedback	Feedback Service Change	Allocation of resources Contract reporting Aggregate reports	Aggregate reports Population reports	Case By Case
Information		**Source**						
Patient	Demographic	Private	**Subject to the role based access matrix of individual frontline clinical systems**	**N**	**N**	**N**	**N**	**Subject to Ethics Committee processes and approval by the organisations that the information is being requested from**
		ACC		**I**	**I**	**N***	**N**	
		General practice		**I**	**I**	**N***	**N**	
		Public		**I**	**I**	**N***	**N**	
	Clinical	Private		**N**	**N**	**N**	**N**	
		ACC		**I**	**C**	**N**	**N**	
		General practice		**I**	**C**	**N**	**N**	
		Public		**I**	**C**	**N**	**N**	
		Sealed by patient		**N**	**N**	**N**	**N**	
Provider	Service/Facility	Private		**N**	**N**	**N**	**N**	
		ACC		**I**	**I**	**I**	**I**	
		General practice		**I**	**I**	**I**	**I**	
		Public		**I**	**I**	**I**	**I**	
	Clinician	Private		**N**	**N**	**N**	**N**	
		ACC		**I**	**I**	**N***	**N**	
		General practice		**I**	**I**	**N***	**N**	
		Public		**I**	**I**	**N***	**N**	

Version: Final(25Feb15)

I	Identifiable
C	Identifiable coded only (excludes clinical notes)
N	Non-identifiable

***** Canterbury DHB has legislative obligations to monitor the delivery and performance of services, provide information to the Minister and to provide identifying information essential for the purposes for which the information is sought. In addition, providers must make available any records that relate to services for inspection and for the purpose of verifying the claim for payment.

PURPOSE MATRIX DRAFT for CONSULTATION 19SEP13

	Purpose	Direct Patient Care	Clinical Audit	Service Management	Monitoring and Resource Allocation	Planning & Service Development	Academic Research
	Use/ Nature	Clinical Interaction	Clinical Interaction	Service Interaction	Service Interaction	Programme Interaction	Case By Case
	Used By	Clinician (responsible for patient care) Clinical Leader/ Director Clinical Coders	Clinician Clinical Leader/ Director Clinical Pathway Auditor Clinical Quality Auditor	Clinician Clinical Leader/ Director Practice Manager Product Manager/ Owner Service Manager	Alliance & Workstreams Operations Manager PHOs Planning & Funding	Alliance & Workstreams Community Public Health PHOs Planning & Funding	Case By Case
	Used For	Clinical Care	Quality Summary Feedback	Feedback Service Change	Allocation of resources, Contract reporting Aggregate reports	Aggregate reports Population reports	Case By Case
Information	**Disclosure Level**	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Patient Demographic - Private funded	Identifiable		N	N	N	N	
Patient Demographic - Private funded	Non-identifiable		Y	Y	Y	Y	
Patient Demographic - ACC funded	Identifiable		Y	Y	N	N	
Patient Demographic - ACC funded	Non-identifiable		Y	Y	Y	Y	
Patient Demographic - General Practice	Identifiable		Y	Y	N	N	
Patient Demographic - General Practice	Non-identifiable		Y	Y	Y	Y	
Patient Demographic - Public funded	Identifiable		Y	Y	N	N	
Patient Demographic - Public funded	Non-identifiable		Y	Y	Y	Y	
Patient Clinical - Private funded	Identifiable - Coded Clinical data only		N	N	N	N	
Patient Clinical - Private funded	Identifiable - All (incl Clinical Notes)		N	N	N	N	
Patient Clinical - Private funded	Non-identifiable (excl Clinical Notes)		Y	Y	Y	Y	
Patient Clinical - ACC funded	Identifiable - Coded Clinical data only		Y	Y	N	N	
Patient Clinical - ACC funded	Identifiable - All (incl Clinical Notes)		Y	N	N	N	
Patient Clinical - ACC funded	Non-identifiable (excl Clinical Notes)		Y	Y	Y	Y	
Patient Clinical - General Practice	Identifiable - Coded Clinical data only		Y	Y	N	N	
Patient Clinical - General Practice	Identifiable - All (incl Clinical Notes)		Y	N	N	N	
Patient Clinical - General Practice	Non-identifiable (excl Clinical Notes)		Y	Y	Y	Y	
Patient Clinical - Public funded	Identifiable - Coded Clinical data only		Y	Y	N	N	
Patient Clinical - Public funded	Identifiable - All (incl Clinical Notes)		Y	N	N	N	
Patient Clinical - Public funded	Non-identifiable (excl Clinical Notes)		Y	Y	Y	Y	
Patient Clinical Flagged by patient as "Sealed"	Identifiable - Coded Clinical data only		N	N	N	N	
Patient Clinical Flagged by patient as "Sealed"	Identifiable - All (incl Clinical Notes)		N	N	N	N	
Patient Clinical Flagged by patient as "Sealed"	Non-identifiable		N	N	N	N	
Provider Demographic - Private funded	Identifiable (Indivdual & Practice)		N	N	N	N	
Provider Demographic - Private funded	Identifiable Practice (not individual)		N	N	N	N	
Provider Demographic - Private funded	Non-identifiable		Y	Y	Y	Y	
Provider Demographic - ACC funded	Identifiable (Individual & Practice)		Y	Y	N	N	
Provider Demographic - ACC funded	Identifiable Practice (not individual)		Y	Y	Y	Y	
Provider Demographic - ACC funded	Non-identifiable		Y	Y	Y	Y	
Provider Demographic - General Practice	Identifiable (Individual & Practice)		Y	Y	N	N	
Provider Demographic - General Practice	Identifiable Practice (not individual)		Y	Y	Y	Y	
Provider Demographic - General Practice	Non-identifiable		Y	Y	Y	Y	
Provider Demographic - Public funded	Identifiable (Individual & Practice)		Y	Y	N	N	
Provider Demographic - Public funded	Identifiable Practice (not individual)		Y	Y	Y	Y	
Provider Demographic - Public funded	Non-identifiable		Y	Y	Y	Y	
Service/ Event Utilisation (non-clinical)	Identifiable		Y	Y	Y	N	
Service/ Event Utilisation (non-clinical)	Non-identifiable		Y	Y	Y	Y	

Subject to the role based access matrix of the individual frontline clinical systems

Subject to Ethics Committee processes and approval by the organisations that the information is being requested