

Commercial principles for data-enabled research and innovation partnerships in the NHS

Practical costing guidance from a working group of
Northern Health Science Alliance (NHSA) NHS Trusts

October 2026



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Foreword

The responsible use of NHS patient data is central to advancing research, innovation and the development of new technologies that improve health outcomes. At the same time, NHS organisations have a duty to safeguard patient information, steward public assets responsibly, and ensure that commercial activity delivers appropriate value for patients, the NHS and society. As commercial interest in health data grows, NHS organisations are increasingly being asked to provide access to data, analytical expertise, infrastructure, clinical insight and associated services in support of research, innovation, product development and validation activities.

In mid-2025, the Northern Health Science Alliance (NHSA) recognised a common challenge across NHS organisations. While commercial data access requests were becoming more frequent and more complex, there was no published guidance to support the NHS in identifying and costing the full range of activities required to respond to them. This created a risk that organisations could unintentionally undervalue NHS data assets, underestimate the resources needed to deliver projects safely and effectively, or adopt inconsistent approaches that weakened the collective position. By convening senior representatives from member NHS Trusts across the North of England, an NHSA working group has shared experiences, compared local approaches and explored the practical realities of delivering data-driven projects. Throughout these discussions, members reached a clear consensus that NHS organisations differ in their governance arrangements, technical infrastructure, delivery models and local approval processes. Equally, requests to use data can range from straightforward cohort identification activities to highly complex projects involving data curation, advanced analytics, artificial intelligence development, secure environments, clinical expertise and long-term collaboration.

For these reasons, this guidance does not seek to prescribe prices, tariffs or commercial terms. Instead, it focuses on the principles, processes and cost inputs that organisations should consider when responding to requests involving NHS patient data. The aim is to provide a practical framework that helps organisations identify the full scope of work required, understand the resources involved, and make informed local decisions about costing and commercial engagement.

A consistent theme throughout the working group's deliberations has been the distinction between cost and value. The cost of delivering a project includes technical, governance, infrastructure and staff effort. The value of NHS data, however, extends beyond these inputs. NHS organisations contribute unique assets, expertise and public trust that can materially enhance the value of commercial innovation. Understanding both dimensions is essential if the NHS is to engage confidently and sustainably in the rapidly evolving data and artificial intelligence (AI) landscape.

As a result, this guidance has been developed in the spirit of "One NHS", reflecting the belief that organisations are stronger when they learn from one another and approach common challenges collectively. It is intended to support greater consistency across organisations while recognising the need for local flexibility. It is also intended to complement, rather than replace, evolving national initiatives and infrastructure, including Secure Data Environments (SDEs), Trusted Research Environments (TREs) and any future national guidance for the NHS.

Finally, this document should be regarded as a snapshot in time. As policy, technology, governance requirements and commercial models continue to evolve, so too will the approaches described within. The working group members position this guidance as a useful starting point for NHS organisations seeking to develop robust, transparent and sustainable approaches to commercial data access requests, which contributes to a broader conversation about how the NHS can maximise the public benefit derived from its data assets while safeguarding resources and maintaining public trust.

On behalf of the Northern Health Science Alliance (NHSA) working group

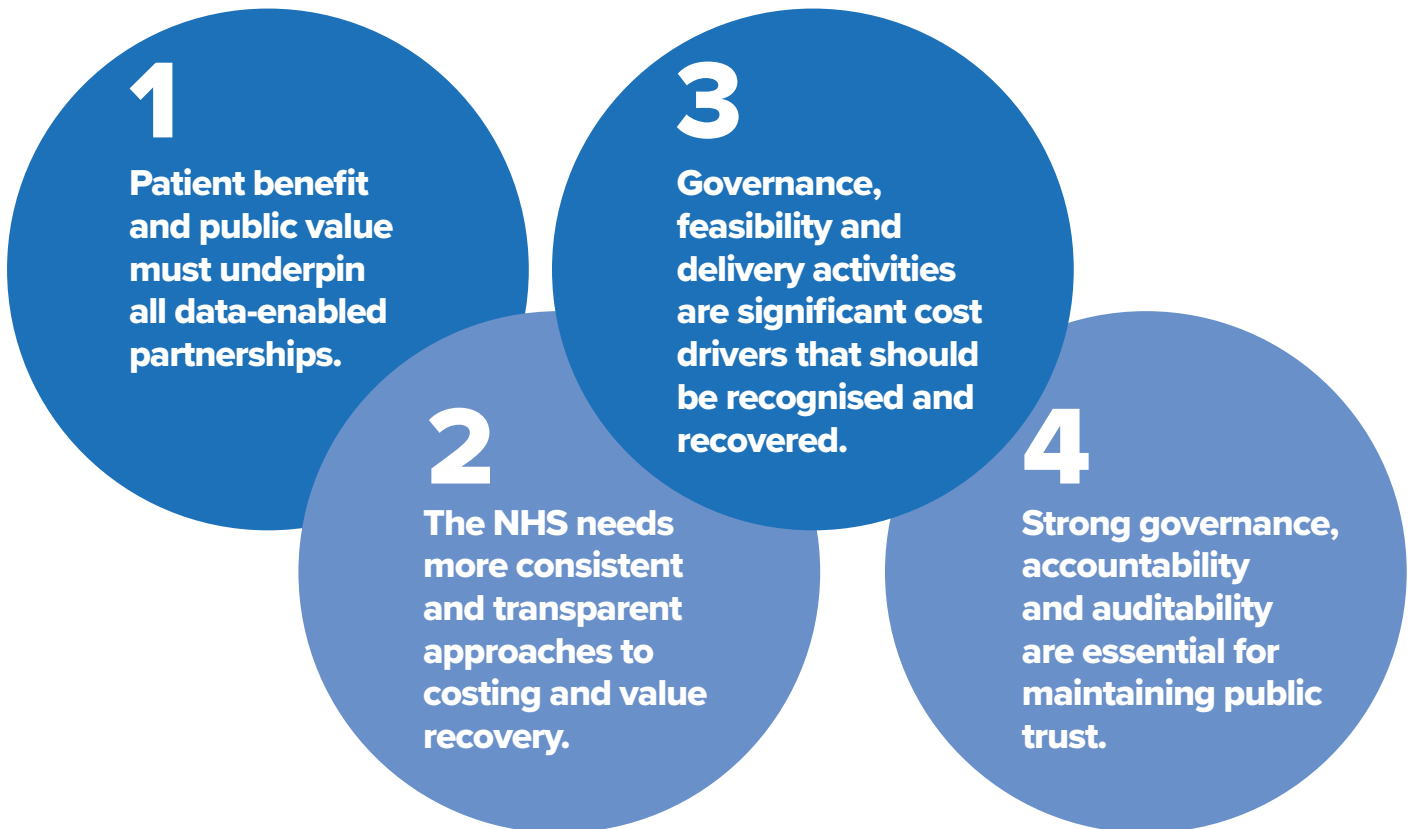


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Key findings



Introduction

The Northern Health Science Alliance (NHSA) is the North of England's health partnership, bringing together leading research-active NHS Trusts and universities across a population of approximately 16 million people, together with the four northern Health Innovation Networks (HINs). A core strength of the NHSA is its ability to create scale and facilitate collaboration across organisational boundaries, enabling members to address shared challenges and opportunities that are difficult to tackle individually. Through its networks and programmes, the NHSA supports collaboration between the NHS, academia and industry to maximise research, innovation and health impact across the North of England.

The NHSA Working Group on Costing Commercial Uses of Patient Data was convened in October 2025 to address the absence of practical guidance to support consistent, transparent and equitable costing of commercial requests involving NHS data. Membership of the working group reflected a broad range of senior leadership, operational and technical expertise drawn from NHS organisations across the North of England. Contributors included directors and associate directors of research and innovation, commercial enterprise and innovation leads, heads of data science, research governance specialists, secure data environment and trusted research environment practitioners, and experts in commercial data partnerships, health data research, information governance and digital transformation. This combination of strategic, operational and technical perspectives enabled the guidance to be grounded in real-world experience from organisations at different stages of commercial maturity.

The group's purpose, scope and operating principles were agreed through a formal Terms of Reference at its inception. Members met regularly, predominantly through monthly virtual meetings, supplemented by an in-person workshop and focused expert sessions with external contributors, including colleagues from the Yorkshire and Humber Secure Data Environment (SDE). Throughout the work, members shared local policies, costing approaches, governance processes and lessons learned from commercial partnerships. The guidance that follows reflects a collaborative process of discussion, challenge, consensus-building and peer review across multiple organisations, with the aim of supporting a more consistent and coordinated approach to costing commercial data-driven projects across the NHS.

Statement on the use of Microsoft Copilot

The working group routinely used Microsoft Teams transcription and Microsoft Copilot-generated meeting summaries to support the capture of discussions, actions and emerging themes across meetings. Copilot outputs were used to assist in drafting working papers, collating evidence from multiple meetings, identifying common themes, supporting the development of illustrative examples, and preparing draft versions of this guidance. These outputs were used as working materials only and were subject to review, challenge, correction and refinement by working group members.

1. Core costing principles

This NHTA guidance builds upon the following core NHS principles, published by the Department of Health and Social Care (DHSC) in 2019: [Creating the right framework to realise the benefits for patients and the NHS where data underpins innovation](#). In summary:

1. Use of NHS data must have an explicit aim to improve patient health and care or the operation of the NHS.
2. Ensure 'fair terms' for the NHS and safeguard the value of the data
3. NHS organisations should not enter exclusive arrangements, nor undermine the wider NHS digital architecture.
4. Arrangements should be transparent and clearly communicated.
5. Arrangements should adhere to all applicable legal, regulatory, privacy and security obligations

The NHTA working group focused on principle 2, in the guidance which follows.

For the purposes of this guidance, "commercial" primarily refers to projects involving private-sector customers or commercial funding. However, the underlying principle of full cost recovery applies to all externally supported activity, including academic, public-sector and other non-commercial work.

1.1 Full cost recovery

All projects should be costed in a way that reflects the true staff effort required, technical and infrastructure overheads, governance and compliance workloads, specialist expertise, automation and tooling requirements, and the intrinsic value of NHS data.

Pricing must avoid a marginal-cost approach. NHS organisations should not subsidise externally funded projects through unrecovered staff time, infrastructure, governance, technical effort or organisational overheads. Locally approved charging policies, overhead rates and profit margins may differ according to the nature of the customer and project. Unspecified real-world examples from the working group members ranged from 20% to 90% negotiated margins, depending on the project and resources required.

"Commercial projects should not be viewed solely through the lens of delivery effort. Storage, governance, infrastructure and organisational overheads can all represent significant costs that need to be recognised."

– Katherine Boylan, Deputy Managing Director for Research and Innovation (Innovation), Manchester University NHS Foundation Trust

1.2 Consistency across organisations

While local rates will differ, the structure and logic of costing should be aligned across participating NHS organisations. This enables comparable commercial offers, reduced internal competition, clearer sponsor expectations, and easier collaboration across regions.

Consistency should apply to the categories of work included, how roles and day rates are described, how overheads are treated, and how feasibility work and value-based components are handled.

"For organisations receiving only occasional commercial data

requests, shared frameworks and common approaches can provide valuable consistency and reduce the need to reinvent local processes."

– James Illingworth, Research and Development Manager, Hull University Teaching Hospitals NHS Trust

1.3 Transparency for sponsors

Commercial customers should receive a clear explanation of what activities are required, how those activities are costed, why governance and preparatory work is essential, where overheads apply, and how any value-based or benefit-sharing component is handled.

At the outset, NHS organisations should clarify the nature of the request and the customer relationship. For example, a fully commercial product development project may be treated differently from investigator-initiated research, early-stage collaborative development or grant-funded work. The principle is not that every route has the same price, but that each organisation applies its own approved policy consistently and transparently. This transparency helps improve trust and prevents disputes later in the contracting process.

"Projects that begin as research activity may evolve into commercial validation or regulatory work. Clear conversations early on can help avoid misunderstandings later in the process."

– Jane Greenaway, Associate Director, University Hospitals Tees Group

1.4 Commercial overheads and value recovery

All projects should recover the full cost of delivery, including direct staff and technical costs, governance and compliance activity, infrastructure and appropriate organisational overheads. For commercial projects, NHS organisations should then consider whether an additional value-based or benefit-sharing component is appropriate, reflecting the contribution made by NHS data, expertise, infrastructure, clinical knowledge or other distinctive assets.

This additional value may be recovered through a specific value uplift, downstream revenue sharing, royalties, milestone payments, licensing income or alternative benefit-sharing arrangements. The distinction between cost recovery and additional value recovery should be explicit, transparent and locally approved.

"As commercial demand for NHS data increases, organisations need to understand both the operational costs of delivery and the value they are creating through access to unique NHS assets."

– Dipak Patel, Associate Director Research and Innovation, Sheffield Teaching Hospitals NHS Foundation Trust

Figure 1. How to assess the commercial value of NHS data and related services

Organisations should distinguish between the cost of delivering a project and the value contributed by NHS data, expertise, infrastructure and governance. While costs should be transparently identified and recovered, additional value may arise where NHS organisations provide assets, knowledge or capabilities that materially contribute to the commercial opportunity, product development, intellectual property or future commercial gain.

Lower-value project characteristics

- Commonly available datasets or information that could be obtained from multiple sources.
- Limited data preparation, linkage or curation activities.
- Minimal need for specialist clinical, technical or methodological expertise.
- Straightforward governance processes requiring relatively few approvals.
- Small-scale or short-duration projects with limited infrastructure requirements.
- Activities where the NHS organisation contributes primarily through routine service delivery rather than unique assets or expertise.
- Data requests that do not materially contribute to the creation of new intellectual property, products or competitive advantage.

Higher-value project characteristics

- Access to unique patient cohorts, specialist datasets or rare conditions.
- Extensive data preparation, linkage, pseudonymisation or quality-assurance activities.
- Significant input from clinicians, data scientists, analysts, informaticians or subject matter experts.
- Multi-organisational datasets or collaboration between multiple Trusts, SDEs or partners.
- Complex governance arrangements, approvals, public involvement activity or contractual negotiations.
- Use of specialist infrastructure such as Secure Data Environments (SDEs), Trusted Research Environments (TREs), cloud platforms or advanced analytical environments.
- NHS knowledge, expertise or datasets making a meaningful contribution to downstream commercial products, algorithms, intellectual property or future revenue generation.
- Projects where value-sharing, royalties or other benefit-sharing mechanisms may be appropriate alongside cost recovery.

The purpose for which NHS data are being used should influence commercial discussions and value assessment. Examples include:

- Initial feasibility assessments to determine whether a project is possible.
- Cohort identification and recruitment activities to support research or product development.
- Data preparation, analysis and technical support delivered by NHS organisations.
- Validation of healthcare technologies, algorithms or digital tools using NHS data.
- Development or refinement of commercial products using NHS expertise, data or infrastructure.
- Deployment of technologies within NHS settings to demonstrate real-world implementation.
- Multi-partner projects involving data linkage, SDE services or coordinated delivery across organisations.
- Commercial projects where NHS organisations retain an interest in future value creation through value-sharing, royalty or partnership arrangements.



2. Stages in costing a commercial data project

The costing process can be broken down into key components. Each component represents a non-negotiable activity required to safely and legally support commercial research involving NHS data. In practice, projects may move through these stages sequentially, iteratively, or in phases.

2.1 Initial enquiry and scoping

At initial enquiry, clarify the sponsor's question, intended use, expected data sources, likely patient population, proposed outputs, requirements for data access, and whether the work is feasible within the local governance and technical model.

This scoping stage should identify whether a standalone feasibility phase is required before a full project quote can be produced.

2.2 Feasibility assessment as a standalone chargeable stage

Many commercial projects start with a feasibility assessment stage. Some end after this assessment because the cohort is too small, the required data are unavailable, governance requirements are not proportionate, or the sponsor chooses not to proceed. Feasibility work can therefore become an unrecovered cost to the NHS if it is not recognised and costed appropriately.

Feasibility work may include cohort identification, inclusion and exclusion criteria checks, data availability assessments, technical scoping, and early clinical or methodological review. Where possible, feasibility should be costed and charged as a standalone stage. If this is not commercially acceptable, organisations should consider recovering feasibility effort within subsequent project pricing or through a risk-based overhead.

"Feasibility work is often dependent on specialist business intelligence and data teams whose capacity is already limited. Even determining whether a project is possible can require significant effort before any delivery work begins."

– Jane Greenaway, Associate Director, University Hospitals Tees Group

2.3 Project delivery

Projects may be delivered through a variety of technical models. Some are undertaken entirely within an NHS Trust using local infrastructure and specialist teams, while others rely on Secure Data Environments (SDEs), Trusted Research Environments (TREs), or hybrid delivery arrangements involving multiple organisations. Costing approaches should reflect the delivery model selected and the resources required to support it.

2.3a NHS Trust-delivered projects

Many data projects are delivered directly by NHS Trust teams using existing local infrastructure, data platforms and specialist staff. In these cases, technical setup activities may include establishing project workspaces, configuring access permissions, preparing data extraction and linkage processes, implementing monitoring and audit arrangements, and developing analytical workflows within existing Trust systems. The extent of technical setup will vary according to project complexity and local capability.

Costs should reflect the staff time required from technical, data, information governance and specialist support teams, using locally approved day rates and overheads. Organisations should also consider the resource implications of data preparation, quality assurance, testing,

project management and any bespoke technical development required to support delivery. The purpose of this stage is to ensure that the technical work required to safely deliver the project is fully identified and appropriately resourced.

2.3a - example scenario

A medical technology company approaches an NHS Trust seeking access to a de-identified dataset to evaluate an AI model for predicting hospital admissions. The Trust extracts and prepares the required data using existing Business Intelligence and Data Engineering teams, undertakes local information governance approvals, and performs the analysis within its own secure technical environment. No external SDE or TRE platform is used. Costs may therefore arise from feasibility assessment, data extraction and preparation, information governance review, project management, clinical input, analytical staff time and local infrastructure support.

2.3b - example scenario

A pharmaceutical company requests access to data from multiple NHS organisations to support validation of a digital biomarker. Rather than each Trust hosting the project independently, data are made available through an SDE/TRE platform. The project requires onboarding of external researchers, creation of a secure workspace, platform administration, audit monitoring, cloud computing resources, data curation, and coordination between participating organisations. Costs may arise from both local Trust activities and SDE/TRE service charges, including secure environment setup, infrastructure usage, governance support and ongoing platform management.

2.3b NHS + SDE/TRE-delivered projects

Some projects are delivered wholly or partly through an SDE, TRE, or other specialist data platform. In these situations, technical setup costs may include establishing secure project workspaces, onboarding users, configuring permissions, implementing monitoring and audit controls, developing data pipelines, and supporting platform-specific governance and operational requirements. Additional costs may arise where services are provided through Platform-as-a-Service (PaaS), Data-as-a-Service (DaaS), managed service arrangements, or through collaboration with external infrastructure providers.

Costs should reflect both the local staff contribution and any charges levied by SDE/TRE partners. Organisations should consider whether specialist platform support, cloud infrastructure, secure computing resources, or multi-organisation coordination arrangements are required. The aim is to ensure that the full technical and operational requirements associated with secure data access and analysis are recognised within the costing process.

"Emerging technologies such as automation and large language models can help make data preparation more efficient, but organisations still need to understand the underlying effort, expertise and infrastructure required to deploy them safely."

– David Ferguson, Consultant Surgeon, University Hospitals Tees Group

2.4 Infrastructure and operational costs

These costs may include secure storage, compute usage, high-performance compute, data transfer and processing infrastructure, ongoing platform maintenance, monitoring, audit logs, and cloud or third-party charges.

Cloud storage and high-performance compute costs can be materially significant. Organisations should estimate expected usage, length of analysis, variability in demand, and whether specialist platform support is required.

“The infrastructure costs associated with large-scale analytics are changing rapidly. Storage, compute capacity and specialist processing environments can become major cost drivers depending on the nature of the project.”

– Chris Herbert, Director of Operations: Research and Innovation, Leeds Teaching Hospitals NHS Trust

2.5 Governance, compliance, patient and public involvement and engagement (PPIE) and Data Trust Committee review

Commercial data projects require rigorous governance, including information governance review, Data Access Committee or Data Trust Committee processes, contracting discussions, risk assessments, documentation, approvals, and audit trails.

Where applicable, costing should include patient and public involvement and engagement (PPIE), lay review costs, lay member honoraria or reimbursement, facilitator support, and preparation work for citizen, patient or Data Trust Committee review. This is mandatory in some organisations and should not be absorbed by the NHS as an unfunded overhead.

“Governance activity is not an administrative overhead. Information governance review, committee oversight and public involvement all require skilled staff time and should be recognised accordingly.”

– Katherine Boylan, Deputy Managing Director for Research and Innovation (Innovation)

2.6 Project phasing

Many commercial studies are delivered in phases, such as discovery or feasibility, main analytical delivery, extension questions, validation, or follow-on analyses.

Phasing provides flexibility for the sponsor, clear contractual boundaries, and easier resource planning. Each phase should have a defined cost, deliverable, and decision point.

2.7 Data preparation and delivery: data as a service

Preparing data for research may include extraction, cleansing, coding and standardisation, quality assurance (QA), pseudonymisation, linkage across multiple sources, creation of research-ready tables, and making data available in a secure environment.

These steps should be costed according to staff roles and grades, time required, complexity of data sources, data quality issues, linkage requirements, and technical dependencies.

“The effort required can vary significantly between projects. Factors such as the availability of structured data, the need to review unstructured clinical records, cohort identification challenges, and the rarity of particular conditions can all have a substantial impact on the work involved.”

– Melanie Shield, Senior Commercial Business Manager, The Newcastle upon Tyne Hospitals NHS Foundation Trust

2.8 Automation and tooling

Commercial data projects may require automation tools, robotic process automation (RPA) bots, scripts, pipeline orchestration, repeatable data processing, and associated licenses or support arrangements. Automation should be visible in feasibility and costing assessments

rather than treated as an invisible technical assumption. Cost inputs may include design, build, testing, validation, support, licensing, monitoring, and decommissioning.

“Automation can significantly accelerate delivery, but the tools, development effort and ongoing support required are often overlooked. These costs need to be visible rather than assumed to be absorbed by existing teams.”

– Olufemi Olajide, Head of Data Science, Alder Hey Children’s NHS Foundation Trust

2.9 Specialist expertise and analytical support: consulting services

Many projects require domain expertise, such as clinical interpretation, advanced analytics, statistical design, methodological guidance, data science input, health economics, project management, and sponsor-facing engagement.

These should be costed separately, using the same role, grade and day-rate methodology. Expertise should not be absorbed into technical costs.

2.10 Value-based and benefit-sharing components

In addition to recovering operational costs, NHS organisations may apply a value-based or benefit-sharing element to pricing. The approach should be agreed locally and reflected clearly in the contract.

Whilst this guidance is primarily focused on identifying and recovering the costs associated with commercial data-enabled projects, it is also recognised that longer term strategic data partnerships with industry have a broader commercial value. Working group members highlighted a growing number of partnership models involving specialist data and analytics companies, where arrangements may include onboarding fees, platform or service charges, revenue-sharing, royalties, milestone payments, licensing income or other downstream benefit-sharing mechanisms rather than a simple fee-for-service approach. In these circumstances, NHS organisations should consider undertaking appropriate financial and commercial modelling to understand the anticipated costs, risks, benefits and value flows over the lifetime of the agreement. The working group also noted the value of peer-to-peer learning, particularly for organisations entering such arrangements for the first time. NHS organisations are therefore encouraged to engage with peer organisations that have experience of similar partnership models to understand practical lessons learned, governance considerations, implementation requirements and the extent to which anticipated benefits have been realised in practice. This reflects the working group’s broader commitment to shared learning and a collective “One NHS” approach to commercial engagement.

“Cost recovery is only part of the conversation. Organisations also need to understand the wider value of their data assets and develop sustainable models for commercial engagement.”

– Sam Prendergast, Head of Commercial Innovation, Mersey Care NHS Foundation Trust

Table 1: Summary of stages in costing a commercial project

Costing stage	Purpose
Initial enquiry and scoping	Clarify the sponsor's question, intended use, data sources, patient population, outputs, access requirements and feasibility within the local governance and technical model.
Feasibility assessment	Treat feasibility as a real, potentially chargeable stage, particularly where the project may not proceed to full delivery.
Environment and technical setup for project delivery	Cost secure environments, user access, monitoring and audit controls, workspace structures, data pipelines, and usage policies.
Infrastructure and operational costs	Include secure storage, compute, high-performance compute, platform maintenance, monitoring, audit logs and cloud or third-party charges.
Governance, compliance and PPIE	Include information governance, Data Access Committee or Data Trust Committee review, contracting, risk assessment, documentation, approvals, audit trails and PPIE or lay review where applicable.
Project phasing	Define each phase with a clear cost, deliverable and decision point.
Data preparation and delivery	Include extraction, cleansing, coding, standardisation, QA, pseudonymisation, linkage and creation of research-ready tables.
Automation and tooling	Make design, build, testing, validation, support, licensing, monitoring and decommissioning visible in costing.
Specialist expertise and analytical support	Cost clinical interpretation, analytical input, methodology, statistics, health economics, project management, and sponsor-facing engagement separately.
Value-based and benefit-sharing components	Consider value uplifts, revenue sharing, royalties, milestones or other public-benefit mechanisms where locally agreed.



3. Costing multi-organisation projects

Where a commercial project involves several NHS organisations, each organisation should cost its respective activities, while the sponsor-facing offer should be coordinated and easy to understand. Responsibilities must be clearly defined to avoid duplication, under-recovery, or gaps in delivery.

At the initial enquiry stage, organisations should ask whether the sponsor is already speaking with, or intending to approach, other NHS partners. This is a practical coordination check to reduce duplication, improve sponsor-facing clarity and support a stronger collective NHS position.

3.1 Practical coordination model

- Nominate a lead organisation or coordinating function to manage the sponsor-facing quote, assumptions log, delivery dependencies and communication between partners.
- Agree a common costing structure across partners, while allowing each organisation to apply its own locally approved rates, overheads and governance charges.
- Identify which organisation or partner will host the workspace, who will support access, and how data will flow between organisations.
- Separate costs for local data extraction, local governance, central workspace hosting, cross-site coordination, data linkage, and analysis support.
- Make explicit whether collaborating partners deliver tasks internally or rely on SDE, TRE, academic, industry or other technical partners.
- Maintain contact across partners to apply this guidance, so organisations can continue sharing learning about commercial models, sponsor expectations and common pitfalls without sharing commercially sensitive information.

“Where several organisations are involved, coordination itself becomes a deliverable. Time spent managing assumptions, dependencies, approvals and communications should not be overlooked.”

– Wayne Elliott, Associate Director of Commercial Enterprise, The Newcastle upon Tyne Hospitals NHS Foundation Trust

3.2 Roles, rates and partner alignment

A shared role taxonomy should be agreed at the start of each multi-organisation project. Partners do not need to charge identical rates, but equivalent roles should be described consistently so that sponsors can understand differences in costing. Local finance and information governance teams should be engaged early to confirm approval pathways and overhead treatment.

3.3 Projects involving wider UK partners

Projects involving non-NHS partners, such as devolved administrations, academic partners, national datasets or wider UK sites may have additional complexity. Differences may include local finance rules, data access models, contracting routes, information governance review, workspace hosting, data transfer arrangements, and benefit-sharing expectations.

For national multi-partner projects, the quote should include a coordination layer and should document how English, Scottish, Welsh or Northern Irish partners, where relevant, will cost local contributions, route approvals and participate in shared delivery. Previous multi-partner projects can be used as internal comparators where available, but local rates and governance requirements must be checked before reuse.

“For multi-site projects, presenting a coordinated sponsor-facing offer can simplify engagement considerably. Behind that offer, however, clear responsibilities and locally agreed cost inputs remain essential.”

– Chris Herbert, Director of Operations: Research and Innovation, Leeds Teaching Hospitals NHS Trust



4. Recommended process for applying these costing principles in practice

The following process is intended as a practical checklist rather than a fixed pathway. It should be adapted to local governance, finance and contracting routes.

- **Adopt a shared costing structure:** Use the principles above to ensure all organisations follow the same stages and include the same categories of work.
- **Clarify the nature of the request:** Confirm whether the request is commercial, research, business development, early-stage innovation or another route. Apply the right local policy for the right customer.
- **Ask about other NHS partners:** Check whether the sponsor is speaking to other NHS organisations, and whether a coordinated approach is needed.
- **Develop template quotes and cost breakdowns:** Use common templates for sponsor-facing quotes, internal assumptions logs and partner costing returns.
- **Align with finance, IG, legal, PPIE and data access teams early:** Ensure approval pathways, governance requirements,

lay review, overhead treatment and contracting assumptions are built into pricing.

- **Discuss feasibility charging expectations as a group:** A consistent stance strengthens negotiation where sponsors resist feasibility charges.
- **Review approaches for multi-organisation projects:** Agree how lead coordination, partner roles, workspace hosting, data flows and non-NHS partners will be handled.
- **Maintain a commercial assumptions log:** Record rate sources, overhead assumptions, infrastructure assumptions, sponsor dependencies, exclusions and value-sharing assumptions.
- **Review against real-world workflows before finalisation:** Check that task headings and activity lists reflect current operational workflows, including data-specific tasks, research costing models and any relevant comparisons such as National Institute for Health and Care Research (NIHR) National Contract Value Review (NCVR)-style costing approaches.

Figure 2. Commercial principles in practice

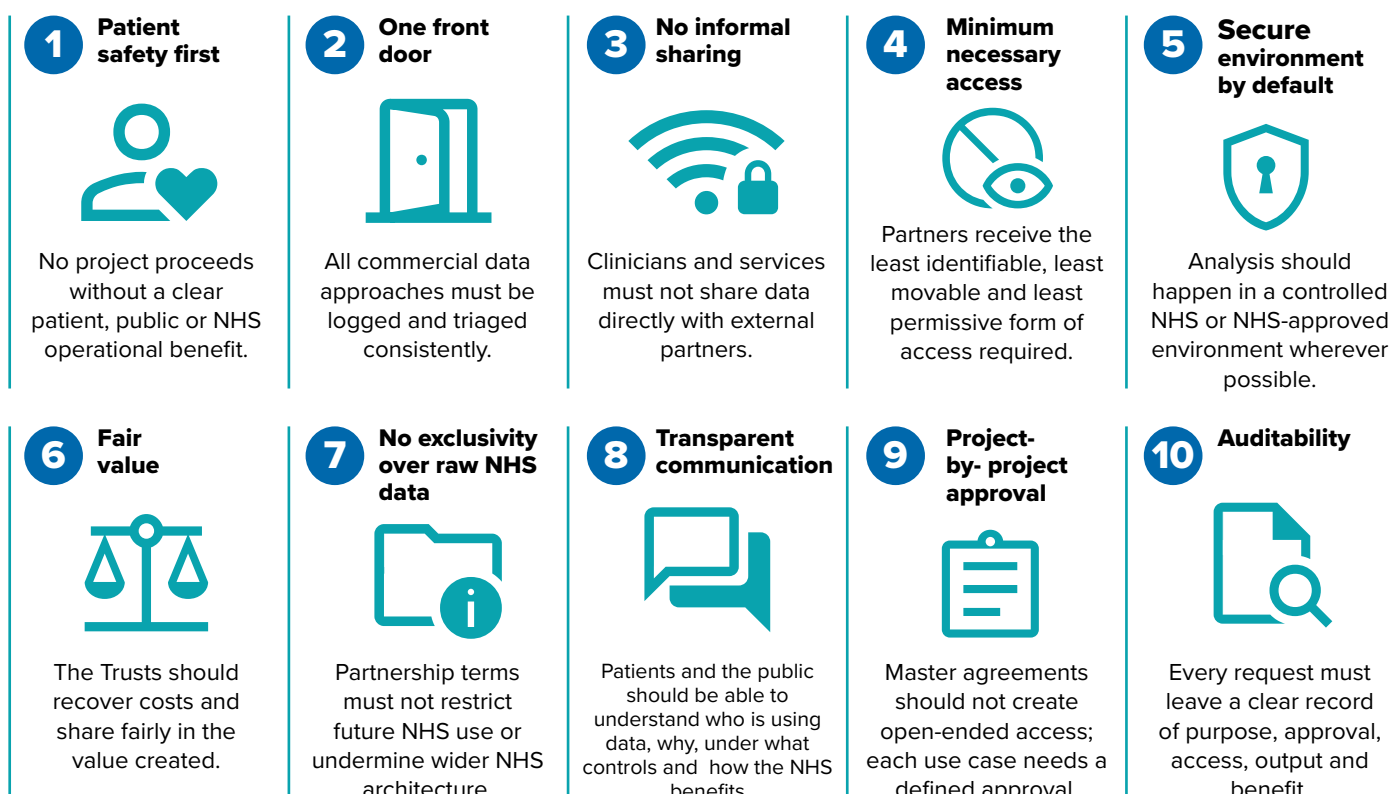


Figure 3. Recommended project delivery and benefits realisation process



5. Supplementary resources

A 'Frequently Asked Questions' (FAQ) document, a model costing template, and a worked example of the template are provided as supplementary resources on the [NHSA website](#). The accompanying costing template and worked example are provided as open resources under a Creative Commons Attribution 4.0 (CC BY 4.0) licence. Organisations may copy, adapt and reuse these materials, provided appropriate attribution is given to NHSA. The resources are illustrative in nature and are not intended to replace local financial, legal, procurement or information governance approval processes.

Disclaimer

The model costing template and worked example accompanying this guidance were developed using Microsoft Copilot to convert all stages and cost components set out in this guidance to an executable spreadsheet. All model cost input sources in the worked example are referenced in the final tab. These are intended as illustrative tools to support discussion, learning and local adaptation. They demonstrate a possible approach to identifying, structuring and documenting the costs associated with commercial data-driven projects and should not be interpreted as a standard tariff, a pricing schedule, financial advice, or a substitute for local policies, governance arrangements, contractual

requirements or finance approvals. The costing assumptions, rates, overheads, infrastructure costs, value-sharing mechanisms and illustrative figures presented are examples only and may not reflect the circumstances, policies or approved charging models of individual organisations.

The Northern Health Science Alliance (NHSA), members of the Working Group on Costing Commercial Uses of Patient Data, and any contributors to this guidance accept no responsibility or liability for any decisions, actions, financial outcomes, contractual arrangements or commercial negotiations arising from the use of the template or worked example. Responsibility for the selection, adaptation, application, quality assurance, validation and approval of any costing model, assumptions, calculations, outputs or resulting charges rests entirely with the organisation and individuals choosing to use them. Users should ensure that all figures, calculations, formulas, assumptions, governance requirements, infrastructure costs, staff rates, VAT treatment, value-sharing arrangements and contractual provisions are independently reviewed, verified and approved through appropriate local finance, commercial, legal, information governance and organisational approval processes before use in decision-making, pricing, contracting or external communications.

Summary of NHSA recommendations for costing data-enabled research and innovation partnerships in the NHS

1. Patient and public benefit should remain the primary consideration

Data-enabled research and innovation projects should demonstrate a clear patient, public and/or NHS operational benefit before access to NHS data is approved.

2. Greater consistency in costing approaches is needed

Variation in costing methods weakens the NHS negotiating position and can result in inconsistent recovery of value. More consistent approaches would support fairer and more transparent arrangements across organisations.

3. Direct data sharing with external partners is inappropriate

NHS organisations should not share data informally or directly with external partners outside approved governance, access and security arrangements.

4. Commercial activity should not be subsidised by the NHS

NHS organisations should recover the full costs associated with supporting externally funded projects and avoid the inadvertent subsidisation of commercial activity through unrecovered staff, infrastructure or governance costs.

5. Cost drivers extend beyond data extraction

The true costs of data-enabled projects often arise from feasibility work, governance processes, patient and public involvement, technical setup, infrastructure, specialist expertise, programme management and automation, rather than data extraction alone.

6. Feasibility work is a substantive project stage

Assessing whether a project is possible, appropriate and deliverable can require significant staff time and expertise. Feasibility should therefore be recognised as a legitimate and potentially chargeable stage of project delivery.

7. The value of NHS data extends beyond delivery costs alone

Approaches to pricing and value recovery should recognise both the operational effort required to deliver a project and the wider public value associated with NHS data assets.

8. Multi-organisation projects require coordinated delivery models

Collaborative projects benefit from a coordinated sponsor-facing approach, while still allowing participating organisations to apply their own locally approved rates, overheads and governance requirements.

9. Benefit-sharing arrangements should be transparent and explicit

Where benefit-sharing mechanisms are used, these should be proportionate, clearly defined and reflected in contractual arrangements from the outset.

10. Approval should be granted on a project-by-project basis

Framework or master agreements should not create unrestricted or indefinite access to NHS data. Each proposed use of data should be subject to appropriate review and approval.

11. Transparency and auditability are essential

All requests for access to NHS data should maintain a clear audit trail documenting purpose, approvals, access arrangements, activities undertaken and outputs generated.





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Teaching Hospitals
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NHS

Sheffield Teaching Hospitals
NHS Foundation Trust

NHS

Manchester University
NHS Foundation Trust

NHS

University Hospitals
of Liverpool
Group

NHS

Alder Hey Children's
NHS Foundation Trust

NHS

Mersey Care
NHS Foundation Trust