Digital North West London
Security & Access Sub Group
Friday 25th November 2016

In attendance:

Raj Seedhar
Angeleca Silverside
Janice Boucher
Stephen Murphy
David Grange
Jacqui Sinclair
Iain Purves
Ian Riley
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Sonia Patel
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Notes / Minutes

- Monthly meetings up until April, task and finish
- There is a conversation about the role of the sub-group and how the decision making is
- De-identified requests for the sub-group, PID to go to the GG to support the data controllers in common model that helps and support.
- Terms of reference should reflect, then ratified, then go out to all data controllers.
- Security incidents are not for this group, all data controllers have the responsible for all data controllers.
- Practices access, processing and new data requests. TOR to be called security and access.
- Question around how Incidents are managed, needs to be taken back to the GG
- Confirmation that we need to make sure that there is one representative from each area
- Mental Health and Primary care needs representation worked on.

Care Information Exchange (CIE)
- Question around whether we should start with a base line access to the general information or grant access to all as a standard- No legal barrier to giving access to all initially from a data protection point of view
- PKB to be a data processor and data controller, therefore there are 2 consents, one is for the Integrated Care Record (ICR) PART A and PART B is opening up the record to the patient.

There are differences between sharing all the record and only parts of the record to create an ICR.

- Conversation around the data controllers having a duty to share and the communication given.
- PKB and NWL change the status of the request of the patient to not share their information
- Lacks capacity and have to record this, and the public interest but you need to make sure that you have the right recording in place. Could also get a court order to over-ride patient's interest, under Mental Capacity Act.
- Patient also needs to have the option to give explicit consent
- Can this be done with safe questions? Possible but care professionals have the right to do it, and there is a need to record the reasons.
- No one should over-ride without good reason, only has 4 reasons stated above, to implement in CIE
- There is a question around whether you give access to others, power to break the glass are only those that are registered and regulated. Administrators should not have the right to change the consent.
- Further RBAC is being further developed by PKB using spine access to verify.
- Should the professional be able to amend the tags in data points- Patients can edit any data point. If patients move the data points and change categories, it will affect the access to professionals based on consent.
- Two points have accessed and two have not accessed the data points, need to come up to the justification to overcome the patient preference. This depends on the rule set for the category and what purpose information is being used and shared, need to make a professional view on it.
- HIV should not be classified as a discriminatory if put under the category of sexual health, it should be put in the general. However if the patient has put it under category of sexual health then there may be cover. This will be difficult to define as this is a case by case basis. Agreed that this is to be allowed until the patient has made a preference.

Outside networks
- PKB have to enforce the same sharing standards on all their other customers
- Important that is all data is being seen, that all use same principles
- How do we ensure that we add an email address on behalf of another organisation; is there is a risk for us that the patient doesn't know of.
- CIE are asking for organisations to identify and verify patients when updating their details. CIE don't keep any evidence of ID. Will continue to ask for the passport etc.
- Need to start an email chain to decide a way going forward
- GPG45 or the GP online should be using the authentication standard set and should be asked at GG

WSIC Dashboards
- Principles for access the de-identified data set

Hounslow request

- 2 practices outstanding for collection of data
- Patient level in 0-18 not possible at the moment, only for adults
- Can interrogate at row level but cannot report on it
- Proportionality and need to make sure the purpose compatible with the programme
- WSIC Need to define what the full list that is required. Only a subset.
- Like someone to QA the test data before it goes out
- Define data retention period

Like Minded Request

- Define data retention period
- Copy of the data sets

Network access request

- Needs to be CQC registered and have toolkit complete to level 2 and a signatory, legal entity
- Honorary contract does not give the duty to legally access the information
- Networks have to commit to attend at least half of the Governance Group meeting otherwise they are not allowed to sign and will be asked to leave the sharing as they would not be acting like a data controller
- For care navigators that are seconded into the large providers, there needs to be an ISA set up between 3rd party providers and the host organisation to mitigate the risk. If there are any breaches by the members that are hosted, liability needs to be taken up between the host partner provider and the 3rd party provider.

New models of care

- New configurations of care providers that are able to give access to organisations so they are able to perform care and plan for care on a population basis. Will be cross cutting a community
- Needs to be worked through further within this group.

Principles of access for non-GP's

- Proposing list of multiple patients and their summary of attendance from a watch list, can put an audit in place to drill down further within the patient journey
- GP's assumed to perform that function however it has emerged that community providers will be doing this
- The name and NHS number can be removed from the list. Can audit the access to PID – discussion around how we narrow it down so you can only see patients names.
- Write up a set of principles and bring back to the group for it to be adopted for future meetings

Feedback and comment from members on operational procedure

AOB

- Draft new forms for the data access forms for the next group

#	Date	Actions and Decisions
SA001	25.11.16	No one should over-ride patient's interest without good reason – CIE to implement only the 4 reasons stated as exceptions.
SA002	25.11.16	HIV should not be classified as a discriminatory if put under the category of sexual health, it should be put in the general. However if the patient has put it under category of sexual health then there may be cover. This will be difficult to define as this is a case by case basis. Agreed that this is to be allowed until the patient has made a preference.
SA003	25.11.16	Need to start an email chain to decide a way going forward.
SA004	25.11.16	GPG45 or the GP online should be using the authentication standard set and should be asked at the governance group.
SA005	25.11.16	Someone to be identified to quality assure the test data before it goes out.
SA006	25.11.16	Define data retention period
SA007	25.11.16	Like Minded Request • Define data retention period • Copy of the data sets
SA008	25.11.16	For network access, there is a need to have CQC registration and have completed the IG toolkit to level 2 and signatory, legal entity
SA009	25.11.16	Honorary contract does not give the duty to legally access the information.
SA010	25.11.16	For care navigators that are seconded into the large providers, there needs to be an ISA set up between 3rd party providers and the host organisation to mitigate the risk. If there are any breaches by the members that are hosted, liability needs to be taken up between the host partner provider and the 3rd party provider.