DATA PROTECTION IMPACT ASSESSMENT (DPIA)

DPIA Screening Questions E120

Will the proposed processing involve a large amount of personal data and affect a large number of data subjects?	Y
Will the project involve the use of new technologies?	N
Is there the risk that the processing may give rise to discrimination, identity theft or fraud, financial loss, damage to the reputation, loss of confidentiality of personal data protected by professional secrecy (e.g. health records), unauthorised reversal of pseudonymisation[1], or any other significant economic or social disadvantage?	N
Is there the risk that data subjects might be deprived of their rights and freedoms or prevented from exercising control over their personal data?	N
Will there be processing of genetic data, data concerning health or data concerning sex life?	N
Are the data to be processed revealing racial or ethnic origin, political opinions, religion or philosophical beliefs, or trade union membership?	N
Will there be processing of data concerning criminal convictions and offences or related security measures?	N
Will personal data of vulnerable natural persons, in particular of children, be processed?	Y
Will personal aspects be evaluated, in particular analysing or predicting aspects concerning performance at work, economic situation, health, personal preferences or interests, reliability or behaviour, location or movements, in order to create or use personal profiles?	Y
Will the project include a systematic and extensive evaluation of personal aspects relating to natural persons which is based on automated processing, including profiling, and on which decisions are based that produce legal effects concerning the natural person or similarly significantly affect the natural person (e.g. a recruitment aptitude test which uses pre-programmed algorithms and criteria)?	N
Will there be a systematic monitoring of a publicly accessible area on a large scale (e.g CCTV)?	N

If 'Y' to any questions – proceed to complete DPIA template below

[1] 'pseudonymisation' means the processing of personal data in such a manner that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person- eg the NHS number

DATA PROTECTION IMPACT ASSESSMENT (DPIA) template V.2.1

Project title	Integrated Respiratory Team (IRT)
Date DPIA started	30th August 2018
DPIA prepared by (project lead with email address)	[redacted]

1. DESCRIPTION OF PROCESSING

1.1 Summarise the project or change, including the benefits (*helpful to refer to/link to other documents such as project proposal/initiation document*)

An enhanced Integrated Respiratory Team (IRT) will receive joint funding from OCCG and Boehringer Ingelheim (BI) over an 18 month pilot period. The aim of this project is to reduce acute diagnosis time, optimise clinical management over asthma, COPD (Chronic Obstructive Pulmonary Disease), bronchiectasis, interstitial lung disease including sarcoidosis and airways clearance advice for patients with neuromuscular disease or on NIV (Non Invasive Ventilation).

Those involved will be CSU (South Central and West Commissioning Support Unit), OCCG (Oxfordshire Clinical Commissioning Group), BI (Boehringer Ingelheim), OHFT (Oxford Health NHS Foundation Trust), OUHFT (Oxford University Hospitals NHS Foundation Trust), Primary Care (GP Practices), and Smoking Cessation provider – Solutions4Health.

The different data reports created will be as follows:

1. Worklists developed by SCW and GP advisor to IRT project are sent out to practices through EMIS Enterprise Search and Reports (EESR). No PID data will be visible to SCW or the GP advisor. No SUS data will be involved.
2. Evaluation of project using pseudonymised data (record level) extracted from primary care data using EESR. Aggregate data will be shared with OCCG, BI and Oxford University.
3. Pseudonymised dataset (record level) extracted from SUS for evaluation purposes. Data will be pseudonymised within SCW only. Aggregate data will be shared with OCCG, BI and Oxford University
4. SUS data will be extracted by SCW analysts and returned to DSCRO for re-identification and sending directly to GP practices for them to import into their EMIS system and work with for direct patient care. We anticipate an average of 6 patients per practice per month and that this will be done on a monthly basis.

Confidentiality agreements will be in place between all clinical members of the IRT project who will be accessing this data and the Practices in question. Attached below are the process flows showing the data and how it will be used by the clinical members of the IRT for direct patient care.

The data in 4 above is regarded by OCCG as being for direct care purposes because it refers to patients who have had a recent respiratory emergency admission to hospital who need additional clinician focus to identify unmet needs and address these appropriately in consultation with the patient or their carer.

GP practices will be asked to update their Fair Processing Notices (FPNs).


PRM V003.docx


Undiagnosed COPD V003.docx


Weekly IRT Clinical MDT Meeting V003.dc


DPIA SUS Data Flow.docx

The clinical members of the IRT, made up of individuals from OHFT, OUHFT and Solutions4Health, will be using the patient information within Primary Care as follows:

- Triaging patients using search data within EMIS to outline which patients require additional care and discussion during Population Review Meetings, Community Clinics and Multi-Disciplinary Team meetings
- Receiving an EMIS IRT referral from primary care
- Entering outcomes of clinical care into EMIS via a Data Entry Template
- Booking and scheduling of IRT clinical appointments within EMIS using EMIS Remote Consultations

Data gathered from providers (primary care record, OUHFT, OHFT) which is processed and analysed by CSU will be used to monitor and evaluate the project. BI will only ever have access to fully aggregated data in the course of evaluating and monitoring the project, this will include suppression of patient numbers below 5. No patient identifiable or pseudonymised data will be shared with BI. The evaluation of the project will be shared publicly in the interests of transparency and wider learning for the NHS, however this will only include fully anonymised and aggregated data. It will be made clear to BI that any information must be destroyed after use and must not be shared.

The Oxford Academic Health Science Network (AHSN) is being appointed as the independent 3rd party evaluator. They will receive aggregated data with the authorisation from the OCCG Caldicott Guardian.

The project will initially be launched in the North and City localities for a period of 15 months. The pilot is scheduled to finish Spring 2020. If the pilot proves to be successful in those areas then it will be rolled out to the rest of the county.

1.1.1 Is there another way to achieve the same outcome without using any PID?

No except to use Insights – IPA which already links data as standard for risk stratification purposes.

1.2. Describe exactly the data to be used, the data flows, and the retention period for the data. If this is a trial or pilot project, include the criteria, process and data that will be used for evaluating its outcome

All data which is to be used as part of the project will be pseudonymised/aggregated by the CSU. The only patient identifiable data which will be used will be by GPs or Clinicians as part of the IRTs, this is in order to act on the decisions made as part of the IRT whilst delivering direct patient care..

The data used from the CSU will be in the form of commissioning data sets.

1.2.1 List each data item, the source of that data and how the data will be received at the CCG:

Data	Source	Method received	Retention period	Will it be shared further?
Commissioning data sets	OCCG/NHSD	Standard datasets	In line with OCCG and SCW Policy	Yes, with AHSN, Oxford University and BI
Primary Care Data (EMIS)	EMIS Enterprise Search and Reports		In line with OCCG and SCW Policy	Yes, with AHSN, Oxford University and BI

1.2.2 If the Source for any data is NHS Digital (eg SUS) do you have NHSD permission to use the data for the proposed purpose?

YES – CSU Commissioning Data Sets.

(Do we have permission for this data based on previous agreements with the CSU?)

1.2.3 Draw / describe the flow of data.

See pages 2/3 above

*Only aggregate data will be shared with BI (Boehringer Ingelheim) subject to the agreement of the OCCG Caldicott Guardian. A Joint Working Agreement has been created and signed by all parties of the project which confirms what BI will do with this data. The confidential Joint Working Agreement will be provided separately as an appendix to this document.

2. COMPLIANCE & PROPORTIONALITY MEASURES

2.1 What is the lawful basis for processing the personal data under GDPR/DPA 2018?
(refer to IG Lead or NHS Digital guidance, particularly sections 5 and 6)

UNDER GDPR/DPA 2018

PROCESSING PERSONAL DATA: Article 6.1.(e) - It is necessary for the performance of a task carried out in the public interest or under official authority vested in the Controller.
Relying on this lawful basis requires that:

1. It is necessary for the controller to process the personal data for those purposes (i.e it is reasonable, proportionate and cannot achieve the objectives by some other reasonable means) and
2. The controller can point to a clear and foreseeable legal basis for that purpose under UK law (whether in statute or common)

Statutory power and official authority:

GP Practices: NHS England's powers to commission health services under the NHS Act 2006 or to delegate such powers to CCGs.**CLINICAL COMMISSIONING GROUPS** - NHS Act 2006.

NHS Digital: Health & Social Care Act 2012.

DPA 2018 section 6(1) (e) '…for the performance of a task carried out in the public interest or in the exercise of official authority…. This is outlined to cover the use of pseudonymised data which would be used by the CCG.

2.2 Is the project only using anonymised data? No

2.3 Is the project only using pseudonymised data inc NHS no? **No. We will be asking DSCRO to re-identify patients using NHS Numbers for report 3 (see top of document) otherwise will be extracting pseudonymised level data.**

2.4 If the project is processing ***Personal*** Data – what is the legal basis: Direct patient care

PA: Same as 2.1 above

No data will be processed by the CGG directly. It will only be reviewing information which has been anonymised by the CSU and then used in reports and potentially dashboards.

2.5 If the project is processing ***Special Category*** Data (e.g. health)- what is the legal basis:

No

2.6 Does any of the data include that from children or other vulnerable groups?

Children - No
Vulnerable groups – Likely (vulnerable groups are not being specifically targeted but may be selected / reviewed due to their medical conditions / diagnosis.

2.7 What is the purpose of processing and what lawful ground is relied on under Common Law Duty of Confidentiality? **(**refer to IG lead)

The Purpose is: Direct Patient Care

The second purpose is indirect care for evaluation purposes but no identifiable data will be shared with OCCG.

3.RISK ASSESSMENT AND MITIGATION MEASURES

3.1 List the relevant stakeholders who have been consulted about data protection and privacy risks (name, role)

[redacted] – Information Governance Manager
[redacted] – Head of Service Delivery & DSCRO Business Lead

3.2. Describe any data protection and privacy risks identified

Describe the source of risk and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary.	**Likelihood of harm** Remote, possible or probable	**Severity of harm** Minimal, significant or severe	**Over all risk** Low, medium or high
1. There is a risk that members of the IRT will be able to access patient information which is not specifically for use within the IRT project.	Remote	Significant	Low
2. Working with a Pharmaceutical company can be perceived to present a risk related to influencing prescribing decisions or transfer of data	Possible	Significant	Low

3.3. Describe the risk management measures agreed (what, why, who, when)**, including how they will be implemented**

1. As for all clinicians using patient records, there will be an audit trail on the EMIS clinical system which will mitigate the risk. Also, honorary contracts are to be put in place between IRT members accessing patient systems and GP Practices detailing the need for patient/practitioner confidentiality which is in any case already part of their professional responsibility

2. Working with a pharmaceutical company can be perceived as a risk. However the OCCG position is that no personalised or pseudonymised information will be shared with BI – only aggregated information will be shared and this can only occur after the information governance (Caldicott) team have sanctioned this. All members of the IRT have been made aware of this. We have signed a robust working agreement (see attached) with BI. There has been a formal review of this project within OCCG related to the risk and appropriateness of working with BI which supported the project going ahead. Prior to the project commencing, OCCG already had agreed which were the formulary medication choices for COPD and asthma and these choices do not favour BI.

3.3.1 Identify additional measures you could take to reduce or eliminate risks identified as medium or high risk in 3.2

Risk	**Options to reduce or eliminate risk**	**Effect on risk** Eliminated reduced or accepted	**Residual risk** Low, medium or high	**Measure approved** Yes/no

1)				
2)				

4.1 Comments / Recommendations - signed by the DPO

Signed (DPO) **Date**

4.2 where requested – comments/recommendations of DPIA Panel

SCW CSU DPIA IG Panel Comments:

- Oxfordshire CCG's Caldicott Guardian approval needed for data processing to take place in relation to flow '4' above (SUS data through DSCRO for re-identification), stating that re-identification of these small number patients are for direct care of the individuals.
- Each GP practice can only have access to its own patient data for re-identification and not from the other surgeries involved.
- DPIA SUS Data Flow above needs updating as:

DPIA SUS Data Flow.docx

- Patient needs to be kept informed before the primary care EMIS referral form is sent out to clinical members of IRT, lest there is no surprises on the patient side and also to comply with confidentiality requirements on patient's 'reasonable expectation'.
- Only aggregate data with low numbers suppressed (<5) will be shared with BI (Boehringer Ingelheim) and The Oxford Academic Health Science Network (AHSN) subject to the agreement of the OCCG Caldicott Guardian.

The Purpose is: Direct Patient Care for first phase and Indirect Patient Care for evaluation phase.
To comply with Common Law Duty of Confidentiality:

- Implied Consent
- Informed consent for GP referral to IRT.

Signed (DPIA Panel) [redacted] **Date 25 March 2019**

4.3 Approved and signed by the SIRO/CG (where DPO advice is overruled, note the reason)

Signed (SIRO) **Date**