

Legal advice regarding Healthcare Commission Diabetes Survey
(Full reproduction of articles written by GPC Lawyer, Shanee Baker)

Firstly, the honorary contract is not necessary and should not be signed by any practice. It is not a question of it being onerous or legally unsafe, it is really much too complicated and unnecessary to have something like this in place to achieve the result that the Healthcare Commission are seeking.

As I understand it, the Healthcare Commission is a statutory independent body (i.e. a public body), engaged by the NHS to conduct in this case, a diabetes survey which is intended to collect detailed data about care, treatment and information from people with diabetes. The data will be used by the HC to assess PCTs and ultimately to improve services for patients with diabetes. We always need to enquire as to why the information is required and for what purpose before we consider releasing information.

Release of patient identifiable information is normally contrary to the principles set out under the DPA. However, there are certain exemptions and qualifications to this which we investigated and resolved almost a year ago when the NHS Code of Confidentiality was agreed and published. The GPC commissioned advice from Ian Gatt QC and the Department of Health commissioned advice from Philip Sales QC. The instructions they received were extremely detailed and although principally revolved around QOF audits, could be extended to most types of requests for a disclosure of patient information.

In summary, disclosure in the context of the DPA will constitute processing and under the first data protection principle (part 1, schedule 1 DPA) such data can only be processed if: one of the conditions in schedule 2 is satisfied and one of the conditions in schedule 3 is satisfied.

In layman's terms, the disclosure of data in an unrelated form can only occur without a patient's consent, if it necessary and it conforms to one of the conditions set out in each schedule. Under Schedule 2 the condition that may apply, is where the processing is necessary for the exercise of any other functions of a public nature exercised in the public interest by any person. The key word in this context is **necessary**. It must be shown that the purpose cannot be possible to be achieved with a reasonable degree of ease without the processing of personal data other than by consent. In this case, in order to improve services for patients with diabetes the processing may be necessary and in the public interest.

One of the conditions in Schedule 3 paragraph 8 which also must be satisfied is that "*the processing is necessary for medical purposes and is undertaken by a) a health professional or b) a person who in the circumstances owes a duty of confidentiality equivalent to that which would arise if the person was a health professional*"

Paragraph 8 (2) further provides that "medical purposes" includes the management of healthcare services.

The current survey can fall within these sections and therefore will be compliant; with the DPA. The people assessing the information must be health professionals and if they are not, then, they must be subject to some form of confidentiality undertaking. I understand that these people have signed up to the Caldicott rules and if that is indeed the case then this condition is satisfied.

Apart from the DPA the common law rule of confidentiality should also be considered in relation to processing of confidential patient information. The Health Service (Control of Patient Information) Regulations 2002 (SI2002/1438) overrides the common law of confidence in relation to the processing of confidential patient information for the purposes of "the audit, monitoring and analysing of the provision made by the Health Service for patient care and treatment".

Conclusion

1. We must be clear that the survey is limited to diabetes and nothing else.
2. The people handling the information must be subject to confidentiality undertakings if they are not health professionals.
3. No honorary contract is necessary.
4. All practices taking part in disclosing patient names and addresses must keep a record of the reasons for doing so.
5. All practices should make it clear in their surgeries through leaflets and posters exactly how patient information is being utilised.
6. If a practice has only a handful of diabetic patients and it is relatively easy to contact those patients to inform them of the disclosure, then they should.
7. Section 60 of the Health and Social Care Act is usually used in drastic or emergency cases but in the light of the interpretation of the DPA, should not be applied here.
8. It is proper in the circumstances to apply the advice given by external lawyers to the situation at hand and I can see no factors that would dictate different rules should apply.

I think we should set the above position out clearly to the HC and ask them to confirm whether this is the basis upon which they are operating or should be operating and wait for that confirmation in writing."

FURTHER INFORMATION FOLLOWING DISCUSSION WITH THE ASSISTANT COMMISSIONER

My previous advice which is mirrored on our expert advice is still valid, but I would like to emphasise the points below which I discussed today with the Assistant Commissioner. These are preliminary thoughts and the IC has promised to revert with a more formal opinion. I expect to receive this within the next few weeks. My opinion and this advice is given on a without prejudice basis and subject to the final formal approval of the IC. However, we should be reasonably comfortable that any advice will not deviate substantially from my previous e-mail and the comments below, and indeed, the Assistant Commissioner appeared to be quite comfortable with the general overview. I would stress however that any publication of these views are publicised with this caveat and not in isolation.

Preliminary View

1. Section 60 of the Health and Social Care Act is only applied for the purposes of research and therefore not relevant here.

This is as we thought.

2. In terms of the management and performance of health care issues and the application of fair processing, he agrees that Schedule 2 and 3 of the DPA could apply and is comfortable that with appropriate compliance and checks accepts that the provision of patient identifiable information is disclosable where it is a necessary function of the operation of the NHS bearing in mind the statutory provisions, contractual provisions (nGMS) and public interest.

This is in line with our negotiations with the DoH and the view of our experts

3. Fair processing however should entail the GP doing all that is reasonable in the circumstances to ensure that patients are aware of what is happening to their information and even in certain circumstances, contact those patients directly for consent where it is not prohibitable to do so.

We have constantly advised practices to display leaflets and posters in their practices and where appropriate to either obtain consent or anonymise where possible. The fact that some doctors or practices may not be doing this is not for want of the GPC in providing guidance which directs them to do so. GPs need to ask the appropriate questions of the PCT or the Healthcare Commission or any other agent of the PCT with regard to the purpose of the

enquiry and the application of the information once obtained. This is important with regard to any audit trails. It is also worth asking which group of individuals will be handling the information, if they are not health professionals they should be subject to confidentiality arrangements. This is as we have stated previously.

4. He said that as long as PCTs were adopting a privacy friendly approach towards the people they were addressing, he does not think this is impossible to square with the DPA and NHS functions where GPs are concerned.

The HealthCare Commission sent us the letters that they were proposing to send to patients after they had obtained their names and addresses. This was sent to us for comment. As it is, those letters do not conform with the preliminary view of the Assistant Commissioner. His concern is mainly that letters sent to patients should be worded in a manner which does not directly, or in detail, refer to their specific illness in the event that the letter is sent to the wrong address or ends up in the hands of another family member. This is especially important when you have members of the same family with similar first initials and the same surname. I frankly don't understand how this will work because in any event, even if the patient calls and agrees, any questionnaire will still have to be sent to his address and there is still a chance another family member may gain access to it. I did mention that the overall public interest may override the handful of circumstances where this may occur and he is looking into it.