

Data (beyond the NHS) to support people in the next¹ national (medical) emergency (pandemic, etc.)

Summary: The Chief Medical Officer should have a reserve power to be able to direct / approve emergency *temporary* data uses in Government – satisfying vital interest as a DPA purpose – when those uses would be supported by emergency COPI powers *inside* the NHS.

This CMO-led approach, drawing equivalence to COPI inside the NHS, would replace any 'special process' for Digital Economy Act (DEA) approvals in the context of medical emergency situations² or others. Any required statutory updates can be included in the COPI-etc bundle. We understand the Department of Health in England is doing pre-consultation work for updating COPI regulations which we have not seen. Any changes would need to be trustworthy.

However, if any party wants to take the extraordinary powers of "wartime",³ it is first necessary to demonstrate competence and trustworthiness in "peacetime" – something the Cabinet Office (CO), Central Digital & Data Office (CDDO) and the Government Digital Service (GDS) have failed to do with regard to the DEA. The CMO is a permanent secretary at the Department of Health which is where such responsibility should lie.

Any DEA-based process will be unfit for this purpose

To maintain public confidence, especially in situations that may become contentious, there must be ongoing full transparency. An emergency process should rely solely on those who recognise the responsibilities of the process and are willing to meet them.

The DEA is a tangled mess of evasions of responsibility by CO/CDDO/GDS over time, and has shown itself to be incapable of operating correctly at a slow pace, let alone in cases of urgency.⁴ CO and CDDO have shown no interest in resolving those issues, and have repeatedly gone out of their way to avoid any responsibility for any of them at all. That failure in an emergency environment cannot be ignored.

¹ Technically, the next emergency after COVID-19 is now known as mpox.

² CO/CDDO has not shared any scenarios for non-medical contingencies, so they are outside the scope of this note.

³ Taking Dame Kate Bingham's framing

⁴ Our many Fols show this, most notably this one

https://www.whatdotheyknow.com/request/subgroups_of_the_dea_review_boar

What CDDO should do

When the pandemic hit, the NHS had flexible contingency plans, and implemented them – and all those plans involved continuing to follow governance rules,⁵ not undermining them.

That approach should be replicated, unless Government believes it cannot meet the same assumption that underpins NHS planning: that there will be competent people able to respond to the situation that unfolds

The equivalent governance and principles, with very tight purpose limitations, should apply.

Interfaces between the NHS, Government, and/or the private sector should be API-based wherever possible – and as soon as possible, if not immediately available – with minimal information provided, only for immediate use (no excess data, no retention).

Leadership by the CMO will maintain the strong public interest focus, which recognises that that the right thing at the time may not be the right thing in retrospect, but people make the best decisions they can at the time.

That having been said, there must be criminal penalties for *deliberate and wilful breach* of the tight purpose limitations; and, some would argue, for profiteering or abuse of the vulnerable. If only because penalties will discourage such abuses.

CO/CDDO can put together a plan from exercises and lessons learned from past events, in the same way the NHS created its plans. These plans should be developed with the full involvement of relevant professions and civil society – it is far better to have these conversations outside of an emergency than in the midst of one.

Building a model without diverse input means that it is less likely to be trusted, and more likely for mistakes to be made.

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⁵ Specific timescales may have been changed temporarily, but with regard to data, the existing IG and DP frameworks still applied. Most NHS bodies understood and complied with this.