GP Data Programme Minutes

NHS Digital

Purpose of Meeting: GP Data Programme Board

Date: 20/10/20 **Time:** 12.30 – 14.00

Location: MS Teams conference call

Attendees	Role	Organisation
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
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Jackie Gray (JG)	Executive Director of Information Governance	NHS Digital
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
Apologies		
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
Tom Denwood (TD)	Executive Director of Data, Insights & Statistics	NHS Digital
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED

1. **Welcome, introduction and agenda**
   1.1. REDACTED (REDACTED - Chair) welcomed the meeting attendees.

2. Review of Minutes and Actions from the Previous Board Meeting

2.1. The minutes of the last meeting were accepted as an accurate record. REDACTED provided an update on the open actions, which were presented in the slide deck circulated prior to the meeting.

2.2. Action No -160: This is an ongoing action, relating to the strategic engagement of the senior GP stakeholder bodies. Senior members of the Programme Team have had meetings with the RGCP and BMA to keep them abreast of the situation. The feedback is now with MN to view and approve

New Action: REDACTED, REDACTED *and* REDACTED *to meet and review the best approach to seek an agreement*

Action No - 180***:*** This is an ongoing action, considering the new governance proposals within GP Data and how they should align with other record sharing programmes and services. REDACTED

2.4 *Action No – 182:* Testing the programme on the scope of GPDfPR. Progress on going outside the board.

2.5 *Action No – 183:* REDACTED

REDACTED

3.0 Programme Update – GP Appointment Data

REDACTED

3.1.2 GP Data for Planning and Research (GPDfPR) Update

3.1.3 Programme has a similar delivery timeline to GPAD on the slides shared by REDACTED

3.1.4 Proposed round table to bring in new stakeholder like the NDG, Help Watch, and senior stakeholders' engagement before the DPN is issued. Programme needs to get their support in a written document to support future impacts to the programme.

3.1.5 There are risks around the DPIA development with the lessons learnt from the COVID-19 Pandemic project.

3.1.6 There will be an agreement meeting on the 6th of December, and the DPN should be issued afterwards depending on the readiness of the document and sign off from all relevant senior stakeholders.

3.1.7 GP system suppliers should be able to provide data with some risks. NHS digital is ready to process the supplied data and to make it available. In the GPSS Swimlane diagram, REDACTED explained the Population coverage arrows on the supplier bar – these bars relate to the 'seeding' of the data store, known as the reconciliation flow – suppliers provide 1% of data a day building to a full set of data by day 100, which will be the 31st of March 2021. Some suppliers will load their historical data before the 100 days, but no supplier should go beyond the deadline of the 31st.

3.1.8 Agenda also has scope of the service, which may have an impact on the time frame to progress.

REDACTED asked if the project can provide clarity information on slide 7 with regards to NHS Digital's ambition to have an NHS GP data service operation, what does this mean? Will all data be available via DARS? Will GPES still be required or will the data extract from GPES be moving over in March into the Programme?
REDACTED says there is a road map of GPES becoming part of GP Data programme after a transition period with any other data extracts.

3.1.9 REDACTED mentioned the key 4 critical risks around GP Data:

- Risks of services not being supported by the GP professionals and key stakeholders.
- Risk to tactical approaches to access data to support covid-19 and flu vaccination. This could undermine trust and compromise GP IT future strategy. The mitigating plan is to use GPES to extract data in support of direct care.
- Risk with clarification on the strategy for the safety approach beyond covid-19 period, which relies on the COPI regulation when it expires.
- Risk around the challenges with the tactical approaches to acquire data for the flu vaccination from system suppliers. Impacting the trust built with profession on having a single trusted route to acquire data. Clarification on the supplier role with regards to data services, EMIS have started presentations on their analytical propositions, there has to be an agreement were NHS Digital has a view first.

3.1.10 GPES is meeting the needs of direct care. Discussions with Open Safety have commenced to come up with the future operating approach will be and NHS X and Digital need to be involved with these discussions. This has been escalated to REDACTED around the flu vaccination and the impact.

3.1.11 Jackie Grey (JG) confirmed she has mentioned to REDACTED on the issues surrounding the flu vaccination programme. JG mentioned that engagement with the ICO has dropped off the agenda. The programme has not gone back to the ICO with the GPES DPIA and the programme needs to submit this as soon as possible. A briefing of what REDACTED intends to engage the ICO with is required. REDACTED to pick this up with JG.

3.1.12 *New Action*: REDACTED to pick up with JG on the contents of the planned engagement with ICO.

3.1.13 REDACTED said there is an opportunity for the GP data Programme to solve all the broader business requirement needs for NHS EI policy team, she also asked is there a team assessing if GP Data can solve most of the business requirement of NHS EI.

3.1.14 REDACTED says NHS EI have the extract from the pandemic research and this was gotten through DAZs. REDACTED said they have offered to provide access to the data for any other purpose required by NHS EI and are waiting on a reply. There has been a communication from the DAZ's team to all users and stakeholders that access to the data is available for any requirement. A

communication has also been sent out with regards to a transition from GPES to GP Data and the time frame.

3.1.15 JG confirmed there is now a new partnership with Data Alliance, this will be a new board to replace the Data Co-ordination board. This will look at the end to end process on how data is collected, with a view to minimise the burden and workload on the frontline. The board will be looking at the efficiencies of collecting data once and reusing it multiple times. A terms of reference (TOR) has been circulated for all stakeholders to sign up to this. Going forward all data collection from the front line will have to go through this board for approval and JG will seat on the board.

3.1.16 REDACTED mentioned some of the request for data from system suppliers do not go through an approval board. JG says this will be addressed by the new Alliance Board.

3.1.17 REDACTED said in terms of requirement, his team have a use case documents, used previously to define the data set.

New Action: REDACTED to update the user case document and share with the wider team and board.

REDACTED asked the board if the programme should look at a collaboration with NHS X, Digital and Improvement to come up with a future primary care data strategy. This should then be discussed at the Transformation and Recovery Board.

REDACTED, REDACTED, and REDACTED to catch up outside the board to discuss and explore this.

3.1.18 REDACTED raised the final risk around TPP being able to deliver. REDACTED and REDACTED have had discussions with TPP with regards to the issues they have. TPP have raised a concern around the volume of data and its impact on their system infrastructure and how the data will flow. REDACTED says an escalation may be needed soon

New Action: REDACTED, REDACTED and REDACTED to meet outside the board to discuss possible next steps on how to deal with the risks with TPP.

3.2. GPDfPR – Review of Strategic Approach

3.1.19 REDACTED referred to the slides on page 12. This was a request from the last board meeting on a statement:

"Ensuring the data from General Practices in England is accessible to those with legitimate needs for research and planning needs, via a robust and transparent governance process"

3.1.20 REDACTED said the scope of delivery is around planning and research and this is very clear in the business case. The need for this has been highlighted by the pandemic and the needs of direct care for access to data at scale.

3.1.21 The NDG report published in August on various sharing of information, describes a clear distinction between the need for direct and indirect care is no longer clear in its definition.

3.1.22 Type 1 opt Outs is still in place and practices will not provide Type 1 data except it is for the patient direct care. RCGP policy published, information and an eight-step policy of the withdrawal of the Type 1.

3.1.23 REDACTED confirmed that the programme aligns with the data strategy being published by NHSX in November.

3.1.24 There are discussions around a legislative review around data sharing.

3.1.25 REDACTED asked the board on the back of JG question, if the scope of the programme being confined to Planning and Research remain appropriate?

3.2 GPDfPR – Delivery Options

REDACTED has provided 5 different delivery options for the board to consider and discuss on page 13 of the shared slides.

3.2.2 Option 1: Stay focused and deliver based on the current scope. Delivering this as soon as possible with no change, with the programme using GPES to deliver the tactical need for direct care and await the

3.2.3 Option 2: Deliver using option 1 and then open a dialog with the GP Profession and stakeholders to come to an agreement that GPES is not a long-term option for Direct Care at scale. Opening this positive conversation on why GP data planning and research can deliver the needs of Direct Care. This will continue to build the open trust, that is being built with the profession and the programme can be open with the challenges being faced. A disadvantage of this is the tactical difference for Direct care may persist. Opening of this conversation might scare the profession

3.2.4 Option 3: Change the programme approach to include the changes to direct care and only access the full data for direct care purposes of patients. This will mean black boxing the data. The risk with this approach is with the GP profession not supporting this in the time frame. There is a risk of a public backlash because Option 1 opt out is not fully being respected. System suppliers will need to do some development to remove Privita from their systems, this is because the data would no longer be Pseudonymised at source.

3.2.5 Option 4: This would mean collect all the data including Direct Care but not collect any form of opt outs. There is risk of stakeholders not supporting this and an increase risk of public backlash to privacy.

3.2.6 Option 5: Is to implement 2 separate flows of data. The first data to support Direct Care and the 2nd data to be pseudonymised at source. This will support planning and research and will require separate governance to manage the different data sets.

3.2.7 REDACTED asked the board the following questions with regards to the options she has shared:

- Are these the right and only options?
- Is there a clear and preferred option for the board to follow?
- Do we need a combination of the options listed or explore this further?

Board Members Responses

3.2.8 REDACTED said the programme need expedience to deliver with Direct access with the GPSS, he is leaning towards Option 2 with elements of Option1 leading to option 5.

3.2.9 JG agrees with REDACTED and believes we should open a dialogue with GP's on the needs of Direct Care. Gaining a commitment were type 1 opt outs can be retired. A clear part needs to be established with the time scales and the need for the data.

JG confirmed option 3 and 4 are dangerous due to the issues with Type 1 opt outs and Option 5 could be expensive with suppliers not been able to deliver. A new solution labelled Option 6 without type 1 opt outs, that can be used for Direct care, Planning and Research.

REDACTED concurred with all the previous speakers that Options 1 and 2 are not the easy options due to the large number of GP extracts currently running, which support flu vaccinations risk stratification, shielded patient list and many more. GPES is being used for a purpose it was not built for. There are 25 collections using GPES presently and these are putting a strain on the team as new collections are added.

3.2.10 REDACTED added to JG point, there is not an easier option. The way forward would be a transition to deliver GP Data for Planning and Research solution, picking up the tactical new in bound request on the new platform or sweat GPES until the new GP data collection platform is matured. The aim is to deliver quickly and manage the risks around Direct care and Type 1 opt outs.

REDACTED said following option 2 with conversations with the profession on the withdrawal of Type 1 data will become a new viable Option 6. The change of option will be led by policy and Communication, with trust being built with the profession. This will be in line with the RCGP requirements for the removal of Type 1 objections.

REDACTED concurred with REDACTED saying option 2 with changes might be the best strategy.
The board agreed that option 2 without type 1 objection will be the best option.
REDACTED had to drop off the call due to the board over running.
REDACTED and REDACTED were, delegated to co-ordinate the rest of the meeting

3.3 GPDfPR – Communication Update

Communication updated provided by REDACTED, who explains they are using lessons learnt on the other communications updates they led with GPES and National Data opt Out.

3.3.2 REDACTED says future emphasis should highlight NHS digital is already extracting data from Primary care for Covid-19 without any issues, to calm public nerves with a culture of no surprises.

3.3.3 Communication should be used to tell people this is a transition of an existing collection of data, which would now be done in a better and safer strategic

solution. This will need to factor in some tricky things like two data sets running simultaneously, GPES overlapping with the collection for GP Data for Planning and Research. Messaging needs to be kept simple, using core umbrella statements.

Core Draft Message from Page 19

- *"Developing a safer"*
- *"Collecting data to reduce burden"*
- *"Making data available to those we trust in a safe manner"*

3.3.4 Engagement has commenced with strong stakeholders like the BMA and RCGP to help cascade the programme messaging.

3.3.5 Support from the National Data Guardian will be published in the DPN once this is given.

3.3.6 REDACTED said the reality in clinical practices is everyone is asking practices to share data via multiple duplicated requests. The programme needs to communicate to clinicians and practices this will be a collect once and use multiple times, data collection. The programme becoming an overarching source for data sharing

3.4 GPDfPR – Transparency and Information Governance Update

REDACTED said they took part with REDACTED in a review of the transparency notice issued for GPES. This is a notice GP's are asked to share and review with patients in their practices. The review conducted with the HDI UK, Patient and Public panel (PPI) and interest group My Data, the review was blunt on how difficult the transparency notice was, it was tedious, autocratic with technical jargons. The current work being done with Transparency for GPDfPR with the public and patients is looking for a better, simpler way and more engaging manner of delivery.

REDACTED gave a quote from Dame Fiona which was published during this COVID-19 pandemic about data collection, which says: -

"Trust is hard won and easily lost"

3.4.2 REDACTED added to REDACTED earlier contribution from a practice perspective, emphasising on the need for an over arching comms strategy, which will encompass all the different asks and requests for practices for all the programmes to be aligned too. This is to reduce the burden of all the multiple requests to share data, example is the new request for GP's to report on workforce data for 26,000 employees and their roles. A singular communication strategy will keep all the programmes aligned and will also benefit practices
New Action: REDACTED suggests Primary care, Communications team, and the Data delivery team, to plan and strategize on a better communication plan for practices.

Meeting finished with REDACTED thanking everyone and apologising for 15 minutes over run.

No other Business was raised.

The next GP Data Programme Board meeting will be held on Wednesday, 16th December from 12:00 to 14:00 via MS Teams. This is an amalgamation of the cancelled November and December meeting.