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BMA

Marie Austin
Clerk, Health, Social Services and Public Safety Committee
Room B32,Parliament Buildings,
Ballymiscaw, Stormont,
Belfast, BT4 3XX

6 August 2015

Health and Social Care (Processing of Data) Bill

Dear Madam,

BMA Northern Ireland is both a Professional Association and a Trade Union which represents the medical profession in Northern Ireland across all Branches of Practice and our mission is, 'we *look after doctors so they can look after you.'*

BMA has 155,000 members worldwide and 75% of doctors and medical students are members in Northern Ireland.

BMA Northern Ireland welcomes the opportunity to respond to the above Bill in respect of the regulation of the use of secondary data in health and social care.

Please do not hesitate to contact, Emmet Doyle, Executive Officer, on 02890269676 or edoyle@bma.org.uk if you require any further clarification on the issues raised or to discuss this further.

Yours sincerely

Dr Padhraic Conneally
BMA NI Council IT subcommittee chair

Clause-by-clause consideration

Clause 1

(1) BMA NI supports the general policy aim of the Bill in seeking to prescribe a legal basis for disclosure of confidential information, when seeking consent is not possible, for appropriate medical purposes which are in the public interest. High standards of confidentiality must be maintained through the oversight and scrutiny by an independent committee, as referred to in Clauses 1(3) and 2.

(2)We are very concerned, however, by the reference to 'requiring' disclosure in 2(a). This would place a legal requirement on providers to supply data. The Act should not be used as a lever to compel extractions of confidential data and this is not consistent with the Control of Patient Information Regulations 2002 applicable in England and Wales which are of a permissive nature, and which we understood the Assembly intended to replicate. The new Act should permit lawful sharing confidential information, however, if GPs (or others who hold data) do not wish to share in particular circumstances then they must not be legally mandated to do so.

BMA NI recognises the importance of a legal framework in which clinicians and patients have confidence. Creating a statutory requirement to disclose which removes control from doctors and patients risks losing this trust which would be extremely difficult to regain. Should patients lose trust in the confidential nature of the health service they may withhold information from the clinicians who are treating them. This will not only have a detrimental impact on the care they receive but it will also reduce the quality and usefulness of the data for the purposes envisaged under the new Act.

(3) BMA NI welcome the creation of the oversight committee referred to later in the Bill, and would stress that clinicians must play a key role in membership of that committee alongside others including those who are expert in the ethics and law in relation to information governance and medical research methodology. It is essential that such a committee must be independent and follow transparent processes in order to carry public and professional confidence and credibility.

(8) BMA NI welcomes the statement on the face of the Bill that processing must be compliant with the Data Protection Act 1998 (DPA). We note that this will encompasses the DPA principle of 'fair processing' which means that patients should be made aware when their information is being disclosed and for what purpose.

(10)(c) It appears that the intention is that all information will fall under the scope of the new Act 'whether or not the identity of the individual in question is ascertainable from the information'. Our understanding is that if the information is anonymous to the extent that an individual cannot be identified then it would not subject to common law obligations of

confidence or the DPA. It seems unnecessarily restrictive to include such information within the scope of the Act.

Clause 2

BMA NI welcomes the establishment of a committee which may authorise the processing of confidential information in certain circumstances when it is in the public interest and consent cannot be obtained. It is imperative that the medical profession both from primary and secondary care, plays a key role in the membership of this committee and we would seek a commitment in the Regulations that this would be the case. Membership from the public health community should also be sought if the committee are to consider applications for data for public health purposes. As previously stated, the committee must have the ability to act independently.

Clause 3

BMA NI welcomes the provision of a code of practice on the processing of information.

Other comments

A number of other issues relevant to our members should also be prescribed or clarified in the legislation or in the subsequent Regulations:

Our primary care colleagues as the guardians of their patients' information take significant care to promote the highest standards of confidentiality in their practices. This reflects the trust placed in them by patients. BMA NI would therefore like to see reference made to respecting patient objections to the disclosure of confidential information. This would allow clinicians to act in accordance with their patients' wishes.

It is also important that in releasing approved information, general practitioners, who are under immense pressure in caring for their patients, are not expected to dedicate large and unfunded sections of work time to processing requests for information.

Data quality and the extraction of data are familiar to many primary care colleagues who carry this out for the Quality and Outcomes Framework, however it is important that statutory code of practice must give clear advice to clinicians on how the new Act will be implemented.