Community ME Service (General Practice) DPIA

Submitting controller details

Name of controller	North Bristol NHS Trust
Subject/title of DPO	Head of Information Governance & Data Protection Officer
Name of controller contact /DPO	Maria Hartnell

Step 1: Identify the need for a DPIA

Explain broadly what project aims to achieve and what type of processing it involves. You may find it helpful to refer or link to other documents, such as a project proposal. Summarise why you identified the need for a DPIA.

What is the Medical Examiners (ME) programme?

The Medical Examiners (ME) Programme is a national statutory programme, creating a legal obligation to review all deaths. The first phase was introduced April 2020 to review all deaths in acute hospitals; the second phase (the focus of this DPIA) is to ensure all non-coronial deaths in non-acute settings begin to be scrutinised from the statutory date of 9th September 2024.

MEs are senior medical doctors who are contracted on a sessional basis to undertake the ME role, usually alongside other clinical commitments. They are trained in the legal and clinical elements of death certification processes. GP and community-based colleagues have also been recruited to support the ME rotas for the second phase. Medical Examiner Officers (MEOs), provide continuity of service throughout the week, preparing an initial pre-scrutiny review and general support for the ME.

What are the aims of the ME programme?

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths.
- ensure the appropriate direction of deaths to the coroner.
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.

- improve the quality of death certification.
- improve the quality of mortality data.

Why is there a need?

The government accepted the recommendations from the Francis Inquiry report, 2013 into the events at Mid Staffordshire NHS Foundation Trust. This included the introduction of medical examiners, creating a new step for the certification of deaths in the community.

Both the Gosport Inquiry and Shipman Inquiries recommended that all medical certificates for cause of death (CoD) should be scrutinised by an independent doctor, known as a medical examiner.

ME offices have now been fully established within Acute Trusts but are currently only reviewing hospital deaths. NHSE stated in June 2021 that this model should be extended, with a second phase for community deaths:

https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/non-acute-nhs-trusts-extending-medical-examiner-scrutiny-to-non-coronial-deaths-in-the-community/

There are a number of non-acute settings (Hospices, Community hospital inpatient facilities, GP Practices) which form part of this second phase.

What is this DPIA asking for?

This DPIA relates to the second phase, where we will require direct access to EMIS systems for all GP practices. This will allow ME / MEO review of GP practice patient records for deceased individuals to commence.

MEs are doctors who will scrutinise and confirm the CoDs that do not need to be investigated by a coroner before a Medical Certificate of Cause of Death (MCCD) is issued. They will also review cases where HM Coroner has decided there is no duty under s1 of Notification of Death Regulations 2019 to investigate or has referred to the ME for a Medical Examiner's Certificate. Medical records are an integral part of mortality reviews under the ME programme; therefore, it is a requirement that the ME has the GP practice patient records to review.

How would authorisation to these systems be beneficial?

The ability to access the record directly will allow a review to be undertaken and enable the MCCD to be issued to the Next of Kin (NoK). This reduces the administrative impact on the GP practice and the need to share records by an alternative means.

The medical record will be accessed upon notification of death. Deaths are currently required by law to be registered within 5 calendar days, unless the death is referred to the coroner. The aim of the ME system is to complete each review within a timeframe that enables the death to be registered within 5 calendar days. Latest guidance advises that when the service becomes statutory, the death must be registered within 5 calendar days of the scrutiny and administration being completed by the ME service. The ME service will initially aim for a 3 calendar day

turnaround time, subject to further updates from the national Medical Examiner office and/or legislative changes affecting process timescales.

This also enables:

- the NoK to have the deceased's care reviewed in a respectful, timely manner and have an opportunity to feedback to an independent service.
- the MCCD to be issued so the death can be registered and funeral arranged.

There may be changes to the 5 calendar day rule in the future, but at this stage it will not be possible to meet this timeframe without direct access to records.

Step 2: Describe the processing

Describe the nature of the processing: how will you collect, use, store and delete data? What is the source of the data? Will you be sharing data with anyone? You might find it useful to refer to a flow diagram or other way of describing data flows. What types of processing identified as likely high risk are involved?
The ME service has purchased the EMIS Web Clinical Service product to link in with GP practices (all of whom already use EMIS). Scrutiny will be undertaken using a fully encrypted NBT Trust laptop with a secure VPN to the Trust's network or standard desktop equipment. The ME service will not be changing any data contained in the patient record. Outside of correspondence with the GP practice, the ME service activity in respect of the medical and clinical records will be restricted to read only review. In terms of the end-to-end process: 1. MEs and MEOs will directly access the records of the individual for which a notification of death / referral has been received. This is achieved through remote access to the individual Practices' EMIS. Initial notification / referral

will be received via the GP Surgery. The referral will be received via EMIS and will include basic contextual information, not limited to:

- Patient's Name
- Patient's DOB
- Patient's DOD (*including time of death and who verified*)
- Patient's NHS Number
- Patient's Address
- When and where the death was verified
- GP queries or concerns, proposed MCCD wording
- Whether case has been discussed with HM Coroner
- Nok contact details

~~1.~~2. We would expect the MEO will then complete a preliminary and proportionate review of the patient's notes via EMIS. The review will be documented within EMIS.
The MEO will need to collect further information to allow the ME to complete their scrutiny. Along with the patient particulars listed above, this review could include, but not limited to:

- Age, gender, a brief social history and main co-morbidities.
- Self-declared ethnicity (this will be a requirement for the new MCCD)
- What is their DNAR/AND Status?
- Are they on EOL/Palliative Plan or Meds?
- Do they have a Learning Disability?
- Do they have a Mental Health Illness?
- Are there any causes for concern?
- Document the patient's deterioration and whether any EOL decisions or meds were prescribed, i.e. Syringe Driver.
- Are there any recent hospital discharges? If yes, what was the reason for admission? What tests were done?
- Document any noted clinical governance concerns for the ME to review.
- Document any noted family concerns or discussion points etc.
- Document any issues with the suggested MCCD wording OR has this case been discussed with the Coroner?

~~2.~~3. The ME will then scrutinise the notes to understand the circumstances that led to the patient's death, adding notes on a local EMIS template as required e.g. key facts, concerns, rationale, and conclusion.

~~3.~~4. The ME Office (MEO or ME) will then notify the referring Doctor of one of the following outcomes:

- To complete the MCCD, scan and save in EMIS as a consultation and notify the ME Office via cross organisational patient note when this has been completed.

- The ME suggests minor changes or alternative wording for the MCCD (with rationale). If the referring Doctor agrees with the proposal, then the MCCD can be completed as above. If not, then the case can be discussed as required.
- The ME would like to discuss the case with the referring Doctor as they have a query such as needing more information, propose a different cause of death or that a HM Coroner referral is required. HM Coroner referral will be undertaken by the referring Doctor via the Coroner portal Report a death - Avon Coroner (avon-coroner.com).

4.5. The EMIS cross organisational task function of the patient record will be used by ME service to correspond / discuss with the GP practice in most cases, unless further information is required. The analysis of the record provides the information to review the care and complete the MCCD accordingly. The outcome of the discussion will then be added to the local template.

5.6. The ME Office will use the NoK details captured earlier to discuss the cause of death with the family. The ME Office will also discuss whether they had any concerns with the care provided. The outcome of the conversation will be noted on a local template.

6.7. The MCCD will then be completed by the relevant Doctor, scanned and saved in EMIS as a consultation. The ME Office should then be notified via a cross organisational patient task when this has been done.

7.8. The ME office will send the MCCD to the Registry Office electronically alongside confirmation that ME scrutiny has occurred. The NoK will be notified via AccuRx that they are able to contact the Registrar to make an appointment to register the patient's death.

If the family and/or ME Office has concerns to raise regarding the care provided to the patient which have been noted on the local template, and the death is not coronial, these will be shared confidentially through the appropriate clinical governance stream for the ICB / PCN or GP Practice.

8.9. The ME Office will then log information captured on the local form via an electronic system (such as a secure spreadsheet or database). The frequency and breakdown of the data (GP practice, PCN, local authority etc.) is tbc, pending advice from the National Medical Examiner Office on quarterly reporting requirements to NHS England and on local agreements regarding the capture of local ME Office performance data. The only personal data that

will be processed post-scrutiny, once the ME service case is closed is for reporting purposes. This could include, but not limited to:

- Patient name, date of death, date of birth
- NHS number
- GP issuing MCCD
- Cause of death
- Self-declared ethnicity
- Referring Dr
- Referring Practice
- Concerns raised

The case will then be closed, with data stored on NBT's encrypted server and only staff members of the ME Office (MEs and MEOs) will have access to this data.

If a paper form has been completed, we would expect this to be required as part of business continuity plans. In the event of computer failure paper forms would be categorised in date and name order and stored in a locked cabinet within a locked office. These records would then be disposed of correctly once the information has been transferred to local systems.

The clinical systems provide an audit trail of access, and an audit could be undertaken at regular intervals to check the access of records against the records of notifications of death; this can be correlated through a patient's NHS number.

Data will be retained and disposed of in accordance with the Updates to the Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk) Data held on EMIS comes under Practice retention schedules, again following the NHS Transformation Directorate Records Managment Code of Practice.

Describe the scope of the processing: what is the nature of the data, and does it include special category or criminal offence data? How much data will you be collecting and using? How often? How long will you keep it? How many individuals are affected? What geographical area does it cover?
The data being shared is patient identifiable information, patient care and health records for cases where there is a notification of death. The geographical area covered will be BNSSG (it is not envisaged that access will be required to records outside of BNSSG). In an average year there are an estimated total of 8000 deaths in BNSSG each year, a proportion of which will be subject to review by HM Coroner. We estimate that approximately 4000 deaths take place in the community, with the vast majority of cases overseen by General Practice.

Describe the context of the processing: what is the nature of your relationship with the individuals? How much control will they have? Would they expect you to use their data in this way? Do they include children or other vulnerable groups? Are there prior concerns over this type of processing or security flaws? Is it novel in any way? What is the current state of technology in this area? Are there any current issues of public concern that you should factor in? Are you signed up to any approved code of conduct or certification scheme (once any have been approved)?	
What is the nature of your relationship with the individuals?	The data accessed is only for deceased persons.
How much control will they have?	Consent to access the notes cannot be gained from a deceased person. When ME staff access the clinical systems, it is recorded that the purpose of access is for a mortality review under the ME programme.

Would they expect you to use their data in this way?	Yes. The process will also be explained to the NoK.
Do they include children or other vulnerable groups?	Yes. All deceased including vulnerable adults. Child deaths are reviewed through the established Child Death Overview Panel process as part of Safeguarding (Working Together 2018).
Are there prior concerns over this type of processing or security flaws? Is it novel in any way? What is the current state of technology in this area?	It is a new process for reviewing community deaths however, it will run parallel with the current process of reviewing deaths occurring in acute hospitals. We are using a process already established in the South West. There are no concerns as access is for medical professionals only. The service will be using existing GP clinical systems established and in place for many years across BNSSG.
Are there any current issues of public concern that you should factor in?	The ME process seeks to provide greater transparency to the bereaved regarding the care and treatment of their loved one. Given the change adds an additional step into an existing process, there is a concern that delays will increase. Delays in conducting the review will affect the timely issue of the MCCD in order to register the death within the legally required framework of 5 days. This could generate increased calls to GP practices from concerned NoK if comms not handled effectively.

Are you signed up to any approved code of conduct or certification scheme (once any have been approved)?	The MEs are all registered doctors and as such regulated by their own governing body, the General Medical Council. They are also employed by the NHS and subject to governance and policies relating to confidentiality and GDPR.

The new process would enable the Medical Examiner's Office to access GP and community records following a notification of death.

The biggest risk regarding the new process is around staff accessing records which are not specifically related to the work of the ME team. MEs are medically trained and regulated professionals, therefore this can be mitigated through the regular audit of access to the clinical system. This can further be mitigated by making clear to MEs / MEOs that they are only to access records in direct relation to their work and that any access outside of this would be subject to disciplinary proceedings. Training would be provided to the ME service in the use of the clinical system for this purpose.

They would be expected to sign to agree to conditions of use at the end of this training – they would not be given access until they had done this.

The technology used meets NHS standards - all personal data will be accessed securely via EMIS when reviewing patient notes, on a Trust encrypted laptop or standard trust desktop setup. Information relevant to NBT reporting requirements will be added to a secure spreadsheet, accessible only by the ME service, stored on NBT's secure, encrypted servers.

Describe the purposes of the processing: what do you want to achieve? What is the intended effect on individuals? What are the benefits of the processing – for you, and more broadly?

Benefits to the ME Service

Access to the relevant records on EMIS will allow the MEs to:

- achieve a review of the medical notes allowing the MCCD to be issued within the required 5 calendar days;
- enable the case notes to be accessed immediately upon notification of death;
- improve the quality of mortality data;
- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths;
- comply with statute.

Benefits to the Practice

Allowing the MEs direct access to EMIS would enable the Practice to:

- reduce administrative work as there will be no need to provide authorisation for access to the notes each time a death needs to be reviewed, and there will be no need to photocopy notes.
- receive advice and assistance on specific cases.
- reduce GP practice staff workload, as the ME service are likely to take a number of calls from NOK previously directed at primary care.
- Practice internal audit of compliance.

Benefits to the family of the deceased

This new process would allow the next of kin to be able to:

- receive a response to any queries they have about the death;
- have their loved one's death reviewed in a timely manner;
- raise any issues around their loved one's care and treatment;
- register the death and arrange the funeral.

Step 3: Consultation process

Consider how to consult with relevant stakeholders: describe when and how you will seek individuals' views – or justify why it's not appropriate to do so. Who else do you need to involve within your organisation? Do you need to ask your processors to assist? Do you plan to consult information security experts, or any other experts?
This DPIA for the second phase will be asked for approval by: • The GP Data Protection Officers for all GP practices in BNSSG (named contacts in LMC) • The GP Data Protection Officers in individual Practices • NBT IG lead (and linked NBT IG internal processes) Engagement is already underway with Primary Care and each practice, or group of practices will need to agree the DPIA and access for the local ME office. As previously noted, this DPIA will be updated and reviewed as the project progresses for other providers. NBT IT have been contacted about this project and an IT Resource request submitted to engage colleagues.

Step 4: Assess necessity and proportionality

Describe compliance and proportionality measures, in particular: what is your lawful basis for processing? Does the processing actually achieve your purpose? Is there another way to achieve the same outcome? How will you prevent function creep? How will you ensure data quality and data minimisation? What information will you give individuals? How will you help to support their rights? What measures do you take to ensure processors comply? How do you safeguard any international transfers?	
What is the lawful basis for processing?	Coroners and Justice Act 2009 Chapter 25 section 20 (e) provision requiring a medical examiner to make whatever enquiries appear to be necessary in order to confirm or establish the cause of death. National Health Service Trust (Scrutiny of Deaths) (England) Order 2021 which confers power on NHS trusts to scrutinise any deaths in England (whether or not the death takes place in a NHS trust's area) where the Coroner has no duty to investigate, or there is some doubt as to whether the death must be notified to the relevant senior coroner. NHS England and NHS Improvement, on behalf of NHS Trusts and NHS foundation trusts, submitted an application under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 ('section 251 support') to process confidential information without consent. The Secretary of State for Health and Social Care, having considered the advice from the Confidentiality Advisory Group, supported the application which means that confidential patient information can be shared with medical examiners by health and care organisations for the purpose of the medical examiner programme. Details of the approved application (ref: 21/CAG/0032) can be found on the Health Research Authority's website https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/confidentiality-advisory-group-registers/. The General Medical Council's (GMC) Confidentiality Guidance advises that doctors should disclose relevant information about a patient who has died where disclosure is authorised under section 251 of the NHS Act 2006. UK GDPR, the lawful basis for collecting next of kin details comes under Article 6(1)(e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority invested in the controller.

Does the processing actually achieve your purpose?	The reviewing of data is to complete mortality reviews. Without the review being completed the MCCD cannot be issued.
Is there another way to achieve the same outcome?	No, it is not thought that this outcome can be achieved in the same way. Access to the BNSSG Connecting Care Digital e-Record could potentially offer a similar outcome – but it does not provide the granularity of data required. It is also used for the purposes of ongoing care, rather than records scrutiny of deceased individuals.
How will you prevent function creep?	This request is for specific processes that fall under NHSE frameworks. Scope would not creep outside of this.
How will you ensure data quality and data minimisation?	The service will not be changing the GP practice data and will have read only access. For the ME service: **Purpose Limitation:** We will limit data collection and processing to only what is necessary for the specific purpose of the medical examination scrutiny. **Data Minimisation:** We will collect and retain only the minimum amount of data required for the medical examination scrutiny. **Secure Data Storage:** We will implement robust security measures to protect the data from unauthorised access, and access controls following industry best practice for data storage and transmission as necessary.
What information will you give individuals? How will you help to support their rights?	The service will only access records for deceased individuals where there has been a notification of death. Consent to access the notes cannot be gained from a deceased person. Within the sign-in process of each occasion the service will access the clinical systems, it is recorded that the purpose of access is for a mortality review under the ME programme. Next of kin will be made aware of the ME process and that it is statutory.
What measures do you take to ensure processors comply?	Regarding access to incorrect records – staff will be trained on the clinical systems and regular audits will be undertaken regarding access to the systems. As part of training staff will be informed regarding inappropriate access to records and the organisational policy regarding this.

Step 5: Identify and assess risks

Describe source of risk and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary.	**Likelihood of harm**	**Severity of harm**	**Overall risk**
Staff accessing records inappropriately.	Possible	Significant	Med
Paper information/records not secure when printed off and at risk of going missing.	Possible	Med	Med
Metadata stored on a computer with access to EMIS.	Remote	Significant	Med
Third party information being included in the Patient Record.	Possible	Low	Low
Unauthorised access following Practice or ME Office staff moving or leaving department.	Remote	Low	Low
Unsecured remote access to patient records.	Remote	Med	Low

Step 6: Identify measures to reduce risk

Identify additional measures you could take to reduce or eliminate risks identified as medium or high risk in step 5				
Risk	**Options to reduce or eliminate risk**	**Effect on risk**	**Residual risk**	**Measure approved**
Staff accessing records inappropriately	Training of staff and policy developed relating to access via EMIS. Clinicians to sign to agree to conditions of use at the end of this training. Regular auditing of EMIS access.	Reduced	Low	YES
Paper information /records not secure when printed off and at risk of going missing.	Paper records to be used at a minimum with the majority of records being on EMIS or via a database on a secure server/laptop.	Reduced	Low	YES

Metadata stored on a computer with access to EMIS.	Computers used encrypted via NHS process. Computers regularly updated with up-to-date Operating Software and patient information systems accessed with secure login credentials.	Reduced	Low	YES
Third party information being included in the Patient Record.	The Medical Examiner Office only completes a proportionate review of the patient notes, reviewing only what is required. In some cases, Third Party information will need to be reviewed to ascertain any influences or circumstances around their death. If not required, the ME Office will not review.	Reduced	Low	YES
Unauthorised access following Practice or ME Office staff moving or leaving department.	The Acute Trusts will regularly review access to EMIS and inform the appropriate parties of access that is no longer needed.	Reduced	Low	YES
Unsecured remote access to patient records.	Majority of cases will be reviewed in a secure Trust setting. Remote access will be limited and where required, the appropriate staff member will be on an encrypted Trust Laptop with a secure server connection.	Reduced	Low	YES

Step 7: Sign off and record outcomes

Item	**Name/position/date**	**Notes**
Measures approved by:	Maria Hartnell Managing Partner 6.11.24	Integrate actions back into project plan, with date and responsibility for completion
Residual risks approved by:	Green Valleys Health Partnership 6.11.24	If accepting any residual high risk, consult the ICO before going ahead
DPO advice provided:	Caroline Dominey-Strange Senior Information Governance Consultant &	DPO should advise on compliance, step 6 measures

	GP Data Protection Officier 23.7.24	and whether processing can proceed
Summary of DPO advice: Caroline Dominey-Strange has been through the documents and is happy they are in line with data protection requirements.		
DPO advice accepted or overruled by:	Accepted by Maria Hartnell	
Comments: N/A		
This DPIA will be kept under review by:	Data Controller – Maria Hartnell.	The DPO should also review ongoing compliance with DPIA.
Comments: This DPIA will be kept under review on an annual basis or as directed by the Medical Examiners Services.		