

## Health Committee

### Oral evidence: Memorandum of understanding on data-sharing between NHS Digital and the Home Office, HC 677

Tuesday 16 January 2018

Ordered by the House of Commons to be published on 16 January 2018.

[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Dr Caroline Johnson; Diana Johnson; Johnny Mercer; Andrew Selous; Maggie Throup; Dr Paul Williams.

Questions 1 - 94

#### Witnesses

[I](#): Yusef Azad, Director of Strategy, National AIDS Trust; Dr Joanne Bailey, Member of the Advisory Panel, National Data Guardian; Marissa Begonia, Coordinator, the Voice of Domestic Workers; Dr Lucinda Hiam, General Practitioner, Doctors of the World; and Professor John Newton, Director of Health Improvements, Public Health England.

[II](#): Lord O'Shaughnessy, Parliamentary Under-Secretary of State for Health (Lords), Department of Health; Sir Ian Andrews, Non-executive Director, NHS Digital; Sarah Wilkinson, Chief Executive Officer, NHS Digital; Caroline Nokes, Minister for Immigration, Home Office; Jonathan Marron, Director General, Community Care, Department of Health; and Hugh Ind, Director General of Immigration Enforcement, Home Office.

Written evidence from witnesses:

- [National AIDS Trust](#)
- [Doctors of the World](#)
- [NHS Digital](#)

## Examination of witnesses

Witnesses: Yusef Azad, Dr Joanne Bailey, Marissa Begonia, Dr Lucinda Hiam and Professor John Newton.

**Chair:** Good afternoon, and welcome to today's hearing. Before we get started, I invite Dr Paul Williams to make an opening remark.

**Dr Williams:** I declare an interest, in that my father holds an NHS contract to provide health services to refugees and asylum seekers. Some of his patients may be affected by this memorandum of understanding.

Q1 **Chair:** Thank you, Paul. For those following proceedings from outside the room, before we start our discussion of a memorandum of understanding on processing information requests from the Home Office to NHS Digital for tracing immigration offenders, I ask each member of the panel to introduce themselves and say who they are representing today.

**Marissa Begonia:** Good afternoon, everybody. I am Marissa Begonia. I am a migrant domestic worker myself. I am also the co-ordinator of the Voice of Domestic Workers. We provide health services to migrant domestic workers through Doctors of the World.

**Yusef Azad:** I am Yusef Azad, director of strategy at the National AIDS Trust.

**Dr Hiam:** I am Lucinda Hiam, an NHS GP and a GP at Doctors of the World.

**Professor Newton:** I am John Newton. I am from Public Health England.

**Dr Bailey:** I am Joanne Bailey. I am here representing Dame Fiona Caldicott, the National Data Guardian for Health and Care. My background is in general practice, and I sit on a panel of advisers advising Dame Fiona.

I feel I ought to make the Committee aware that I am also a member of IGARD, the Independent Group Advising on the Release of Data. It is an independent group, advising on applications for confidential data from NHS Digital. I do not feel that there is a conflict, because it is an independent group, and the matters under consideration today have not come before IGARD, but I thought I ought to make the Committee aware of that.

Q2 **Chair:** Thank you very much for clarifying that important point.

I start by asking you to set out, as grittily as possible, whether you are satisfied that the arrangements set out in the memorandum of understanding adequately take account of the public interest in the maintenance of a confidential medical service.

**Marissa Begonia:** I am very worried about the current situation with what is being proposed at the moment. Encouraging migrant domestic



## HOUSE OF COMMONS

workers to step forward, who are already undocumented, is very difficult. Through Doctors of the World, we provide a once-a-month health service to help them register with GPs, and for those who already have a serious disease like cancer.

There have been times when none of them would appear, especially if they have heard that immigration officers are patrolling around, and when they heard about one of them being arrested in the clinic. To tell them directly that the Home Office would access this information would drive them more underground, and we will have difficulties in finding them and in encouraging them to step forward if they are seriously ill, whether that is with something contagious or cancer or pneumonia, and we have already had that situation. It will not really help us to find them easily, and the more they will hide.

**Yusef Azad:** There are exceptional circumstances when patient confidentiality can be breached without consent. The guidance on those cases is found, for doctors, in GMC guidance and, for NHS bodies, in the NHS code. They agree—they say the same thing, which is that the test is, “Is there serious harm to the individual?” In the case of offences, it is, “Are they serious offences, such as rape, murder or manslaughter?” Immigration offences do not meet that seriousness test, so the MOU is not compatible with NHS guidance on confidentiality. We do not believe that NHS Digital has applied the public interest test correctly. I can talk more to that later, perhaps. I do not want to speak for too long at the beginning.

The bottom line is that NHS Digital is operating to a different and lower standard of confidentiality than the rest of the NHS. I cannot see how that is acceptable, given that NHS Digital is the safe haven for all our patient data.

Q3 **Chair:** Thank you. We will return to that issue in more detail in a minute, but that, for you, is the key concern.

**Yusef Azad:** Exactly.

**Dr Hiam:** As a doctor, I would say—and medical colleagues here will know—that confidentiality is the cornerstone of the doctor-patient relationship. It is the reason patients trust us; it is the reason patients tell us very personal information. Without that—with that broken—I do not think that you can carry on having such a good relationship. If you have to break confidentiality, as Yusef alluded to, it is a fraught decision. You consult your defence league and you consult your colleagues, and it is a horrible decision to have to make.

At the moment, it is happening without us knowing, all the time and routinely. I do not think that enough consideration has been given to the damage that has been done to public trust or to the consequences of that.



**Professor Newton:** It is a specific question, and I will answer it specifically. The public interest test is a balance. NHS Digital has helpfully set out in its submission to your Committee how it went about making that decision. We would argue that not enough weight was given to the problem of dissuading migrants from seeking care—the care-seeking effect.

We note that NHS Digital, in making that decision, referred to our submission, which you have; Duncan Selbie wrote to you in March 2017. We say that there is no direct evidence linking the MOU to care-seeking behaviour. However, we would say that the absence of evidence is not evidence that it is not there. There is a strong suspicion that fears in general about confidentiality do have an effect. It may well be that the MOU is having some effect. We have been asked to investigate that further, as I think you know.

**Dr Bailey:** The question that you ask goes to the core of Dame Fiona's work. If I may take a minute, I am sure she wants me to emphasise three key points, if you could bear with me. If not, please say as I go along.

Dame Fiona places paramount importance on public trust in the confidential medical service. It is vital that patients feel that they can have trust that the information that they have shared with doctors is held in confidence, is handled with sufficient security and is only shared with a high threshold. Traditionally, the threshold has been high, and that is clear in published guidance.

She has concerns that the public interest criteria that are applied, either by doctors using the GMC confidentiality code or by NHS staff using the Department of Health NHS code, are not reflected in the MOU.

Her key concern is that the implications of the policy behind the MOU for public trust are far-reaching. The policy has obvious consequences for undocumented migrants and also for wider health. Her concern is that, if the approach that is taken with these data releases was extended to other parts of the NHS or to other crimes of a comparable gravity, patients may well come to feel that the NHS family is disclosing their information at too low a threshold or without strong enough safeguards. Dame Fiona is concerned about the broad public trust implications on care, patient safety and the wider health system.

**Chair:** We will explore many of those issues in greater depth now.

Q4 **Dr Caroline Johnson:** I will talk about the relationship between patients and doctors. I am a children's doctor—a paediatric consultant.

First, to the NGOs, do you accept the GMC's view that the memorandum of understanding does not require doctors to do anything that would break their code of practice? Its guidance says that personal information may be disclosed in the public interest, without consent, and in



## HOUSE OF COMMONS

exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential.

We are not talking, are we, about people discussing medical or personal details with the Home Office, but rather details such as name, address and date of birth? Do you accept the GMC's assertion?

**Yusef Azad:** It is the case that it is just demographic information, so it is not as sensitive, for some people, as clinical information. In its correspondence with your Committee and with us, the GMC has made it clear that it cannot think of an instance where it would consider it ethical for a doctor to provide an address to the immigration authorities simply on the basis of an immigration offence possibly having been committed.

The NHS Digital process puts GPs in a very difficult position. The GMC has advised that they should not, in almost all circumstances, provide that information to the immigration authorities if they are approached directly, but they are expected to provide NHS Digital, a third party, with that information, knowing that NHS Digital will pass it on, if approached, by those same immigration authorities. It is very problematic.

**Dr Hiam:** I agree with that completely, but I also think that confidentiality begins before the consultation. As soon as you hand over details to your general practice, that is the confidentiality beginning.

The distinction, and the decision whether those data are less or more precious than your health data, is not one that we can make. In our Doctors of the World clinic in particular, we often see people in exploitative situations, where the GP is the only safe place they might be able to go to speak to someone safely and securely. One of the threats that they will be given from the people who are exploiting them is their immigration status being used against them. Turning the GP into a place that they can also fear is very dangerous.

For example, a few weeks ago, I saw a woman from Eritrea who had been living in this country for seven years, being kept as a slave and subjected to horrendous sexual violence. She did not feel able to go to a GP. That is the atmosphere of fear that we are creating. For many of our service users, the distinction is irrelevant.

**Q5 Dr Caroline Johnson:** Professor Newton, you said that you felt that the new arrangements "may impact significantly" on how clinicians engage with their patients. My understanding is that, essentially, this has been happening for some time. How do you think it will impact significantly now, when it has not been already?

**Professor Newton:** The difference is that it was not known by many clinicians that data were being passed by NHS Digital's predecessors. This is the sort of thing that we plan to assess in our review: the extent to which there is evidence that clinicians' knowledge and attitudes have



## HOUSE OF COMMONS

changed as a result of the MOU. There is anecdotal evidence that that is what has happened.

**Q6 Dr Caroline Johnson:** I work in Peterborough, where we have been part of a pilot, under which patients, when they come for a routine appointment—when they are not clinically in need of urgent treatment, but come for routine treatment—are asked to provide details of their eligibility for NHS treatment, which includes things like their passport or a household bill. Presumably, that sort of data is already being collected, and clinicians are aware that it is being collected. That does not seem to be resisted by patients. In fact, many of them welcome it.

**Professor Newton:** Referring you back again to the broader evidence base, we know that, internationally, migrants are dissuaded from seeking care for a variety of reasons, of which confidentiality is one. It is often linked to concerns about eligibility. In fact, one of the primary reasons is the sheer inaccessibility of services for migrants and the lack of information and support. We need to see these factors that provide barriers to care-seeking behaviour, including stigma—that is the other one, from our point of view, when it comes to things like TB and HIV.

The evidence suggests that the fear about confidentiality compounds a number of other concerns, and it can be the thing that stops patients consulting.

As we have tried to make clear in our evidence, it is difficult to identify the specific effect of confidentiality concerns, let alone the specific effect of confidentiality concerns about a particular agreement about data sharing.

**Q7 Dr Caroline Johnson:** You are suggesting that people were worried already. You talked about the tragic case of the lady from Eritrea. If people were worried already that this was happening, and it was really happening, how does this change things? How does our knowledge of it really change things? What do you think has changed now?

**Professor Newton:** What has changed is the more formal guidance that is now being given to healthcare providers that the MOU is in place. It is partly related to the guidance about charging overseas visitors for care. Increasingly, professionals are expected to advise patients that their data will be shared in certain circumstances. Of course, that is an important principle of the management of confidential data—that patients should know what we do with their data. Increasingly, patients are being told what happens to their data. Therefore, there is more potential for that to have an effect on care-seeking behaviour.

**Q8 Chair:** Is it fair to say that, in the past, it happened on a case-by-case basis, whereas now it is happening on a routine scale?

**Professor Newton:** With respect, our colleagues may be better able to answer that than I am.



## HOUSE OF COMMONS

**Marissa Begonia:** The problem is that, in encouraging them to come to our organisation, it is already difficult to gain their trust. In encouraging them to access Doctors of the World, we try to let them understand that they can utterly trust Doctors of the World, and it will not do anything like report you to the Home Office or give your data or information to the Home Office. That is very difficult.

If they find out that one of them has been arrested inside a clinic, that will put them off.

Q9 **Chair:** To clarify, are you saying that that has already happened or that people fear it is happening?

**Marissa Begonia:** It shocked them. They were not aware it is happening—there are so many of us—but they had no idea whether it is related to that. However, it still frightened them off. We have had some months when none of them would appear, even those on my list, because they had that information that someone had been arrested in the clinic, and they will not register in that clinic any more. Building that trust again is very hard. Making this known will frighten them away still more.

We have one case of someone who came in last Sunday. She was diagnosed in hospital with Bell's palsy. When she went for a check-up, she was questioned in the hospital about her immigration status. She immediately ran out of the hospital and never sought any medication again. She turned up last Sunday because the disease was back. She told us about how scared and frightened she was to go to hospital again, because of this interrogation happening to her.

We also have cases of death. Domestic workers are now mostly undocumented, because of the change that happened in 2012, with the six-month tied visa. We have one member who died, having never sought any hospitalisation or gone to a GP, because she was too frightened. She was not even aware of what kind of disease she had. She was coughing very badly and thought it was just a cold. This is very sad. She came from abusive employment. Hot water was poured on her. It was unreported, because she was too frightened to step forward to the authorities. That did not kill her—she survived that. What killed her was her being too frightened to access healthcare. It is very sad for me to witness that.

**Chair:** That is very sad, and I am very sorry to hear about that case.

Q10 **Rosie Cooper:** I will start with a question to Dr Bailey. Does the National Data Guardian accept the Department of Health's contention that an "inaccurate presumption" has been allowed to grow up in the health sector with regard to the applicability of the common-law duty of confidentiality to demographic or administrative information?

**Dr Bailey:** The Department of Health takes an interesting view to the National Data Guardian. In fact, the presumption of confidentiality for this data is long standing and very well established. All the published



guidance, for example from the General Medical Council but also from the British Medical Association and the royal colleges, makes it clear that all data held by doctors, hospitals and the health service are held with a duty of confidence. That published guidance informs public expectations. A view could perhaps be taken: we wonder whether a presumption has grown up within the Department of Health that demographic data such as names and addresses should perhaps not be held with a duty of confidence but, from the health service's perspective, it is long standing that those are confidential data. That is the view that the National Data Guardian is very comfortable with.

**Q11 Rosie Cooper:** If I could develop that a little, I have a question for Professor Newton. In February 2014, the Committee questioned the transparency of data releases by the Health and Social Care Information Centre, which is now NHS Digital. That was followed by the Partridge review, which highlighted inconsistencies across functional areas and a lack of rigorous controls. That was then followed by the Goddard review, which provided, for each service, a requirement of the validation of the legal basis, the value and the identification of areas for improvement.

This week, we have had the story of Public Health England releasing 180,000 pieces of information to a company working for a tobacco firm. Can you please explain to me why the Public Health England data release register says that the legal basis for the release of personally identifiable data is section 251(2), for which there is a medical purpose? Is this not yet another example of the cavalier and irresponsible attitude on the part of people in departments such as yours when the public need to have trust in you? You are not learning any lessons, and you are doing what you like. If you feel like sharing it, you are doing it anyway. It is a disgrace.

**Professor Newton:** Thank you for the opportunity to clarify the facts of what happened here. With due respect, the account that you have given of what has just happened is not strictly accurate. I apologise if, in any way, Public Health England has provided data that are misleading in that respect. The data release that you are referring to was not a release of confidential data; it was anonymised data, which is fully compliant with the Information Commissioner's Office guidance on anonymised data, of the form that could just as easily be released on the web under licence on data.gov. This is not at all the same as releasing patient-identifiable data.

We were asked by a legitimate agency to provide data on the incidence of cancer, which could be used for a comparative study of the incidence of cancer in different countries. That is exactly why cancer registries were set up. Many patients have benefited as a result of those sorts of investigations.

I completely share your concern about patient confidentiality. We feel that the reports that have been made of this particular release must be very worrying, and they have no doubt caused concern, but they are



## HOUSE OF COMMONS

inaccurate, and we have written to the Minister to explain the basis of how we were—

**Chair:** Thank you.

Rosie, if I could just make an observation, I have been copied in on a letter to the Secretary of State about this. I propose that, when the facts are in the public domain, we could perhaps explore that aspect of it. I am conscious that, today, we are trying to focus on a really important issue around the memorandum of understanding. Having raised the matter, Rosie, could we return to that on another occasion?

Q12 **Rosie Cooper:** Absolutely, but, if I may say, the core of this question is trust. I would look at Professor Newton and ask, "Are you saying, Public Health England, that the risk register is wrong, and that they have made a mistake?" If it has made a mistake, does it correct its mistakes? I know that it was told of other mistakes last November, and they are still not corrected.

**Professor Newton:** I sincerely apologise. If there is a mistake on our risk register, I sincerely apologise. I would be much happier to apologise for a mistake on our risk register than I would for what you have suggested, which is that we have released data without a good basis. We operate the cancer registries at a very high level of information governance.

**Rosie Cooper:** I would be much happier if you just got it right.

**Professor Newton:** In this case—and I accept that you have not seen the letter—we feel that we did get it right, and we have shared the basis on which we made the decision. I am very happy to talk separately about it.

Q13 **Rosie Cooper:** Okay. Could I go back to Dr Bailey? Do you accept that a review is required of the NHS code of confidentiality? Is the Data Guardian sufficiently involved in it? Are her views being adequately taken into account? This goes to the core of what is going on.

**Dr Bailey:** The NHS code of confidentiality has been around for a while, and we accept that a review would be warranted. We notice that there are some points that the Department of Health seems to think are not correct, one of which you have raised already—the matter of whether demographic data should be treated in confidence. We are concerned about that point in the code being revised, for the reasons that I have already touched on.

Apparently, it is early days for the review of the code, but Dame Fiona has been approached and has been assured that she and her panel will be involved in that review. However, we are no further on with the detail of that.



## HOUSE OF COMMONS

One thing that she would like to emphasise is that there should be more than just herself and other specialists or interest groups—there should be a wide consultation on that point, including among the public and professionals, possibly with focus groups or citizens juries. There should be a wide consultation on that, and she is very keen to be involved in it.

**Q14 Rosie Cooper:** Will the other NGOs be wanting to make a submission?

**Yusef Azad:** We certainly would. We have regretted the lack of involvement in the agreement of the MOU in the review, and we very much agree with the position as set out by Dr Bailey on the common law and demographic information.

**Q15 Rosie Cooper:** So, you would want to make a submission.

**Yusef Azad:** Yes, absolutely.

**Rosie Cooper:** I hope people are listening.

**Q16 Dr Williams:** Yusef, what evidence is there of a risk to public health from the disclosure of data allowed under the MOU?

**Yusef Azad:** I would refer to the excellent PHE submission to the review. It gave 16 references to academic literature in its submission. Duncan Selbie called it “a wealth of evidence” around the fact that fear of immigration enforcement can deter people from healthcare. Some of those 16 references were to literature reviews, which referred on to scores more papers. Some were statistical and quantitative; others were qualitative, ethnographic and semi-structured interviews. They all came to the same conclusion. On the basis of that evidence, PHE had no compunction in saying that it felt that immigration tracing had the potential to deter people from healthcare and could undermine its strategic role in dealing with contagious disease.

I know that NHS Digital has asked for robust statistical evidence. The irony is not lost on us, to be asked for statistical evidence by a tracing service desperately trying to find the basic whereabouts of thousands of migrants every year. The Home Office itself does not have robust statistical evidence around undocumented migrants. That is the problem. So, we are all in the same boat.

The fear of authorities both deters people from healthcare and makes them unavailable for the kind of statistical analysis that NHS Digital claims to need, but we would strongly argue that there is no need for that. The evidence is clear.

It is also self-evident, in our view, that, if a migrant who is worried about the authorities is told that if they give their GP their address the immigration authorities might access it, that will be a deterrent from healthcare.

**Q17 Dr Williams:** We have heard a lot of evidence, particularly on communicable diseases and deterrence from healthcare. What other



evidence is there? What other consequences are there to the health service or to individuals' health?

**Dr Hiam:** In our clinic, there are pregnant women, in particular, who are too frightened to access healthcare. That really worries us. Just this morning, someone who was eight weeks pregnant was on the phone to our line. She was in tears, and she was too scared to go to the GP or to an antenatal clinic. Last week, we had a woman who was 17 weeks pregnant who would not even give us her address. We are trying to help her to access healthcare, and we cannot even do it, because she is too scared of us. Trying to assuage those fears is not working.

Some evidence that King's and Imperial collected at our clinic last year showed that two in three of the pregnant women we had seen had not had their booking appointment by 10 weeks, which is the NICE guidance. One in four had not had it by 18 weeks—they had not been seen.

In one extreme circumstance, we had a lady presenting in labour to Doctors of the World, because she was too scared to go to hospital. Our patients, even pregnant women, will often go to A&E, where they do not have to give their details, and will use that as a route for healthcare.

In terms of public health and the cost to the health service, that is obviously much higher than seeking appropriate, timely antenatal care.

**Q18 Dr Williams:** That was going to be my question. Is there any evidence of preventive things that are not happening, which then leads to greater cost or greater harm later?

**Dr Hiam:** In our clinic, we see that the average time that people have been in the UK before even trying to access healthcare is six years. When they present to us, often with conditions such as diabetes and high blood pressure, which can be easily and cheaply managed, the conditions are out of control. We had to send 45 people directly to A&E last year. We had one case of a man from the DRC who had been imprisoned and tortured for his political opinions. He came to use and presented as suicidal, because he had not been able to access mental health support or support for his physical healthcare.

Just to return to Dr Johnson's point about whether this has been happening all the time and whether there has been any change, since it became public in January 2017, we had to change the advice we were giving in our clinic. We were aware of it before then, but we thought it was a very low risk, and we measured it to be reasonable to tell people it was safe. Now, we still tell our patients to register with a GP, because we think the best thing is for them to access preventive primary care, but we have to say that their data might be shared. Many people are now not going, so it has changed, from what we see day to day.

**Q19 Diana Johnson:** Have you seen a change in demand for your services since then?



## HOUSE OF COMMONS

**Dr Hiam:** We run at capacity. We turn people away every day. On demand, I suppose it is hard for us to say, because we do not measure the number of people we are turning away. Perhaps that is something that we should be doing as well.

I run a service group with women to find out what we could do to make GPs more aware of the issues that they face. We never got to that, because all they said is, "I wouldn't go to my GP any more." One of the women had experienced severe violence in her home country and was having very bad physical and mental effects from it, but we could not persuade her to go to the GP.

Q20 **Dr Williams:** The National Back Office did a review, and I will quote from it. It mentioned "the potential harm that might arise by not processing these tracing requests, i.e. an individual would be out in the community without appropriate support for longer." Do you recognise that potential harm?

**Yusef Azad:** That is a possible harm on an individual basis, and the serious harm test would apply. That is fine. Of course, if someone is worried about a vulnerable person, they make the case that serious harm might be relevant, and the data can be disclosed. However, that is different from routine provision.

**Professor Newton:** In looking at the number of times that the data-sharing MOU is used in the two categories, category 1 and category 2, where category 2 has defined a person for their benefit, the numbers are much greater in category 1 than they are in category 2.

**Chair:** Of course, the purpose of it is to find and locate them to deport them, not to give them treatment. I guess that is the obvious distinction.

Q21 **Diana Johnson:** I wish to ask about immigration control. Obviously, immigration is a hot political issue, and the public are very conscious about ensuring that people who should not be in this country are removed. I just wanted you to give me your take on what you think the actual effect and contribution of the memorandum of understanding is to that effective immigration control.

**Yusef Azad:** One interesting thing that came out of the review is that it gave information that is not available in the routine quarterly reports from NHS Digital: not only the number of traces approved but the proportion of cases where NHS Digital was able to give back to the Home Office any information that was different from the information that it had originally received from the Home Office. The percentage was very small. For the last year, about 3.2% of approved traces involved any new information going back to the Home Office compared with what it knew in the first place.

Q22 **Diana Johnson:** That had gone down, had it not? I have the 2014-15 figure, which was 7.9%, so it has gone down.



## HOUSE OF COMMONS

**Yusef Azad:** It did—exactly that. We do not know what has happened since, but, if you want to consider the practical value of this in terms of immigration enforcement, I would argue that it is not very great compared with the loss that now seems to be proposed across the whole English population of a particular protection around confidentiality for 55 million people. That is the first point: I do not think it is proportionate.

The second broader point is on immigration policy and the fact that it is a hot political potato, as you have said. We have a very precious asset in this country, which is a great degree of consensus of trust in our national health service. Patients believe that doctors will look after their data and keep them confidential. One reason for that consensus is the fact that, to date, the criteria that apply for breaching that confidentiality are ethical criteria, not political criteria. Who could argue that, in cases of rape, murder or manslaughter, it may be appropriate to pass information on to the authorities? That is understood. Every right-thinking person would think that.

As soon as you move the criteria outwards to hotly debated issues of public policy, be it immigration, benefits, drug use or what have you, you get different points of view and significant proportions of the population not agreeing with the practice, and you lose a national trust in our national health service. I think it is a very dangerous direction of travel.

**Dr Bailey:** While completely agreeing with all those points, I think it is important to say that the National Data Guardian, while not being an expert in matters of immigration, would certainly support the need for effective immigration control. On that point, you asked about the value and use of the data. I think this is in the memorandum of understanding, but it might be in the review—I apologise for not having that fact at my fingertips—but we note that the Home Office is to analyse the value of the service and the releases from time to time. That is an important point. PHE is being asked for data to improve the evidence base, but publishing analysis of the value would be very helpful in weighing out the other side.

Dame Fiona's concern is that the weighting is not being balanced correctly between the public interest in the immigration service and the public interest in a confidential health service.

Q23 **Andrew Selous:** Professor Newton, what progress has been made on Public Health England's review of the impact on public health of the memorandum of understanding? Have you had any assurance from the Government that they will take notice of your work and perhaps change policy as a result?

**Professor Newton:** Thank you for the question. We were only asked to do it in November 2017<sup>1</sup>, so we are still in the scoping phase.

---

<sup>1</sup> Professor Newton has provided clarification on this point, noting: Although the recommendation that PHE should undertake the review was published in the NBO



Q24 **Andrew Selous:** What is the timescale for your work? When do you expect to have an outcome?

**Professor Newton:** We have been asked to do it within two years, but we hope to produce results as soon as possible. It depends a little bit on exactly how we go about things. There are a number of aspects to the review. For a start, we will need to update the literature, because the evidence that Yusef Azad refers to was compiled in 2015, and there will have been published works since then; so, we will do that.

We are planning to try to get some information directly by talking to people providing care services and, hopefully, to focus groups of migrants themselves. We would be very happy to receive submissions from interested groups with direct experience. We hope that all that sort of material will be available quite soon. I imagine that we would be able to give some interim findings to the Department well within the two-year period.

Q25 **Mr Bradshaw:** I have a quick question for the National AIDS Trust about the process. Reading your very interesting exchange of emails, it would appear to us that, having been promised that you would be able to engage meaningfully in the process, you were then deliberately excluded, in effect. Is that also your reading of what happened?

**Yusef Azad:** Yes. As you see in the evidence, we were given many assurances throughout the process that came to nothing. I feel that NHS Digital basically tried to protect itself from challenge and proper scrutiny during the review process. Our view is that that is a poor decision-making process, and poor process can lead to poor decisions.

Q26 **Mr Bradshaw:** Have other organisations experienced a similar exclusion from the process in the same way as yours, or were you uniquely discriminated against or excluded?

**Professor Newton:** It is fair to say that we were consulted on the back office review, and our evidence was made available to NHS Digital. It refers to it, so our evidence was clearly considered by it.

**Yusef Azad:** If I may add a postscript about our concern, the letter was not just from us—it was signed by, off the top of my head, 18 other organisations across the spectrum. None of us, as NGOs with an interest in this area, was consulted. What we experienced was what every NGO experienced.

**Chair:** Thank you for your detailed memorandum on that.

**Dr Bailey:** On the point about engagement, the National Data Guardian does not feel that she is being excluded, but she has expressed some

---

"Goddard" Review in November 2017, the Department of Health and Social Care had already written to Duncan Selbie in August 2017 requesting PHE to start scoping such a review. The Department of Health and Social Care has asked PHE to complete its review by 16 January 2019.



disappointment. She first engaged with the National Back Office review in 2015, provided some information and asked for further information. She has expressed disappointment at the timeliness of her involvement in 2017, although, more recently, efforts have been made to keep in touch.

Having said that, Dame Fiona was disappointed to discover that the MOU had been reviewed by a notice on the NHS Digital website. Late last week, the chief executive of NHS Digital wrote to her with an expansive letter, which is encouraging, and Dame Fiona is considering her response to that.

**Q27 Mr Bradshaw:** It sounds to me as if it had already made up its mind and wanted to make its own life easier. You are all nodding to that. Why was that? What happened, do you think? What was the reason for it to exclude you in this unusual way? Do you have any intelligence that you can share with the Committee? Have you heard any reports or inside information?

**Yusef Azad:** Well, I am looking forward to the second half of the evidence session. I had the sense that there was some tension and stress across the three bodies involved—the review team and NHS Digital, the Department of Health and the Home Office. That was at one or two removes, however.

**Q28 Mr Bradshaw:** What do you mean by “stress”?

**Yusef Azad:** As to the degree to which the review should reach outwards to consult people other than organisations, as it were, on the—

**Q29 Mr Bradshaw:** Was it that the Home Office did not want any proper consultation, but the others did? Is that your understanding?

**Yusef Azad:** I would not want to speculate further than what I have said.

**Q30 Chair:** John, if you are producing an interim report, would you be able to share that with the Committee? That is an area of ongoing interest for us.

**Professor Newton:** I cannot see why not. We would be keen to be entirely transparent about the review.

**Q31 Chair:** When are you expecting that to be available?

**Professor Newton:** I thought you might ask me that. As I say, we are still scoping it, but we could certainly offer you an interim report after a year. We were asked to do this in November 2017<sup>2</sup>, so by November 2018 we could certainly offer you an interim report. However, it would be difficult for me to be precise about how much we would be able to cover by then.

**Chair:** Thank you very much for that, and thank you for coming this afternoon.

---

<sup>2</sup> See footnote 1.



## HOUSE OF COMMONS

I am conscious that we have a number of votes coming shortly in the House, and that our next evidence session is extraordinarily important. I would like to adjourn this session now, so that the Committee can make a decision about whether to postpone the second session, given the seriousness of the matters under consideration.

I thank all of you for coming today and for your very powerful evidence.

*Committee suspended for Divisions in the House.*

*On resuming—*

### Examination of witnesses

Witnesses: Lord O'Shaughnessy, Sir Ian Andrews, Sarah Wilkinson, Caroline Nokes, Jonathan Marron, and Hugh Ind.

Q32 **Chair:** Welcome back and thank you very much for your patience. We are not expecting any further votes at this time. Moving on swiftly, could I ask members of our second panel to introduce themselves for those following from outside this room, starting with you, Jonathan Marron?

**Jonathan Marron:** I am Jonathan Marron. I am the acting director general for community care in the Department of Health.

**Lord O'Shaughnessy:** I am James O'Shaughnessy, Parliamentary Under-Secretary for Health in the Lords.

**Caroline Nokes:** Caroline Nokes, Minister of State for Immigration.

**Hugh Ind:** Hugh Ind, director general for Immigration Enforcement.

**Sarah Wilkinson:** Sarah Wilkinson, chief executive of NHS Digital.

**Sir Ian Andrews:** Ian Andrews, senior independent director, NHS Digital.

**Chair:** Thank you very much. Dr Williams is going to start the questioning this afternoon.

Q33 **Dr Williams:** Lord O'Shaughnessy, do you expect GPs, doctors and nurses to inform their patients that their names and addresses might be shared with the Home Office?

**Lord O'Shaughnessy:** The issue here is the legal basis on which the data holder, which in this case obviously is NHS Digital, is able to share information. From that point of view, given that NHS Digital has established it is a lawful thing to do, if GPs want to inform their patients that that is what happens they are able to do so.

Q34 **Dr Williams:** I work as a GP. Patients often ask me, "Is the information that I am giving you going to be held in confidence?" I have always told them that it will be held in confidence unless they commit a serious offence, say, if they are suspected of murder or rape. But should I also



## HOUSE OF COMMONS

mention to them that if they commit an immigration offence that information will be shared with the Home Office?

**Lord O'Shaughnessy:** I do not think it is quite the case that it will be shared. Obviously, the topic under discussion is that this is administrative information, which is a critical point. We are very clearly not talking about medical or clinical information—

Q35 **Dr Williams:** It is not any instance of murder either. I would not share any medical details; I would only share their name. But, anyway, go on.

**Lord O'Shaughnessy:** I understand. That administrative information, which, as you know, case law has concluded is at the lower end of the spectrum of confidentiality, can be shared because of the 2012 Health and Social Care Act, which gives it that legal basis, if there is a request from the Home Office that passes the tests and goes through the processes that are operated by NHS Digital. That is the reality, and so, from your perspective, that is—

Q36 **Dr Williams:** So, there is that recommendation that doctors and nurses tell their patients that—

**Lord O'Shaughnessy:** I do not really have a position on whether it is a recommendation or not, but that is the reality of what happens, or the situation that can happen.

Q37 **Dr Williams:** Do you recognise that the sharing of this information might have an impact on the relationship between doctors and nurses, health services and their patients?

**Lord O'Shaughnessy:** I do not see that it should, because the NHS shares administrative information with other bodies for a number of purposes. One of the examples is for the recovery of debts, for example, or it shares this kind of information with the Office for National Statistics. Information is shared for a wide variety of reasons according to tests of lawfulness and proportionality, and so on. I do not think that ought to affect the relationship.

Q38 **Dr Williams:** We heard evidence earlier on today that there are patients—people—sometimes pregnant women, showing symptoms of illness, who are being deterred from seeking medical services because they are worried that their demographic information might be shared with the Home Office, with immigration officials. Does it concern you that people are not accessing—

**Lord O'Shaughnessy:** We have a system, critically—it is important to state this—that, whatever your immigration status, you are able to access primary and emergency care, and to do so for free. That is a very important point. It is equally important to underline that fact to patients—that they are able to do that. Clearly, the question we have to consider is: where immigration offences have occurred, what is the proportionate response to sharing that information? That is the process that we as a health system have gone through to make a judgment about



## HOUSE OF COMMONS

what is the right approach in those circumstances. I am sure my colleagues who are operationally delivering this will explain how they have gone about providing that reassurance.

- Q39 **Chair:** We have heard some very powerful evidence this afternoon about the real impact that this is having on trust and on people's willingness to come forward. It is clearly having an impact, yet you say that it is an inaccurate presumption that the duty of confidentiality should apply to such information in the health sector.

**Lord O'Shaughnessy:** I am sorry—I do not think I said "an inaccurate presumption."

- Q40 **Chair:** The evidence we are hearing, and it is very powerful evidence, is that it is clearly having an impact. Therefore, this data is important and there is a sense in which the idea that this data is important, and part of confidentiality has just been run roughshod over. There has been a change in the way it is being treated.

**Lord O'Shaughnessy:** I do not think it has been run roughshod over. What we have established are a set of processes and governance in an area in which—don't forget—this information has been shared for decades, which now provides proper governance, proper rules and processes. We have established case law on which it is based. There is a robust process that assesses public interest in each individual application for information.

- Q41 **Chair:** But it is not assessed individually; this is the point. It is not happening on a case-by-case basis, is it? It is happening—

**Lord O'Shaughnessy:** It is assessed on a case-by-case basis, as my colleagues from NHS Digital can explain, because, of course, they are operationally doing that. The role of the Department is to make sure that the health system is operating in a way that is legal and proportionate.

**Chair:** Perhaps we could bring NHS Digital in at this point, because that is an important point.

- Q42 **Rosie Cooper:** Sorry, Chair, but before we go on would the ministerial team let us have a list of those organisations with whom they will share the data, because I have never heard of it being used by people who are trying to collect debts? Some of the things you just said then I find really incredible.

**Lord Shaughnessy:** Of course we can share that.

**Rosie Cooper:** If people knew that, they would be horrified.

- Q43 **Chair:** Just to clarify, you are talking about people who have debts to the Health Service itself; you are not talking about other forms of debt collection.

**Lord O'Shaughnessy:** Debts to the Health Service, yes.



## HOUSE OF COMMONS

Q44 **Chair:** We are not talking about debt collection agencies.

**Lord O'Shaughnessy:** No, no.

Q45 **Chair:** We need to make that very clear to people, because that could be a message that could go out from this room. So, could you just be absolutely clear that it is debts to the NHS?

**Lord O'Shaughnessy:** Absolutely. It is debts in the NHS for services provided by the NHS.

Q46 **Dr Williams:** It is not shared outside the NHS.

**Lord O'Shaughnessy:** No, no, no.

Q47 **Dr Williams:** I misunderstood you then, because I thought you were talking about it being shared with debt collectors.

**Lord O'Shaughnessy:** No.

Q48 **Dr Williams:** What other circumstances are there where the information is shared outside the NHS? There are serious offences such as murder, rape and potential serious harm to the individual. Then it has been considered that disclosing this information for immigration offences is a proportionate response as well.

**Lord O'Shaughnessy:** Just to be absolutely clear, I am talking about the collection of NHS debts, so debts incurred for the provision of NHS services to people who are not eligible for free care. Thank you for the opportunity to—

Q49 **Chair:** We have to be very careful, as I say, that that is not misinterpreted.

**Lord O'Shaughnessy:** If I may, just on that point, section 261 of the Health and Social Care Act 2012 provides the statutory basis for disclosure, and it gives three categories. One is a criminal offence, and it is important it says "criminal." It does not attempt to define a serious criminal offence; it says "criminal offence." The second is to fulfil statutory functions, and the third is to promote an individual's welfare. So, just to be absolutely clear, that is what the statutory basis is for data sharing.

Q50 **Dr Williams:** That is the legal basis, although of course my question was about doctors and nurses. They have guidance.

**Lord O'Shaughnessy:** Yes, the code of conduct.

Q51 **Dr Williams:** It does not talk about all criminal offences; it talks about serious criminal offences.

**Lord O'Shaughnessy:** Indeed.

Q52 **Dr Williams:** There is a difference between the guidance that is given to doctors and the law.



## HOUSE OF COMMONS

**Lord O'Shaughnessy:** What reviews like the National Back Office reviews and others have concluded is that there needs to be a review of that to make sure of the compatibility of the different interpretations. That is something NHS England is undertaking, to conclude, I believe, by the end of the year.

Q53 **Chair:** It is surely a very worrying matter that the guidance to doctors is at odds with the guidance that you are operating under, in these circumstances, given the point that Paul raised at the beginning. Should he, as a GP, be sharing that information? Does he then immediately put himself in conflict with professional guidance because he is sharing it, in the knowledge that someone else is operating under a different ethical code when it comes to sharing that information with immigration officials?

**Lord O'Shaughnessy:** That is what we need to establish, to make sure that those two are in harmony with one another, which is the purpose of the review.

Q54 **Chair:** Will that review adequately bring in those who have concerns about this?

**Lord Shaughnessy:** Yes, of course.

Q55 **Chair:** Because we have very serious concerns that those organisations who were assured that they would be involved in a review were then not included in the review. Will that adequately involve the Information Commissioner? Will it involve the GMC? Will it involve all of those who have a clear interest and concern in this matter?

**Lord O'Shaughnessy:** Yes.

Q56 **Chair:** You give this Committee your absolute assurance that that will—

**Lord O'Shaughnessy:** Yes. It will be a broad review, with, obviously, stakeholders being involved.

Q57 **Chair:** Thank you. We were slightly side-tracked because I was just about to ask if Sarah Wilkinson could comment on that point about whether it genuinely is a case-by-case basis, because what people understand by that is that every individual's case will be considered. Our understanding is that it is happening almost at a guideline level; if there is a request made, then that request is processed. What do you mean by case-by-case basis?

**Sarah Wilkinson:** The process is defined in such a way that it is effectively on a case-by-case basis, based on the public interest test having been applied to a particular kind of application that satisfies very specific criteria. Category 1 applications, which are, as you know, more than 99% of those that we satisfy, have to meet very specific criteria. They have to point very specifically to the particular immigration crime under section 24 and 24A of the Immigration Act 1971, and they have to fulfil a number of other criteria. The Home Office has to confirm that it



## HOUSE OF COMMONS

has done its own public interest test and that it has satisfied a number of other things.

If those applications are received and our clerks are content that they are absolutely precisely following the structure that we have defined for them, then we have assessed that applications that meet those criteria will meet our public interest test. The public interest test was devised at the level of the category of application such that it could be safely applied to every single application in that category.

- Q58 **Chair:** One of the problems is that, when we look at the factors that were taken into account around the public interest test, featuring quite heavily here is that the loss of contact with public authorities may prejudice or compromise the health and welfare of immigrants through them not receiving the appropriate support and services. If you were looking at that on a case-by-case basis, if the purpose of this is to deport them, then, clearly, they are not going to receive those appropriate services in any case. So, how much does it feature in your case-by-case analysis whether or not they have something that should be treated?

**Sarah Wilkinson:** There are two categories of application that are used by the Home Office today. One is the category A application, where they suspect somebody to be potentially guilty of an immigration crime. That is more than 99% of the applications from them that we respond to. There is a smaller proportion that we respond to that are category 2 requests, which is where there is a welfare concern. If there is a welfare concern, we do have a process for looking at individual public interest test considerations, because those are, by nature, just more complex, more bespoke, and they have more information in them, whereas for the category A requests, which are the bulk of it, it is really quite a simple process.

The Home Office has to say, very specifically, which immigration offence it suspects this individual to have committed and it has to tick a bunch of other boxes. If it does that, our existing public interest test for category A applications says that we should process those requests.

- Q59 **Chair:** Right. So, there is not somebody looking genuinely on a case-by-case basis, as clinicians would understand it.

**Sarah Wilkinson:** The process is simply designed in such a way that that is unnecessary for category A applications, because the public interest test that we have defined considers all the factors in favour of disclosing this data and all the factors against disclosing it for applications that are for suspected criminal offences within those very specific clauses in the Immigration Act—nothing else. It is very specific.

**Chair:** It is not exactly what other people would consider to be a case-by-case basis.

- Q60 **Luciana Berger:** It will be helpful because the evidence we received from NHS Digital said, in paragraph 31, that the public interest test has



been conducted at the level of the application category.

**Sarah Wilkinson:** That is right.

- Q61 **Luciana Berger:** On reading that, that does not suggest that it is on a case-by-case basis. I understand, from the explanation that you have just given, that that might be the case, but it does not chime with what you have given in point 18 about how you consider other factors considered in favour of disclosure versus against. It would appear that you just appraise each application according to those factors that you consider in favour of disclosure, not those that you consider in favour of not disclosing. I do not believe that that paragraph that you have shared with us is accurate in light of the explanation that you have just given us.

**Sarah Wilkinson:** I apologise if that is not clear, but, as we say in the document, the public interest test is applied at the level of the category. So, any category A application that arrives and fulfils the precise and exact criteria for a category A application is pre-qualified by our public interest test, which applies to applications of that nature.

- Q62 **Luciana Berger:** Why do you believe, according to everything you have shared with us, that the public interest test is required, essentially, to breach the patient-doctor relationship? That is what is not really explained in the evidence that you have provided to us.

**Sarah Wilkinson:** There is indisputably an unhelpful gap in terms of the use of the words "serious crime" in the NHS code of confidentiality, versus the guidance that we have in the Health and Social Care Act that defines the legal gateways for disclosure for us, but we simply seek to execute our statutory duty. We receive requests from the Home Office. We have simply looked to the Health and Social Care Act guidance as to whether we need to respond to that or not. Section 261(5) describes the gateways for disclosure, which Dr O'Shaughnessy has outlined. Section 261(6) refers to the need to look at the common-law duty of confidentiality, and then that is assessed with respect to the public interest test, which we do carefully.

As I say, there is this potentially unhelpful terminology difference in terms of the nature of the crime, but all we can properly do in NHS Digital is look to the legal framework that we are constituted under and attempt to precisely follow that.

- Q63 **Luciana Berger:** If I could just follow up on that, very briefly, Kingsley Manning is the former chair of NHS Digital, and he does not support the action that is being taken at the moment. If I can quote him, he said: "The lack of transparency in the decision to share any patient data between the NHS and the Home Office threatens that trust and therefore the integrity of the NHS as a safe haven for personal data." What is your response to that and why do you not share his view?

**Sarah Wilkinson:** The fair processing information on our website says very clearly and publicly that this data might be shared. I am obviously



## HOUSE OF COMMONS

very new to NHS Digital. I have taken a completely independent look at whether we are doing the right thing here. When you look at the legal basis for disclosure and the public interest test that we have conducted, it becomes clear that we are duty-bound to respond to these requests.

**Q64 Dr Williams:** Coming in on the public interest test, it comes down really to the public interest in maintaining the integrity of our immigration system versus the public interest in maintaining the trust in our health service.

**Sarah Wilkinson:** Exactly.

**Q65 Dr Williams:** There is a judgment to be made here. There is clearly a legal basis for what you are doing, but whether the consequence of what is being done undermines the public interest in the health service is probably the question that we are grappling with. The evidence that we heard from many different people in the first session was that, from a patient's perspective, their trust in the health service is being undermined.

**Lord O'Shaughnessy:** I would make two points, if I may. First of all, it is inevitable, in the process of these things, to hear from people with that view rather than people with the contrary view. It is important to identify patients, not least, as you say, for their own welfare. I do agree with you it is a balance. This is a balanced judgment and it has to be proportionate. That is the dual test of lawfulness and proportionality. As you say, the judgment on proportionality needs to be made on the basis of the evidence that is available and that evidence in itself being statistically reliable.

The second point I would make is that we do want to get to the bottom of what impact, if any, data sharing and existence of the MOU have on health-seeking behaviours, which is obviously why we have commissioned Public Health England to carry out the review that it is doing. At the moment, there is not statistically robust evidence that there is that kind of behaviour. Obviously, you have heard evidence that there is, and it is important for us, as a health system, to establish that there is, because, clearly, that is going to inform any judgment about the balance.

**Q66 Andrew Selous:** I am glad you have mentioned Public Health England because it is your statutory public health adviser within the Department of Health. It was clear to you about its concerns on the impact on public health of this measure. It gave you advice, which you ignored. What was the reason for that?

**Lord Shaughnessy:** I need to know what sort of advice you are referring to.

**Q67 Andrew Selous:** I can read you Public Health England's advice: "In summary, it is the opinion of Public Health England that sharing demographic data from health records to facilitate the tracing of



## HOUSE OF COMMONS

individuals in relation to possible immigration offences is concerning from a public health and personal healthcare perspective." That is from Public Health England.

**Lord O'Shaughnessy:** Indeed. What it has also said is that there is not the robust statistical evidence to back up that degree of concern. That is why we have commissioned it to carry out that study, so that we do have the evidence on which to make a proper judgment, which is the right thing to do.

Q68 **Chair:** We also know, from our earlier panel, the obvious point that absence of evidence is not evidence of absence and effect, and that there are very clear reasons for believing that there could be such an effect. Should you not have applied the precautionary principle to this?

**Lord O'Shaughnessy:** What we have discussed is the need for proportionality, and we have to work on the basis of a strong evidence base that is reliable in making a judgment. We want to have that evidence base, which is why we have done it. That is a perfectly reasonable thing to do. It was a recommendation of the National Back Office review to do so and we are carrying out, if you like, its recommendation.

Q69 **Andrew Selous:** It is a little bit late, is it not? The National Data Guardian suggested that it happen in 2015, so you are a little bit behind the curve on this. I know you weren't in post then.

**Lord O'Shaughnessy:** No. The point is it has been commissioned and it will report in a year's time.

Q70 **Dr Williams:** You have used the phrase "robust statistical evidence." We are talking about a population of people who, by definition, are undocumented. The Home Office does not have robust statistical information about this group of people. That is why it is trying to seek this information. What evidence could Public Health England collect that would be able to tell the story if this group of people were being deterred from accessing the health service?

**Lord O'Shaughnessy:** I do not think that is for me to say. That is for it to make a judgment. It has been asked to carry out the review and it will use whichever methods of research it thinks are appropriate.

Q71 **Dr Williams:** It has provided a number of pieces of evidence already.

**Lord O'Shaughnessy:** We have not sought to limit the scope of that review in determining one research method over another.

**Chair:** I know Luciana wants to come in, and then we are going to move on to another aspect of this.

Q72 **Luciana Berger:** Further to what we heard in the last session, this really is a life or death matter for some people. We heard some really striking evidence about someone who was burned, who would not come forward because of this, and eventually went on, for a different reason, to not



## HOUSE OF COMMONS

access treatment. On the basis of that, I am going to ask the Ministers, do you not think this is something you should reconsider? We are talking about, essentially, the most marginalised group of people in our society, who, as my colleague has just pointed out, are not documented. This is a life and death matter. Do you not think that is important in the consideration of why this should be in place?

**Caroline Nokes:** It is important that we know who people are and where they are, which is why the Home Office makes a range of checks with a range of different organisations, to try to identify where immigration offenders are, where they are living, where they are drawing on services. It is part of a suite of products that we have. We do not wish to deter anybody from seeking health treatment where it is necessary, but, equally, we have a public interest to make sure that we know where as many people are as possible.

**Lord O'Shaughnessy:** Of course it is important. No one seeks to diminish the instances that you are talking about. The NHS exists to provide care to people. Again, I would reiterate the fact that primary care and emergency care are provided for free, whoever you are. That is quite an unusual feature, if you look internationally. That ability to access care is not diminished; that exists. At the same time, obviously, we have to weigh that in the balance for public interest with having a robust immigration system that has security concerns and that has the confidence of the public. I do not think these are ever easy judgments, but they are judgments based on the balance of evidence.

Q73 **Andrew Selous:** On that issue of judgment and proportionality, perhaps I could ask the immigration Minister; I understand that in 2015-16 there were 195 cases in which a tracing request to NHS Digital resulted in an update on the information already held by the Home Office. In how many of those cases did that extra piece of information lead to the apprehension of a person sought and the resolution of an immigration case?

**Caroline Nokes:** It is important to reflect that in many instances we will have sought—in all instances we will have sought—information from other organisations. What we cannot know, from the data we receive from NHS Digital, is whether that is confirming an address that we already had, whether it is providing an address that is no longer current or accurate, and whether, indeed, that necessarily means that somebody moves to removal or, in fact, they might then have the opportunity to regularise their immigration status. It is impossible to draw a cause and effect from, "NHS Digital has provided us with an address that we have then used and somebody has been removed," because, in many instances, the information provided may not add anything more. It may simply confirm something we already had. This is all part of the suite of the compliant environment, which is important to us in having a robust and enforceable immigration policy.

Q74 **Andrew Selous:** Perhaps Mr Ind might like to comment on my second



question as well. If the Home Office was not able to make tracing requests of NHS Digital, how serious a blow would that be to the maintenance of effective immigration controls?

**Hugh Ind:** I think it would be very significant. As the MOU says, this information will be used in conjunction with other information we have. Therefore, it is not surprising that we cannot precisely separate out all of these bits of information and what conclusion they led to. We cannot apologise for that; it is on the face of the memorandum of understanding. I know addresses are very valuable to us in tracing people and re-establishing contact, and it is re-establishing contact that we are after.

**Q75 Andrew Selous:** Coming back to you, Lord O'Shaughnessy, again, it is a judgment, as you have already said, about the potential damage to public health. We are thinking of possible infection and things like tuberculosis; we are thinking of some conditions—diabetes, for example—which, if left over a period of time and they deteriorate, are much more difficult to treat and much more expensive to treat, so therefore adding extra cost to the NHS. How is the balance of that decision made between the impact on public health and possible NHS cost, and demand on NHS resources, when conditions deteriorate, as opposed to the immigration benefit? How is that decision made and what factors are you taking into account?

**Lord O'Shaughnessy:** First of all, let us start with the kind of offences that we are describing. We are not talking about the most serious category of offences, but we are talking about things like escape from detention, obtaining leave by deception and failure to comply with reporting restrictions. We can class these as significant offences. They are not low-level offences.

Then the question is: is the data being shared appropriate, if you like, proportionate to the level of offences that we are talking about? As the case law has established, it is at the low end of the spectrum of confidentiality; so, that is a factor as well. If you like, we are the receivers of a request as the health system, and therefore our duty is to comply with the law. That is obviously what NHS Digital has to weigh up and it has to make a judgment to say, "Is the level of information being given proportionate to the kind of offences being described, in a way that complies with the law?" That is the judgment that has been taken, as I said, on the basis of the information that we have.

I should point out the reason that we have commissioned the review is precisely so that we make sure that we are making that judgment on the basis of the fullest set of information, so that we can comply with the law.

**Q76 Andrew Selous:** You said something interesting in one of your earlier answers, about sometimes only one side of the argument can be heard in this debate. Within the Department of Health, do you have any polling evidence on what the public's view overall is about the use of NHS services by people who may not be entitled to its use and who have committed immigration offences? Is there a public voice here that



## HOUSE OF COMMONS

perhaps has not been heard?

**Lord O'Shaughnessy:** If there is I have not seen any, but—

**Jonathan Marron:** Not to my knowledge, but would you allow me to check and come back if we have? I do not have all the information—

Q77 **Luciana Berger:** Mr Ind, you just said that it would be very significant if you were not able to access this information. If I can just clarify the details. I do not have the exact number in front of me, but in 2015-16 around 6,000 requests were made to NHS Digital, of which, as my colleague Mr Selous just said, only 195 cases came back with any sort of updated information.

The question was then asked: of those 195 cases, how many resulted in any action by the Home Office in terms of apprehension or a resolution of the immigration issue to be addressed? Doing my maths, that is just over 3% of cases that came back with any additional data. You are not able to tell us today, of the 3% of requests, what resulted in any action as a result.

We have requested the figures for this financial year, and, as I understand it, the Clerk of the Committee has had a response from NHS Digital to say that the team has been focused on service commitments, which is why you are unable to give us the data for this year. I wondered if, perhaps, NHS Digital can tell us when we might expect the data, and if Mr Ind can tell us if he perhaps might reappraise his assessment that this is such a significant issue.

**Sarah Wilkinson:** I will make sure you have the data by the end of the week.

**Luciana Berger:** Thank you.

**Hugh Ind:** I do not want to reappraise my opinion. Any address is useful information to us. As the Minister said, it may confirm something we already knew. It may be a new address that we have never heard of. All of this information is useful to us, either to corroborate what we already know or to give us new information. It is not all about telling us an address we have never heard of before.

Q78 **Chair:** If there are 195 cases where there is an update, is that so significant that it is worth all the potential harms that we have had set out so clearly to this Committee?

**Hugh Ind:** We think the data we receive back is significant and it is definitely worth continuing with the operation of this MOU.

Q79 **Chair:** In what way? Given that you cannot tell us how many times it results in a change of action, how can you be sure that it outweighs the very serious harms that we have had outlined to us by the first panel?

**Hugh Ind:** Because one of the key issues for immigration enforcement is retaining contact with people; because the value of current addresses is



extremely important across the range of partners we deal with. So, in general terms, I am very well aware of the value of updated or corroborated addresses. That is precisely the information and the only information we receive from this arrangement with NHS Digital.

- Q80 Dr Williams:** Are you familiar with the harm, though, and the fact that the trusting relationship between a clinician and their patient is at the very heart of the contract that the NHS has?

**Hugh Ind:** Now you are taking me out of my area of personal expertise, into Department of Health and PHE colleagues. I understand what you are saying. I just think our professional colleagues should make that judgment.

- Q81 Chair:** It is very interesting that the public interest in confidentiality is not mentioned at all in the memorandum of understanding. Why was that left out?

**Lord O'Shaughnessy:** I do not know, I wasn't there when it was written. We can certainly find out. The point about the MOU is that it was intended as an internal governance arrangement to formalise a set of processes that had been going on, but not in a uniform way. It is an operational document, if you like, rather than a strategic document.

- Q82 Chair:** Does it concern you that maybe the voice of health was absent and that it became a second-level interest to the interests of immigration?

**Lord O'Shaughnessy:** No, I do not think that is the case. There was obviously a discussion with all the relevant partners—the Department, NHS Digital as the data processor and the Home Office—to come up with, as I say, an arrangement that means we abide by the law and we carry out our duties in a proportionate way. As you know, I was not there doing it personally, but my understanding is that is the process that was gone through in order to establish the MOU. I should point out that formalising this process was a recommendation of the National Back Office review, which was carried out precisely to give a more formal set of rules around these kinds of behaviours.

**Jonathan Marron:** I would just say that we are confident that the voice of health was heard in this process and in reaching that balance between the two interest tests. If that does not spring off the page of the MOU, then maybe we should think about how we communicate that. The MOU really was an attempt to put a proper process around an existing data-sharing arrangement, so we approached it with that spirit. If we had thought this was going to be the document that would be the document used to explain to the public, we might have thought harder about exactly how we expressed it, but I do not think it changes the test, how we used it or how we applied it.

- Q83 Chair:** All I would say is that there are five paragraphs to the public interest in disclosing information for the purposes of immigration, but



## HOUSE OF COMMONS

there is nothing on the interests of a confidential medical service. We have heard very clear evidence this afternoon and in our written evidence about the risks of undermining that very important principle, and yet there is nothing there. Why is there nothing there?

**Jonathan Marron:** The assurance is that we take the confidential patient relationship very seriously. The importance of that to the health service is clearly very important to us. In this case we believe we have a proportionate judgment, that sharing administrative data, which as the Minister sets out is at the lower end of confidential data, for the purposes of assisting in having a robust immigration system, was proportionate and met the test. I find that the question, "Why did you not write more of that in the MOU?" is a really good challenge. I do not think you should read the MOU as, "We did not do it," or, "We did not care about it." I am accepting a drafting challenge rather than as an insight into how the Department felt.

**Chair:** I think it needs to be more than a drafting challenge. Paul, did you want to make another point there?

Q84 **Dr Williams:** Yes, because I have heard two things. I have heard that the MOU was just an attempt to write down an existing arrangement, but I have also heard that proportionality was considered at the time of drafting the MOU. Which is right? Was proportionality considered? Again, was the whole system reflected upon at the time of the MOU, or was the MOU just a way of writing down a decision that had already been decided and post-rationalising it?

**Jonathan Marron:** The process of getting the MOU followed the process of looking at the data-sharing arrangements that existed, a thorough set of reviews that you have heard about in the evidence and were mentioned in the other sessions, and then agreeing between the three bodies a clear basis both for the process and a clear understanding that what we were doing was both lawful and proportionate. So, I think it is both.

Q85 **Luciana Berger:** Are you able to confirm, please, if the MOU was entered into under ministerial direction or whether it was entered into under direction from NHS Digital? Where did it initiate from? Where did it come from?

**Jonathan Marron:** It initiated from the initial reviews of the existing arrangements for sharing data. I am afraid I do not know back to the 1980s—

Q86 **Luciana Berger:** Who co-ordinated it? There is always a co-ordinator. Where was the co-ordinator based? Was it in the Department of Health, with Ministers, or was it in NHS Digital?

**Jonathan Marron:** The process starts with NHS Digital. Obviously, the Home Office has an interest in the data. The Department of Health played a role in bringing the two together and being part of our role in overseeing the system on healthcare, so we are involved in that way.



## HOUSE OF COMMONS

**Sarah Wilkinson:** The Health Select Committee triggered two reviews, conducted by our board, which were discussed. That triggered us setting up the MOU. That is how it came into being.

Q87 **Luciana Berger:** So it was co-ordinated from NHS Digital.

**Sarah Wilkinson:** Yes, that is what I am saying. The review process of what data was being shared and the recommendations that came out of that to formalise that through MOUs was the work of NHS Digital following a Health Select Committee recommendation. That resulted in the nature of this data-sharing arrangement being written down, if you like, in the MOU.

Q88 **Chair:** Can I just clarify that our recommendations triggered the back office review, but they did not trigger directly the memorandum of understanding?

**Sarah Wilkinson:** Indeed.

Q89 **Chair:** That is a very important distinction. Thank you.

**Sir Ian Andrews:** Chair, would it be helpful if I provided some background?

**Chair:** Yes.

**Sir Ian Andrews:** I am here as a senior independent director of NHS Digital, but also the last representative standing from the steering group of this particular programme. One also has to recall that the original trigger for this was the Partridge review, looking back at the history of data release from precursor organisations to what was then the Health and Social Care Information Centre and now NHS Digital. That identified that there were a number of mechanisms for sharing, from NHS Digital, outside the family. The NHS Digital board, at the time, was very concerned about that and commissioned a review by my then colleague, Professor Maria Goddard, into the operation of the National Back Office in Southport.

That was really to establish two things: the legitimacy of the processes that were going on and the fitness for purpose of the way in which the office operated. In that process, the review team took a lot of evidence from people, including those whom you were hearing evidence from earlier, and it identified a need to codify what was a slightly haphazard process whereby requests would come in and they would be channelled to the particular primary care service provider. The advice of the review team was that this needed to be codified in a way that was consistent, that provided transparency, and that ensured consistency of judgments, because the judgment made by whichever primary care service provider the request was directed to would vary.

It was important to provide guidance to the National Back Office staff, and in particular the Home Office staff, on the responsibilities on which they had to focus, on the specific legislative offence, and also, as part of



## HOUSE OF COMMONS

our statutory duty to reduce burdens on the system, to relieve the primary care service provider of having to handle a whole lot of requests.

Q90 **Chair:** So far so good. I do not think anyone would have any issue with that.

**Sir Ian Andrews:** I just think there is some context here, Chair.

Q91 **Chair:** But it is very important for people following this to have some context of it.

**Sir Ian Andrews:** Yes. One of the recommendations was that there needed to be a codified process. In discussion with Ministers, the proposal was that that should be a formal MOU. That is where the MOU came from. As colleagues said earlier, there is no significance in it being an MOU. This is a document that defines the process in a consistent way and enables people to apply it.

Two of the other recommendations of the review were that they identified, absolutely, the inconsistency between the existing NHS guidance and the need to revise that. Indeed, I might add in parenthesis, that that will also need to be revised against the background of Dame Fiona Caldicott's recommendations and GDPR, as it happens, and also the fact that there were conflicting views on the issue of the impact on health-seeking behaviour. Again, the recommendation of the review, which the NHS Digital board absolutely endorsed, was that further research needed to be commissioned into that.

Q92 **Chair:** Thank you for setting that background. One of the issues at stake here is, from that onwards, whether there was sufficient engagement with all those who had concerns about it, despite reassurance that they would be involved. Is that your understanding? Do you yourself have any knowledge of why, having been assured they would be involved in that process, they were then excluded from it?

**Sir Ian Andrews:** I was a member of the steering group; I was not chairing the process. I was not intimately involved in it, but my understanding and certainly my recollection was that a great deal of work went on during the early months of 2015. That included meetings to receive evidence from a range of stakeholders, including all the people you have mentioned and a number of others as well.

Then, during the summer of 2015, arrangements had been made for a workshop to which stakeholders would be invited in June. That, unfortunately, was derailed by the election. It was rearranged for August, but that did not happen. Indeed, Maria Goddard wrote to all the people who were due to be at that event on 22 July 2015, explaining that, as a consequence of changes in ministerial responsibilities, we were not in a position to make further progress in addressing some of the issues that had been raised, but we had taken those on board, recognising that the next stage would be that the report would come out and would reflect the conclusions that had been drawn on the evidence. That letter went to all



the people who were due to be at that meeting and made clear that, in effect, there would not be a further opportunity before the report was due because we had run out of time.

**Q93 Chair:** Do you think, on balance, it would have been better to extend the time that you gave to this before introducing the MOU and to take fuller account of the concerns expressed by PHE, the Information Commissioner and from all those who submitted that evidence?

**Sir Ian Andrews:** With regard to the NGOs who were consulted, Maria Goddard expressed her disappointment that this had happened, and I recognise that it would have been disappointing, but the fact is that we were where we were.

As far as the MOU is concerned—there is, if I may, just a little risk of misunderstanding here—the MOU was put in place to codify a process that had been going on, in a slightly incoherent way, for some time. In my view—and I have been around in the public sector for more decades than I care to remember—an MOU is not a legally binding document. It is something that defines a process by which different parties work. I do not believe that it would have been appropriate to have consulted on the MOU. The report made clear that the recommendations were that the process needed to be codified, and that, I think everyone would agree, was the right thing.

**Q94 Dr Williams:** Who has the power to stop this? If NHS Digital were to decide, for policy reasons, that it was inappropriate to be sharing information given to health services in confidence with immigration authorities, would NHS Digital be able to stop this?

**Sarah Wilkinson:** Yes. If we decided that there was evidence that meant that we should review our public interest test assessment and the result of that review concluded the other way than it has done now, absolutely we would stop the data sharing.

**Chair:** Right. Thank you all for coming this afternoon.