NHS Scotland Public Benefit and Privacy Panel for Health and Social Care (HSC-PBPP)

Committee Meeting: 10th November 2020

Item No.: 2.1

Paper No.: 2020/21-017

Unapproved Minutes of the HSC-PBPP committee meeting held on 8th September 2020 by MS Teams

Purpose
A record of the discussions and decisions of the committee.
Recommendation
For committee members to check and approve minutes at the meeting.
Name of the Author: **Designation:** **Email:** phs.pbpp@phs.scot

Public Health Scotland

NHS Scotland Public Benefit and Privacy Panel for Health and Social Care

Minutes of the Committee meeting held on 08 September 2020 by MS Teams

Present:	Dr Lorna Ramsay (Chair) (LR) Professor Helen Colhoun (HC) Professor Danny McQueen (DM) Dr George Fernie (GF) Carole Morris (CM) Professor Abbe Brown (AB) Martin Bell (MB) Penni Rocks (PR) Alan Ferrier (Al F) Dr Steve Pavis (SP) Kenneth McLean (KM) Dr Richmond Davies (RD)
In attendance:	Professor Roger Halliday (RH) Dr Marian Aldhous (MA) Phil Dalgleish (PD) Susan Kerr (Secretariat)
Apologies:	Professor Alison McCallum (AM) Professor Corri Black (CB) Dr Angus Ferguson (AF) Dr Maria Rossi (MR)

1. Chair's Welcome

The meeting is quorate with RD present as PHS representative.
There are no conflicts of interest.

LR thanked both GF and KM who have extended their membership for another term, until 2023.

RD gave an introduction and advised that he was here on behalf of Andrew Fraser, Caldicott Guardian from PHS. In future a Consultant in Public Health Medicine, newly arrived from NHS Grampian will represent PHS.

2. Minutes and Actions of Previous meetings

2.1. Minutes of meeting held on 16 June 2020

The minutes from the previous meeting on 16 June 2020 were approved.

2.2. HSC-PBPP committee Action Log

Action 04-02-20/ 02 SHARE: this has now been superseded due to COVID and is now closed. No further comments.

3. Matters Arising

3.1 Update on special (commercial) applications

RDS to progress commercial model; develop based on experience from Health and Social Care. NSS will process this as part of wider Innovation Steering Group. Commercial work to take forward under Innovation Enablers.

More work will start soon on health matters, to review what is applicable beyond health. Now new national innovation steering group. A number of work streams with different enablers and will work around this commercial model. One work stream on innovation enablers (LR leading), around commercial model, including Scottish Enterprise, Research Data Scotland (RDS, Roger Halliday) Tom Steele (SAS), Christine Mclaughlin (SG). The group reports to the Cabinet Secretary.
LR agreed to keep committee up to date with progress.

3.2 Safe Haven accreditation

For the National Safe Haven, non-health accreditation is going through via UK Statistical Authority and ONS accreditation under the Digital Economy Act and Digital Accreditation. National Records of Scotland (NRS) is in process of providing information about their components. Once all three are in place, it would then be full accreditation. This will thereafter be reviewed annually; if there are significant changes from the previous year, this have to be a more comprehensive review.

HC asked about access for user groups? Not every application will host in a Safe Haven.
PR replied that we need proportionate and consistent standards for secure environments, with compliance expected across the public sector. Scottish Government has set up competent authority to look at this, as it all needs to be used in consistent way. Work is being set out but not yet in place.

4. Standing items

4.1 *Panel Manager Report*

Numbers are given to end July 2020.
MA explained that there has been some delay to non Covid-19 applications due to Covid-19 applications taking priority. An extra Tier 1 panel has been arranged to address the backlog.

KM asked whether there would be a review of the quality of decision-making on applications approved by the rapid review panel?
LR suggested a review of the quality of decisions made on rapid COVID19 applications should take place. It was agreed that 25% e.g. 4 applications would be reviewed. It was suggested that it would be good to have a few people who were and who weren't involved in initial review.
AB, HC and KM volunteered to be part of this group.

MB suggested Simone Scott who is working with him could be part of this, Simone was a DPO in her previous post.
Timescale available for next meeting in November.
If any decision was thought inappropriate, then it would come back to LR as the HSC-PBPP Chair.
MA to identify applications and arrange the review by HC, AB, KM and Simone.

ACTION: 08-09-2020 / 01 MA

4.2 Policy Decisions and Case Law

Nothing specific to add to this document.
HC asked about the new intra-NHS Data Sharing Accord and its implications for HSC-PBPP. Public Health Scotland (PHS) and NHS National Services Scotland (NSS) are keen to do intra health and social care sharing, not just health.
PR stated that she could provide update which would include Health and Care Accord that PHS and NSS are doing.
AB informed group that she had included the following link:
https://www.informationgovernance.scot.nhs.uk/wp-content/uploads/2020/06/2020-06-17-Intra-NHS-Scotland-Sharing-Accord-v2.0.pdf.
This Accord has been developed to facilitate the legitimate, justifiable and proportionate sharing of personal data between NHS Scotland organisations as referenced in section 2A of the National Health Service (Scotland) 1978 Act for health care purposes. This Accord should be used: a. when there is a need to share or disclose data for the routine facilitation of patient care between NHS organisations for established purposes; b. for exchange of data pursuant to the management of the healthcare system in Scotland and c. when there is a need to rapidly and safely share data between NHS Scotland organisations in order to monitor and manage public health emergencies.

HC stated that the accord seems to say that there should be few bars to intra NHS transfer of information for three purposes: patient care, management of health care system and to manage health care emergencies. This potentially wipes away many things for HSC-PBPP.
PR said that this was a mechanism to ensure that didn't have to go to every health board for data sharing for direct care. Cross boards should come to HSC-PBPP to assess the benefit to public of the work carried out and risk of privacy to participants, with appropriate data protection paperwork. Rapid way of getting data controller approval across the piece.

RD stated that data is shared across NHS boards every day for specific purposes for many business as usual (BAU) purposes. He felt that this is not really anything to do with HSC-PBPP. E.g. Local Authorities, dashboards shared across public sector for health and social care.
HC stated that the Accord does not cover research, but have previously had applications for BAU transfers within the NHS, which would come better under the Accord. Someone needs to check remit of HSC-PBPP, in the light of the new accord, as does include research and patient care.
AB stated that from Terms of Reference (ToR) for HSC-PBPP, paragraph 1 includes "*Its remit is to carry out information governance (IG) scrutiny of requests for access to health data for purposes of health and social care administration, research and other well-defined and bona fide purposes, on behalf of individual data controllers*" and paragraph 2 "*This HSC-PBPP has a formal mandate to scrutinise requests to use NHSS-controlled data, and the NHSCR, controlled by the Registrar General, for research, direct care, healthcare planning, audit, or other well-defined and bona fide purposes.*
SP said he is in favour of accord to share data between GPs and boards for COVID work.
HC said so maybe this statement for purposes of health and social care administration is now unclear? Does the statement on HSC-PBPP ToR needs to be modified in light of this?

PR needs clarity for remit for HSC-PBPP. What should HSC-PBPP focus on and needs clarity. Need to put practical

MA and RD will review to review NHS Accord and provide clarity to applicants regarding what should come to HSC-PBPP in light of NHS Data Sharing Accord. MA to update ToR accordingly.

ACTION: 08-09-2020 /02: MA & RD

4.3 Scottish Government update

PR gave an update on the proximity app for Covid-19 exposure notifications. This tool adds additional benefits in contract tracing. It uses the same supplier and codes as that in Northern Ireland and Republic of Ireland. The app is anonymous in capturing people and unknown contacts: these are held in phone and not in a central database. If someone tests positive, then will be sent authorisation code to share alerts with other phones and give advice of what to do next. It helps people to know when the have been in contact with others with COVID-19 for immediate action. Statistics at UK level provided by Google and Apple. No symptom tracker or medical advice and does not access health records. Cannot book a test but can do that through NHS Inform. Uses ID keys through Bluetooth. Positive test goes to contact tracing service. Authorisation code then provides an exposure alert to others with appropriate advice. To go live on 11th September 2020.

LR asked about Google/Apple concerns and what further information is available about assurances about what it does/doesn't do?
PR explained that this has all been done through the Scottish Privacy Forum. Privacy Notice (live with launch), meetings with ICO, full DPIA (130 pages), web will give more details on privacy. The app is completely voluntary and each person can switch off notifications at any time.
The relevant privacy documents will be sent to the committee.

ACTION: 08-09-2020 / 03: PR

HC said that much has been written about precedents that are set. What about termination date for holding the data or wider issues for other tracking? https://www.nature.com/articles/d41586-020-01578-0
PR stated that this App is voluntary and a tool but not mandatory, people can uninstall and turn off Bluetooth. All Privacy information is available when downloaded and each person can agree or not to authorisation codes to be sent. This App is only for contact tracing not surveillance or compliance. Otherwise would lose the trust of the public.

DM asked about the Scottish App and how territorial e.g. residents in Borders get care in England?
PR People can download the App but it will only work in Scotland and can only authorise if in Scotland and not resident elsewhere. If phone NHS 24/ Inform will go through Scottish process; if use elsewhere will go through their system. WHO looking at ensuring that apps can be interoperable under EU and WHO authorisation.

LR will ports have advice that people should download the app?
PR stated that the app will be advertised on TV and Radio, and via NHS inform and NHS 24

AB stated that if becomes interoperability then challenges might arise from other countries systems being able to talk to each other? Has any thought being made in due course on interoperability to the challenges which might arise from (possibly) other countries systems being less privacy secure?
PR stated that looking at MOUs being developed with ROI and NI for interoperability. MOU will contain data protection sections and dependent on public trust. Ethics template for the app based on developing ethics framework with Data intelligence network.

AB felt that she would query word ethics as for some people has specific meaning and need to be clear in definitions.
HC stated that one important privacy issue in her view is whether apple and google are allowed to retain data on who has downloaded the App? Can they retain the info? They will know who has downloaded it. What are the implications for this?
PR confirmed that number of times the App is downloaded and keys shared only recorded not by whom. Statistics provided are at country level.

SP stated that the App is being hosted on the NES AWS cloud, so NES heavily involved in ensuring security.
The committee were reassured by amount of public engagement. Suggested link to privacy notices would be helpful so can be reassured.

4.4 Update from HDRUK

CM confirmed that the Director of PHS, Phill Couser has now become a member of HDRUK Alliance. The alliance is the representatives of the data controllers across the UK to provide insights and awareness of what is going on in creating HDRUK gateway, with the metadata of what data is available through UK. The aim is to streamline data access processes.
More recently, the Scottish Data & intelligence network has been put in place to coordinate and create a framework of research in relation to COVID-19 throughout UK. A national connectivity and core data research study over next 3 years, investigating demographics, symptoms, infrastructure and support for trials. There will be monthly sprints to establish what data is available through four trusted research environments (TREs, NSH in Scotland, NHS Digital in England, SAIL in Wales and Honest Broker Service in NI) and research accreditation processes. eDRIS is involved, to help establish whether the best approach for each research study question is through all four TREs or whether go through a specific one: the answer will depend on the specific research question and the resources available. Applications to HSC-PBPP will come through this way in future.
Will there be principles agreed for assurance for applications which will come through before the whole process is finished? There will be a framework of engagement as this would be good for the panel to see this earlier rather than later.
Scottish data preferred to be analysed within NSH as there are different legal arrangements.
It was agreed that we need to understand the projects before can advise.

HC asked if this is the same biosecurity for Public Health England (PHE) and PHS?
RH stated NHS Digital and NHS England will be face of HDRUK rather than digital biosecurity centre.

HC stated good initiatives but structures should not be used which might prevent other work to go ahead. If have people who know data well with those who know what questions to ask but HDRUK will have taken more time. HDRUK good but should not be only route to get work done.
CM stated that she is not seeing HDRUK as only route. But HDRUK as entry point ensures no duplication of work and data provision.
LR asked CM to keep us updated as the principles come in. CM agreed.

4.5 Update from RDS

RH gave update from RDS and IG aspects. RDS aims to use data for public data, allowing access while maintaining privacy, access by qualified researchers, and the data pseudonymised. Any income reinvested into service and any commercial outcomes ensure that benefits flow back to public sector. Three areas of development:

- Service design: journey for researcher. Nearly ready to share development plan, but needs IG input.
- Finance: funders and development of financial model
- Legal basis for company being set up: hopes to have this in place before end 2020

A proposal for the IG arrangements, to meet objectives of faster data access with reassurance for data controllers. DPIA for system for data and access to data by researchers. Suggestion that Data processing agreements (DPAs) will need to be in place between data controllers, eDRIS, and Safe Havens. eDRIS will concentrate on health data, while RDS on non-health datasets.
Now looking at scrutiny of individual projects and a system of data access agreements with researchers. There needs to be some sort of panel or steering group.
In the medium-long-term for IG, they are working with ICO to have safe researchers, data pseudonymised in Safe Haven environment. Will these data be classed as anonymous?
Aligning documentation with Stats-PBPP or other models of data owners. All have advantages and disadvantages and need to be assessed. Some engagement with HSC-PBPP as this develops.
Nothing definitive yet but moving towards short and longer term solutions to meet goals of RDS.

LR asked how will you want to engage with HSC-PBPP? What input do you need from whom? Or will you bring things to committee?
RH stated that some particular people are helping and some from this group.
Currently testing with individuals' knowledge and skills and will come back with clear proposition for November meeting.

ACTION: 08-09-2020 / 04: RH

LR asked about lay representation and input? CM, HC and RD already involved.
RH has spoken to Scottish Centre Administrative Researcher (SCADR) public panel but all still in development.
LR thanked RH. RH to let MA know if any input required in meantime.

5. PBPP Review and COVID-19 update

5.1. Chief Executives review

LR explained that this is currently not a high priority for the Chief Executives (CEs) and they are not concerned about the work of HSC-PBPP. Recent work for COVID-19 has been very useful to look at the processes and ways of doing things, and for implementing improvements. LR will report to the CEs group towards the end of the year.
Committee agreed for this to be taken off the agenda.

ACTION: 08-09-2020 / 05: MA

5.2. COVID19 response from HSC-PBPP and eDRIS

There have been some conversations with Stats-PBPP & eDRIS RCs regarding some COVID-19 applications and similar concerns have been raised by both panels. Concerns have usually been about quantity of data requested. It was agreed that it is useful to have that line of communication for consistent feedback and regular updates ongoing.
A report was provided to the committee. Recommendations made are; updated application form, data management plans for applicants, eDRIS review important; Tier 1 use of teams.

Need an opinion from committee on a few things:

- Capacity

LR stated that it is good to see perspective of eDRIS and panels. LR asked if comments we need to have formal feedback from applicants? Comparisons between previous and new applicants? LR noted that eDRIS and HSC-PBPP should be seen as whole process, despite different teams. Efficiencies put in place need to become part of normal processes and protocols.
PR agreed that this was a really helpful paper with useful recommendations. PR understand the arguments for sustainability as it was thought this would be short term. If the model is not sustainable is there a possibility of looking at something different that includes speed with thoroughness of scrutiny?
It was agreed to ask the Ops group are to address applicant feedback and capacity issues.
ACTION: 08-09-2020 /06: Ops group

- Prioritisation of COVID-19 applications:

CM feels that eDRIS are now seeing more applications that are more "nice to have" than urgent COVID priority. Need to be clear on prioritisation.
LR asked whether this could this be done by the Ops group?
CM felt probably not Ops group. Queries come in relating to different groups of patients, and which should take priority: COVID or non-COVID applications? Thinks this needs some clinical input, and input from RD regarding other types of initiative to come through HSC-PBPP?
LR stated that prioritisation now needs to be addressed.
CM, RD, GF, MA to look at prioritisation
ACTION: 08-09-2020 / 07: CM, GF, RD and MA

- Onward sharing of unconsented data

GF agreed ongoing sharing of unconsented data should be discussed.
HC agreed that secondary data sharing needs to be really thought about, outside approved researchers and we cannot review applications for secondary sharing, or additional sharing with collaborators. If need new collaborators, then they need to be added in amendment and use same security and server infrastructure that already been approved.
LR agreed need to reinforce principle of data sharing, needs to be very good case for anything non-anonymous.

- IG training

This has polarised opinions between those who feel HSC-PBPP should monitor the IG training of applicants and those who feel that trust is a good element to have.
GF thought that IG training should be consistent and specified rather than allow people to do their own thing. Emergency protocols should be time-limited.
LR thought that IG training as "lighter touch" for midst of pandemic but should we go back to normal now?
KM felt need to revert back to approved list of IG training, as we should scrutinise as thoroughly as applicants should train. Applicants should be nudged for requirements.
LR noted there was a correlation between quality of application and training, and we need to show due diligence.
PR stated that the IG forum is doing work around the IG profession from staffing and career pathways, and will ask whether they have knowledge of suitable IG training for applicants?
RD stated that Tracey Gill in NES looking at developing IG training programme for across public sector. MRC course has been used within NHS NSS and PHS.
LR confirmed that IG training should revert back to the usual lists and possibly a Safe Researcher list. Might there be situations that more trusting approach that could be thought through?

5.3. <u>COVID database in NSH and implications for minimal standard dataset</u>

CM stated that the circulated paper is self-explanatory: having data in one place and available has been helpful for provisioning data within shorter times. Further queries and discussion with applicants could improve this provisioning.
There will be regular updates look at this process and the next step is looking at provision of data as minimum standard datasets, rather than bespoke datasets.
NHS NSS IT needs to provide next set of data to NSH for provision for next round of urgent projects.

5.4. <u>COVID Data and Intelligence Network (DIN)</u>

This is a group for Ethics and Engagement; Overarching IG group chaired by PR.

Doreen Grove, Head of Open Government for SG joined the meeting from Ethics group of DIN and presented the role of DIN to the committee.

DIN is to minimise spread of COVID and understand impact of COVID on society and health and care. DIN was set up by RH to make data available. There are a number of taskforces and groups to take things forward: two of these are i) Communications and Public Engagement; ii) Ethics. For a Target operating model, technology is required, with project definitions. The aim is not to create new work but use ongoing work to achieve objectives.
IG in DIN comes from across the public sector and is not exclusively health. IG supports candidates, ensures data flows to data platforms can be done well; builds trust and comfort for public and data controllers; and provides agile and scalable IG solutions.
There are a number of challenges: correct IG resources, BAU, Data retention within network.
A number of IG tasks have been identified:

i) overarching cross sector IG framework;
ii) national catalogue of IG tools and products;
iii) national IG cross sectoral lead role for Scotland,
iv) work closely with ethics and public engagement;
v) establish harmony between IG and data ethics frameworks; support to deal with immediate IG challenges;
vi) Public engagement for use of data within D&IN,
vii) Practical implantation of information security and privacy protocols.

Governance framework: what do we have and what do we do? What should we use?
Need a consistent governing body across the sectors for operational and management of use of data. Centralised or federated approach for IG.
RDS fits in here somewhere

DG: Role of data ethics framework for DIN.
This is to think about what exists and build on what is there. Not to replace stuff but build ethical framework at the beginning of a project. Now tracking and tracing population as we have become a surveillance society, which leads to loss of trust in use of data.

- Data security
- Documenting public benefit
- Transparency monitoring and scrutiny – not just us marking own homework
- Communications engagement and participation

They have developed a hierarchy of intent: follow our values, make a difference, mitigate risk, mind compliance. Can ethics help frame what trying to do? Use the values we all hold. Expediency of getting stuff done fast but also doing the right thing because we believe it is the right things. This is a framework of questions and prompts to make people think through their process. Generally,

people are comfortable with government using information if it secure, not sold and is right thing to do. This process asks questions at beginning, which will then be embedded into framework to assess and enable to move through the system.

DIN framework and principles – 7 or 8 important principles

- Be clear on problem and need and the public benefit of the outcome
- Identify proportionate requirements to meet need. Not straying into "useful" angle
- Unintended biases – resistant to test and trace. How have these been thought through?
- Implement relevant codes of practice
- Embed technology responsibly; use safe havens
- Use robust practices and skillsets – need right people with right skills.
- Transparent with real oversight and scrutiny. Show workings.
- Embed public participation – impact of COVID is such that if going to maintain public trust and how these will engage the public. Citizen audits.

AB stated that this was all reassuringly familiar. She questioned the use of term "ethics", as ethics committees do something quite different and need to be clear that this is a broader approach to this. Need to be really clear about what you mean by ethics.
DG doesn't want things to be subsumed beneath all of the other governance processes. Ethics should be about helping to solve moral dilemmas. Feels important that as this is using people's information without their permission, and therefore it ought to be more ethically based for everything we do in public service. That is why need full ethical assessment. This will be dynamic and wants an "Ethics" Caldicott Guardian in Scotland outwith Government so that we can become an ethical digital nation but need to be proportionate about it.

DM asked about public participation: how actively involved has any member of the public been?
DG said that the Ada Lovelace Foundation was involved around the tracing app. Work of taskforce 2 will be put to wider public with series of public panels. This will change when public get more involved.
DM thought there should be true and consistent public involvement throughout. Need range of ways of involving public.
DG said that they had specifically been involving and consulting people who were not normally involved in public sector.

LR was glad to see that both ethics and IG being taken seriously. Helpful if could have follow-on discussion of where this has got to and could circulate paper. What do you want?
DG said that feedback on document would be helpful. Public engagement is important. She is going to host discussion about how to go about this and if anyone is interested in being part of that, or knew others who would be interested, please send details to PR.
LR asked for panel to be kept updated. To be readdressed in the next meeting.

ACTION: 08-09-2020 / 08: PR to circulate paper from Doreen Grove
ALL to give feedback on documents to PR

6. Application

Review of 2021-0102 Sudlow: a COVID-19 application from HDRUK that may be a model of how HDRUK applications are proposed for ongoing work. The questions were asked: what are the precedents would be set by this application, what are the concerns as a model for the future and how should we approach this?

GF thought that KM had produced a very helpful paper. His view was dictated by evolving knowledge of COVID19 which helped recalibrate the right to privacy of individual. CVD risk is important in COVID19.
KM stated this type of application is helpful, positive, cross-nation collaboration on research, compared with other applications where there was not a lot collaborative work. In future, do we reflect on this as types of applications and encourage body to oversee so do they can be seen to have merit? There are assumptions by applicants that suggest that the credentials of an application or commissioning body will lead to automatic approval. Applications should be reviewed on own merits, with clear articulation of the need for some applications. Need is different from public benefit, but these have been conflated.
HC agreed, that it can be tricky but some can request data to inform policy. Clear articulation of policy for clinical decisions should be taken seriously. Policy groups need to be considered as clear need and priority. Timeliness for questions that needed to be answered early during. Large scale collaborative framework is good but speed can be of the essence.
KM asked who has oversight of the different strands and who sees the overlaps of the different research projects? National datasets differ across four nations then these need to be addressed and thought about in advance. Applications to be done very quickly but the scrutiny is also done quickly and bad applications are really hard to scrutinise. Needs to be made smoother for both applicants and reviewers.
DM asked if could we use short video or guidance or FAQs for applicants?
CM stated that numerous groups are discussing and reviewing protocols before brought to HSC-PBPP or other permissions bodies. Trying to stop duplication of effort and people have different funding and grants behind it.
AB informed the group that so many people live with masses of documents. Is there a place for video and FAQs? These should complement the info already out there.
CM thought there would be mixed reactions; some applicants are fantastic, whereas others don't see why we need the level of information requested.
KM suggested prompts for application form and add these to the application form. E.g. Public Engagement: have you talked to an interest group or patients?
PD stated that there is lots of guidance for applicants, and we are trying to update website to provide clear and accessible information.
LR raised that there were recurring areas: e.g. dismissive of public engagement; clarity on the need for an application; tying with reviews and how to add additional information to the application form and front-page with hints and tips if taken seriously. **Suggested that the Ops Group should address some of this.**

ACTION 08-09-2020 / 09 Ops group

7. Review of Amendment requests to HSC-PBPP

The paper was to provide some reassurance to the committee that there are suitable processes in place to review the amendment requests that will come for applications. There was a recommendation the once approved, any applications that were for Business as Usual (BAU) or Once for Scotland, that once had been approved by HSC-PBPP, and amendments were done by the NHS boards / PHS/ NHS NSS as appropriate.
RD noted that some BAU does come through HSC-PBPP, but this might change, with the legal remit of PHS.

LR suggested that a report for amendments should come to the committee once a year. Proposal for BAU NHS NSS / PHS and some pieces of work through digitally-enabled services. Need to use the committee appropriately and within capacity where challenges will lie with new things. Supportive of something coming to HSC-PBPP for the first review but after that to be run by the organisation.
HC thought that some categories of amendments that could be done more routinely and safely.
LR noted that this also links back to discussion on intra NHS sharing agreement.
Ops Group to provide bullets on what should be brought back to HSC-PBPP.

ACTION 08-09-2020 / 10: Ops Group

8. PBPP Development day

Discussion took place on the two options: one cancel completely and the other to do something on specific small things that could be addressed remotely?
A number of suggestions were made:
LR thought that some of the large programme of work where specific projects will come through to HSC-PBPP e.g. iCAIRD, but might not be familiar to Tier 1? Help to inform some Tier 1 and future application processes?
AB thought that there has been so much change and evolving practice, that it might be good to gather some of these together.
KM suggested this could be an opportunity to reflect on Tier 1 criteria to assess applications and how these could be used for sort a set of rapid review questions for rapid review panel, or Tier 2?.
LR suggested to have some sort of half-day session and look at into New Year, e.g. Jan/Feb. Any ideas and thoughts on what would be helpful for suggestions.
Ops group to explore the feasibility of a half-day online workshop.

ACTION: 08-09-2020 / 11 ALL / MA and Ops Group

9. AOB

No other business

10. Date of next meeting

The next meeting will take place on Tuesday 10 November 2020.

ACTIONS LIST:

08-09-2020 / 01	To identify four COVID applications approved by the rapid review panel, for review by HC, AB, KM and Simone Scott.	**MA**
08-09-2020 / 02	To review the NHS Accord documents and provide clarity regarding what should or should not come to HSC-PBPP in the light of the NHS Data Sharing Accord and update the HSC-PBPP Terms of Reference accordingly.	**MA & RD**
08-09-2020 / 03	Privacy documents relating to the Scotland Test and Protect App to be sent to the committee.	**PR**
08-09-2020 / 04	To bring proposal to November committee meeting some clear proposals for IG processes for Research Data Scotland.	**RH**
08-09-2020 / 05	Remove Chief Executives review from the HSC-PBPP committee agenda.	**MA**
08-09-2020 / 06	To explore the capacity issues and applicants' feedback.	**Ops Group**
08-09-2020 / 07	To look again at the prioritisation of COVID-19 applications.	**CM, RD, GF & MA**
08-09-2020 / 08	PR to circulate paper on data ethics from Doreen Grove. ALL to give feedback on document to PR.	**PR and ALL**
08-09-2020 / 09	To address some of the recurring problem areas of applications e.g. through additional instructions on the application form and further guidance to applicants.	**Ops Group**
08-09-2020 / 10	Related to Action #2: To provide further guidance as to what BAU should be reviewed by HSC-PBPP.	**Ops Group**
08-09-2020 / 11	To investigate the feasibility of a half-day training session for HSC-PBPPP in the New Year.	**MA & Ops Group**