The British Medical Association (BMA) is an apolitical professional association representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 154,000, which continues to grow every year.

Executive Summary

- The BMA supports measures that enable providers to ensure that no avoidable harm comes to patients whilst in their care. However, any regulations relating to this must be drafted in full consultation with the medical profession and other healthcare professionals to ensure they are not unnecessarily over burdensome for doctors or clinical staff and interfere with their primary duty of treating patients and providing care.

- We support the use of the NHS number as a consistent identifier, whenever possible, as widely as possible throughout the NHS. However, we would not want the NHS Number to be used as the main identifier outside of the NHS and adult social care services.

- The Bill gives patients the possibility to object to the inclusion of a consistent identifier (an opt out) in sharing information. We think this is unnecessary and a possible safety concern that may adversely affect how consistent identifiers are used.

- Only relevant information about a patient should be shared between those providing or supporting their care. The sharing of excessive or unnecessary information is likely to undermine patient trust in the confidentiality of their health data.

- Health information sharing is governed by professional obligations to share relevant information for effective patient care, underpinned by patient consent. It is unnecessary to replace this with a statutory framework without clear justification as to why it is needed and which risks weakening confidentiality safeguards that currently apply.
In relation to the proposed new objectives for health and social care regulators and the Professional Standards Authority we are concerned (a) that the inclusion of promoting and maintaining public confidence in the profession as a stated objective could lead to 'trial by media' and (b) that the inclusion of the term 'well-being' in the objective of protecting, promoting and maintaining the health, safety and well-being of the public could import considerations not relevant to clinical care. We are seeking reassurance that these concerns will be addressed in guidance for fitness to practise panels that properly relates ‘public confidence’ and ‘well-being’ to public protection.

Introduction
The Health and Social Care (Safety and Quality) Bill covers a number of areas including the safety of health and social services in England; the integration of information relating to users of health and social care services in England; the sharing of information relating to an individual for the purposes of providing that individual with health or social care services in England; and the professional regulation of health and care professionals, other than doctors.

The BMA supports aspects of the Bill such as the use of consistent identifiers across health and social care services. However, we have concerns about the proposals for the sharing of information and changes to professional regulation. This briefing goes through these in turn.

Consistent identifiers
The Bill mandates the use of a unique identifier relating to individual patients across health and adult social care services in England (Clause 2). Clause 2(6)(b) provides the patient with the possibility to object (opt out) to the inclusion of a consistent identifier in sharing information. The BMA believes that this right to object to the use of the NHS Number should be removed on the grounds that it risks patient safety, will cause a number of practical problems in relation to linking patients to their episodes of care and also undermine the implementation of patients’ right to object to uses of data beyond their care.

The absence of a consistent identifier will remove the ability of healthcare providers to distinguish between patients who have a similar name. Very simply, if a hospital has a patient called John Smith booked in for an operation it will use the NHS Number to verify that procedure will be performed on the correct John Smith. This is a vital check which provides assurance against the devastating consequences which would arise should a procedure be carried out on the wrong patient or a prescription be issued to the wrong patient.

In addition, NHS Numbers feed into the collection of Hospital Episode Statistics (HES) data by the Health and Social Care Information Centre (HSCIC). HES data allow hospitals to be paid for the care they deliver, as well as being use to assess the effective delivery of care. If patients can remove their NHS Number from their hospital record, it is unlikely that hospitals will be able to effectively administer and manage their payments system. It may also mean that a patient’s name and addresses would have to be used to verify the episode of care.

Furthermore, the BMA believes that the right to object to the use of a consistent identifier will also have implications for the Government’s commitment to allow patients to opt out of the use of their information for purposes beyond their direct care, for example for the care.data programme. This is because in order to implement the objection the HSCIC requires the NHS Number so that it can identify which patients have registered an objection.

The BMA supports amendment 6 from Baroness Finlay of Llandaff and urges peers to support it.
**Duty to share information**

Whilst consensual information sharing to facilitate direct patient care is a principle which can be supported by all, this does not entail the sharing of everything. Only relevant information about patients should be shared on a ‘need to know’ basis between those individuals who are part of the healthcare team providing or supporting patient care. This principle was recently re-affirmed by Dame Fiona Caldicott’s review of information governance.¹

Clause 3 makes no reference to the relevance of information sharing, nor does it clarify to whom the information may be disclosed within a provider or commissioning organisation. Clause 3(2) requires that information be disclosed to ‘persons working for the relevant person’ and ‘any other relevant health or adult social care provider with whom the relevant person communicates about the individual’. This is very broad, and without clear definition, we are unclear as to how it might be interpreted in practice. This may result in confidential information being shared more widely than is currently the case, and beyond that which patients would expect, particularly if organisations take a cautious approach and share more information than is necessary for fear of not complying with the new legal obligation.

This can be illustrated by the following example. A patient is referred by her GP to the local hospital for knee surgery. A statutory duty on providers to share information for the facilitation of care might be interpreted by the GP practice as meaning that the patient’s entire GP record, which includes the fact that she terminated a pregnancy, should be shared with the provider. The term provider might be interpreted to encompass both hospital managers as well as the orthopaedic surgical team. Sharing of the entire record will result in an irrelevant and unnecessary disclosure of highly sensitive information on two counts. Firstly, hospital managers should not have access to confidential information and secondly, the orthopaedic surgical team does not need to know about the patient’s past termination of pregnancy in order to operate on her knee.

In addition, it is a long established legal and ethical principle that information sharing for the purposes of direct care is limited to relevant information and is governed by implied consent. The BMA is concerned that if a statutory duty on providers replaces consent as the legal mechanism by which confidential data are shared, patient autonomy and control over information sharing will be undermined and eroded. This concern is further underlined by the reference in Clause 3(3)(b) to sharing when it is ‘in the individual’s best interests’. The principle of sharing information when it is in a patient’s best interests currently applies only to those lacking the capacity to consent. This principle should not apply to autonomous adults where information sharing should take place on a consensual basis.

**We support amendment 7 from Baroness Hollins as it would require the sharing of information that is relevant to the episode of care, and welcome debate on this issue. However there should be further clarity and restriction on who information can be shared with for this purpose.**

**Objectives in relation to the regulation of health and social care professions**

In relation to the proposed new objectives for health and social care regulators and the Professional Standards Authority in Clause 5 and the Schedule we are concerned

- that the inclusion of promoting and maintaining public confidence in the profession as a stated objective could lead to ‘trial by media’
- that the inclusion of the term ‘well-being’ in the objective of protecting, promoting and maintaining the health, safety and well-being of the public could import considerations not relevant to clinical care
We have raised these concerns with the Department of Health in relation to the similar new objectives for the GMC that have been proposed in a draft order. We are seeking reassurance that they will be addressed in guidance for fitness to practise panels that properly relates ‘public confidence’ and ‘well-being’ to public protection.

The guidance should make clear to panels that they should not assess public confidence on the basis of purely personal condemnation of the conduct found or the media’s response to it and should not assume too readily that considerations of public confidence are engaged (given that the relevant case law is focused on cases of serious misconduct).

The guidance should, in particular, make clear to panels that they should respect a professional’s right to a private life. A recent GMC consultation on changes to its sanctions guidance proposed that panels should be guided to consider more serious action where certain issues arise in a doctors’ personal life. We recognise that this might be appropriate in relation to some of the specific examples that were listed (e.g. “misconduct involving violence or offences of a sexual nature”) but were concerned by the catch-all clause “any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings”. We were concerned that this formulation, which will now be removed, could have led panels to take more serious action against doctors on the basis of relatively minor issues unconnected to the health and safety of the public and could have undermined their right to respect for their private life under the European Convention on Human Rights. We note that the Law Commissions in their report on the regulation of health and social care professionals expressed concern about “the examples given which suggested that the regulators were inappropriately imposing moral judgments in essentially private matters under the guise of maintaining confidence”.

The guidance should make clear to panels that they should continue to ask whether a professional’s progress towards remediation satisfies any legitimate ‘public confidence’ concerns. The GMC sanctions consultation proposed that panels should be guided to consider taking action to maintain public confidence in doctors in some cases even when a doctor has remediated, i.e. when there is no threat to public safety. Our fear is that this proposal could lead to panels punishing doctors who pose no threat to the health and safety of the public on the basis that failure to do so might incur the disapproval of the public.

The guidance should make clear to panels that they should give proper weight to the requirement of proportionality. The GMC sanctions consultation proposed that where action is necessary to protect patients and maintain confidence in doctors panels should be guided to consider taking action “without being influenced by the personal consequences for the doctor”. This formulation, which will now be dropped, appeared to conflict with the principle of proportionality in the current sanctions guidance (which requires panels to weigh the interests of the public with those of the practitioner). The impact of a sanction on the individual professional, even if it is not the primary consideration, is always a relevant one.

Finally, with regard to the use of the term ‘well-being’, the term is broad enough to include matters that go well beyond a profession’s responsibility for providing clinical care and potentially to include anything that could be said to affect quality of life and contentment. This problem should be addressed in guidance to panels that relates the term to public protection.

We support amendments 9 and 10 from Baroness Ilora Finlay of Llandaff and welcome discussion on the issue of guidance for fitness to practise panels.
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References

1 Dame Fiona Caldicott [March 2013] Information: to share or not to share? The information governance review.
2 The General Medical Council [Fitness to Practise and Overarching Objective] and the Professional Standards Authority for Health and Social Care [Referrals to Court] Order 2015.
3 General Medical Council [August 2014] Reviewing how we deal with concerns about doctors page 27.
5 General Medical Council [August 2014] Reviewing how we deal with concerns about doctors page 19.
6 General Medical Council [August 2014] Reviewing how we deal with concerns about doctors page 17.