

Police, Crime, Sentencing and Courts Bill

House of Lords: Committee stage
October 2021

About the BMA

The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

1. **Medical confidentiality:** The BMA and the National Data Guardian (NDG) share significant concerns¹ about provisions in the Bill which override the duty of medical confidentiality, including legally requiring confidential health information to be shared with the police. Concerns from the GMC² about these provisions were also raised at Second Reading.

We welcome amendments from Peers seeking to raise the serious detrimental impact on the doctor-patient relationship by overriding medical confidentiality. We urge the Government to amend the Bill to remove the provisions in Part 2, Chapter 1 that set aside obligations of confidence.

2. **Abuse of emergency workers:** The BMA supports the Bill's intention to increase sentencing for those convicted of abusing an emergency worker. We are also calling for verbal abuse and harassment of an emergency worker to be classed as an aggravating factor in sentencing.

1. Medical confidentiality

Preventing and reducing serious crime - the use of confidential health data

The BMA and the NDG have significant concerns about provisions in the Police, Crime, Sentencing, and Courts Bill which we believe fall short of the well-established ethical and professional criteria for the sharing of confidential health information (Chapter 1: clauses 9, 15, and 16). These provisions are:

- CCGs (clinical commissioning groups) and LHBs (local health boards) will be legally required to provide confidential health information to the police (clause 16 (4)). The duty of confidentiality has been set aside here (clause 16 (5)).
- There are also permissive powers in the Bill for regulations to enable CCGs and LHBs to share confidential health information with a wider list of recipients i.e. other specified

¹ Read about the NDG's concerns:

-Blog, Oct 2021, available at: www.gov.uk/government/news/data-driven-innovation-why-confidentiality-and-transparency-must-underpin-the-nations-bright-vision-for-the-future-of-health-and-care

-Interview with The Independent, Oct 2021, available at: www.independent.co.uk/news/health/nhs-data-guardian-police-covid-b1934912.html

² The GMC's concerns were raised at the Bill's Second Reading: <https://hansard.parliament.uk/lords/2021-09-14/debates/4D726E25-3924-4BB5-B399-4C839D773815/PoliceCrimeSentencingAndCourtsBill#contribution-5FF55816-8EAD-4EC3-8AD8-A7A3E1C9DBD4>



authorities, including councils and educational authorities, as well as the police (clauses 9 and 15). Again, the duty of confidentiality is set aside here.

We believe that setting aside of the duty of confidentiality, to require confidential information to be routinely given to the police when requested, will have a highly damaging impact on the relationship of trust between doctors and their patients. A removal of a long-established protection for confidential health information, alongside a broad interpretation of 'serious crime', may mean many patients are reluctant or fearful to consult or share information with doctors.

Status quo - sharing confidential data to prevent, reduce, or prosecute serious crime

There are already well-established routes for doctors to disclose confidential information on 'public interest' grounds, on a case-by-case basis, if it is necessary for the prevention, detection, or prosecution of serious crime or where there is an imminent risk of serious harm to an individual. This is recognised in the GMC's guidance on confidentiality.

There is no legal definition as to what constitutes a 'serious' crime but in the BMA's view, serious crime includes murder, manslaughter, rape, treason, kidnapping, violent assault, and abuse of children or similar acts which have a high impact on the victim. Serious harm to the security of the state or to public order and serious fraud will also fall into this category.

Confidential healthcare information - a special legal status

The BMA recognises the Bill's intention to comply with existing data protection legislation, but this alone does not offer adequate protections for confidential healthcare information. The particular sensitivity of health information has long been afforded special legal status, over and beyond the Data Protection Act, in the form of the **common law duty of confidentiality**. People must feel that they can share information with health professionals in confidence, without worrying how it will be used - an erosion of trust could negatively impact on the doctor-patient relationship and deter some people from seeking care, with potential adverse impacts on those individuals but also on public health.

Cases before the courts have reaffirmed that society has an interest in maintaining a confidential health service,³ and, moreover, Article 8 of the Human Rights Act 1998 supports this common law duty of confidentiality. It is, therefore, extremely concerning that the Bill sets aside this special legal status.

We believe the Bill must be amended to ensure the common law duty of medical confidentiality is not set aside. The Government must remove the provisions in Part 2, Chapter 1 that set aside obligations of confidence.

Separately, we hope discussion on amendments will address the wording in relation to statutory data protection legislation, such as in clause 9(5)(a). It is not clear to the BMA whether this wording would permit disclosures that contravene data protection legislation if there is a caveat that *'in determining whether a disclosure would do so [contravene], any power conferred by the regulations is to be taken into account'*.

Anonymous versus identifiable health data

It is our understanding that the intention behind the data-sharing provisions in the Bill is for government and specified authorities to collaborate to prevent and reduce serious violence in England and Wales, i.e. for planning purposes. We wholly support this ambition, but we have sought clarification from the Home Office and Department of Health and Social Care as to why

³ See *Ashworth Security Hospital v MGN* [2002] UKHL 29 and *Campbell v MGN* [2004] UKHL 22.

identifiable, confidential health information about individuals would be necessary to fulfil this purpose.

It is our view that **anonymous** data, instead, would suffice to assist a specified authority in its planning to prevent and reduce serious violence in a given area. This would allow numerical data about the prevalence of serious violence to be used - for example, a disclosure that there were x number of attendances last month for y injury at A&E in Hospital z. Such anonymous data-sharing could facilitate planning to reduce and prevent serious crime without breaching doctor-patient confidentiality.

Based on our understanding of the Bill's stated aim, anonymous data should be sufficient; no justification has been provided as to why planning would be impeded by the use of anonymised information.

Even if it is the case that there are purposes for which the Home Office wishes to identify individuals, the existing thresholds for disclosure (as highlighted in the 'status quo' box above), which reflect the importance of medical confidentiality, must still apply. This will no longer be the case if the common law duty of confidentiality is set aside in favour of the disclosures which will be required and permitted under this Bill.

Interpretation of 'serious violence'

The duty in clause 7 to 'prevent and reduce serious violence' is broadly drafted; for example, 'violence' includes damage to property (clause 12 (3)). This is very different to our interpretation of serious violence (as set out earlier), and we believe that the envisaged data-sharing falls some way short of the established ethical and professional standards of medical confidentiality that are central to public trust in the health service.

We believe that the provisions in Chapter 1 drastically alter the existing basis on which confidential data might be shared in order to prevent or detect serious crime.

Compulsory, blanket disclosures versus discretionary, case-by-case disclosures

The Bill's inclusion of a compulsory, blanket obligation for CCGs and LHBs to share confidential health information with the police is extremely concerning. Currently, doctors use their professional discretion to balance the benefits and harms of disclosure, taking into account the level of seriousness of the crime, when the police request access to confidential information. Doctors are not automatically required to override their duty of confidence to their patient.

A doctor's professional judgement about when to disclose information in the public interest should not be replaced by a blanket compulsion for CCGs to share confidential data.

Future consequences

The future ramifications of the Bill's provisions must also be highlighted, as the planned replacement of CCGs with Integrated Care Boards could have a real impact on the potential for police to access significant amounts of confidential health information.⁴ These Boards could potentially hold large quantities of confidential information to which the police will have access under these provisions.

The consequences of setting aside duties of confidentiality in this Bill could be even more damaging in the future given the forthcoming changes to CCGs.

2. Abuse of emergency workers

Doubling sentencing for abusing an emergency worker

⁴ CCGs are to be abolished under the Health and Care Bill (Section 13 inserts 14Z27 into the NHS Act 2006 'Abolition of Clinical Commissioning Groups')

The BMA supports the Bill's intention to increase sentencing for those who assault emergency workers to 2 years. We are aware of increasing reports of abuse directed at those working across the NHS. A staggering two-thirds of GPs (67%) have told us that their experience of abuse, threatening behaviour or violence has got worse in the last year, with half (51%) saying they had been personally verbally abused, and 67% witnessing violence or abuse against other staff.

We believe the approach in the Bill is proportionate and will help to tackle the growing instances of abuse against those working across the NHS.

In addition to increasing the penalty for common assault or battery of an emergency worker in clause 2 of the Bill, we would also like to see an additional clause clarifying that verbal abuse and harassment of an emergency worker will also be classed as an aggravating factor in sentencing.

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