



Department
for Education

A consistent identifier in education and children's services

Research Report

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Executive summary

This study was commissioned to gather evidence on the possible implications of extending to education and children's services the Health and Social Care (Safety and Quality) Act 2015 duties to use a consistent identifier when sharing information between health services and adult social care agencies. The NHS number has been specified as the consistent identifier in regulations.

Through a review of the existing evidence and a consultation with key stakeholders the study addressed the following questions:

- Which organisations may be affected if the duties were extended;
- Whether a consistent child identifier is needed to support effective information sharing practice;
- What would be the benefits and challenges of using the NHS number as a consistent child identifier; and
- What effects the extension of the duties could have on national policy aims and local practice.

Who could be affected by the extension of the duties

Below we list the agencies that could be affected by the extension of the Health and Social Care Act 2015 duties. One would have to consider if all these agencies should be asked to adopt a consistent identifier or only some, depending on the benefits and challenges of introducing a consistent identifier in different contexts.

Local authority children's social care delivered by the statutory, voluntary and private sectors, including: adoption; fostering; residential care; residential family centres; holiday schemes for disabled children; Local Safeguarding Children Boards; housing/ accommodation for children in need, care leavers and homeless young people.

Local authority early childhood services again delivered by all sectors, including: childminders; nurseries; infant classes; children's centres; and Family Information Services.

Local authority education functions, that is: state funded maintained schools; academies/free schools; maintained boarding schools; residential special schools; Pupil Referral Units/alternative education; sixth form and FE colleges.

Independent schools.

Information sharing and a consistent child identifier

Section 3 of the Health and Social Care (Safety and Quality) Act 2015 Act places a duty on health and adult social care providers to share information about a patient or service user with other relevant persons, when this is likely to facilitate health and social care provision and is in the individual's best interests. Therefore, the question of whether a consistent child identifier is needed must be considered within the wider context of why information sharing matters, and current legislation and guidance in relation to information sharing.

Effective information sharing is seen as crucial to deliver timely, high quality and fit-for-purpose services to children, particularly the most vulnerable, that is, children at risk and in the care system. Information sharing is also seen as important to support effective service planning locally, and policy analysis and monitoring nationally. However, there is no single piece of legislation that sets out what information should be shared between agencies that provide social care, early years and education to children. Currently there is also no legislation setting out when these agencies must share information with health services (and vice versa). In some circumstances public bodies are legally permitted to share information (e.g. in a child protection case), but legal powers are often permissive, creating discretion to share information rather than making it a legal requirement. There is guidance from central government, local authorities and many professional bodies on information sharing to safeguard children, but this guidance sets out what good practice should look like, with no legal obligation to comply with it.

Within this context, the requirement for services working with children to use a consistent identifier could be seen as an important step towards clarifying and underpinning data sharing requirements. It would also mean achieving a consensus of when it is in the child's best interest to share information, as well as supporting more effective information sharing practice.

A consistent identifier and the Health and Social Care Act 2015

As it has been noted elsewhere (Low et al, 2015):

- A consistent identifier is a code which confirms a person's identity and enables, with consent and information sharing agreements, appropriate and proportionate information to be shared within the purposes of the Act.
- Its use or presence does not mean that information would be shared and that the information shared is sensitive.
- Its use and presence enables complete confidence that two or more agencies are exchanging information about the same individual.

- The information to be shared using a consistent identifier would be supported by governance and confidentiality agreements.

Benefits of the NHS number as a consistent child identifier

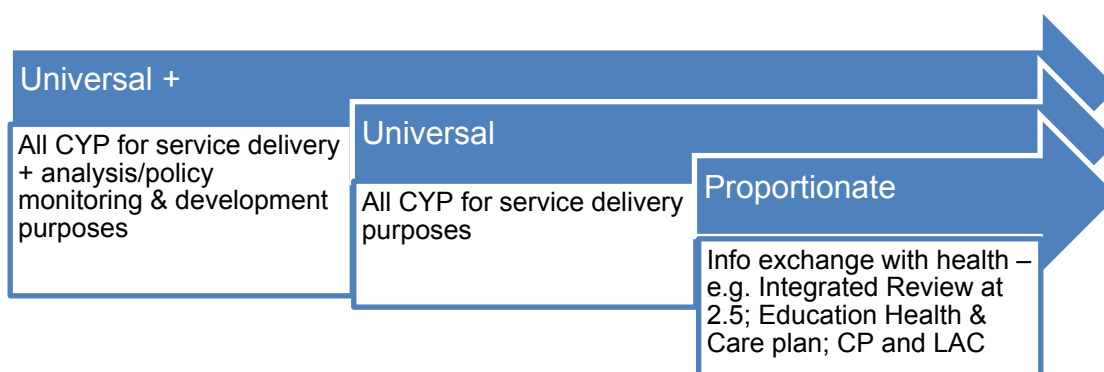
While children are currently given local identifiers (e.g. by social care) and national ones (e.g. the unique pupil number in school), the NHS number is seen as having the unique advantage of being a national and universal identifier which is 'for life'. The literature indicates a growing consensus for adopting it to support more effective information sharing and service improvement. Adopting the NHS number as a consistent identifier has been recommended by: the NHS Future Forum when advising the Government on the NHS reforms; the Children and Young People's Health Outcomes Forum; two recent reports on the Integrated Review for 2 to 2½ year olds. Local government organisations such as SOLACE (Society of Local Authority Chief Executives) have also noted the benefits of using the NHS number as a unique identifier.

The NHS number is also used in Child Protection Information Sharing (CP-IS) system introduced to connect local authorities' children social care IT systems with those used by the NHS in unscheduled care settings. The aim of CO-IS is to provide better care and earlier intervention for children subject to a Child Protection Plan or who looked after.

Views on the possible use of the NHS number among those we consulted were also typically, but not universally, positive, and fall into three broad groups:

- **Proportionate:** those who believe that the NHS number should be used by education and children's services to exchange information with health to support current information exchange requirements and practices. For example, the NHS number could be used in Education, Health and Care (ECP) plans and early years Integrated Reviews.
- **Universal:** others believe that the use of the NHS number should not be limited to information exchanges with health, but that it should become the consistent identifier for all services delivered to children, used alongside other identifiers individual services may use. This option seemed particularly attractive to services which do not currently have a national identifier for children (i.e. early years and social care). Furthermore, it seems that planning around the use of the NHS number in adult social care and CP-IS mean that local authority children's social care have already accepted this as an inevitable, as well as positive, move.
- **Universal+:** a third group believe that the NHS number should become the consistent identifier for children not only for service delivery purposes, but also for local service planning, and national policy analysis and monitoring. This option was seen as helping to deal with current service planning difficulties caused by a lack of a common identifier (e.g. identifying eligibility for targeted early years services), and to fill big evidence gaps (e.g. variability in services provided to disabled children;

outcomes for looked after children; levels of mental health needs in children).



Universal Plus - all children and young people for service delivery and analysis/policy monitoring and development purposes.

Universal - all children and young people for service delivery purposes.

Proportionate - information exchanges with health e.g. Integrated Review at 2.5; Education Health and Care Plan, child protection and looked after children.

While there was support for the 'Universal' options, we were told these options are extremely unlikely, if not impossible. The Department for Health has given an undertaking to the Information Commissioner that the NHS number will be used for health and social care only, in response to the Information Commissioner's concerns about the NHS number being used for other purposes.

Issues to consider in using the NHS number as a consistent child identifier

The key issues to consider in extending the use of the NHS number to non-health agencies include:

- How one would ensure that the wide range of providers that may be involved (e.g. from childminders and children's centres to independent schools and FE colleges) in different settings and sectors obtain the NHS number and that relevant information is kept up to date.
- Whether consent would be required from parents and children to use the NHS number beyond the current purpose i.e. direct delivery health care.

- How one would ensure that the range of agencies and providers that would have access to the NHS number had adequate information governance and complied with the information governance, data security and other requirements specified by the Health and Social Care Information Centre (HSCIC), the body that generate, owns, allocates and manages the NHS number.
- The accuracy of the NHS number and associated personal information (e.g. name, date of birth) is currently maintained through an iterative process between HSCIC and health agencies and local authorities. Extending the use of the NHS number to a larger number of agencies, with very diverse data management practices, could also increase the number of agencies who had to double-check the accuracy of their information, or require some local body to do so for them.

Potential effects of extending the duties of the Health and Social Care Act 2015

There seems to be a growing appetite for adopting a consistent child identifier as this is seen as an important step towards improving information sharing practice. Out of a range of possible identifiers currently available, the NHS number seems to be the most suitable and its use appears to be growing. The challenges of introducing a consistent identifier for children would be considerable as potentially a large number of very diverse agencies and services could be involved, although gradual implementation and/or a careful selection of agencies to be involved would make the task more manageable.

The duty on adult social care to use a consistent identifier (the NHS number) to share information with health agencies and the roll-out of CP-IS mean that in the near future all local authorities will have a tested and established system for obtaining, storing and validating the NHS number. It was reported that between two-thirds and four-fifths of local authorities already have access to a system for obtaining the NHS number.

We also identified examples of voluntary use of the NHS number either through local level agreements between the NHS and other agencies, or individual services taking the initiative. For example, it was reported that some schools and early years' settings ask parents to provide the NHS number so it can be used in a medical emergency.

Those consulted pointed out that adopting a consistent identifier for children would require a considerable investment of time and money. It would be a long-term project requiring extensive planning, robust piloting and incremental scale up. However, the evidence we gathered suggests that the benefits of such a move would also be extensive:

- As well as supporting effective information sharing practice, the introduction of a consistent child identifier could provide the opportunity to clarify data sharing

requirements, and consolidate a national consensus on the crucial question of when it is in the child's best interests to share information.

- The use of a consistent child identifier, supported by appropriate data sharing agreements, could improve national policy analysis and monitoring by enabling different government departments and agencies to link the extensive data they individually collect on key policy areas. This could also save money in the long term, as currently the problems associated with cross-departmental data linkage mean that considerable resources are required to overcome these difficulties.
- Locally the use of a consistent child identifier would support improvements and efficiency in care provision and care planning, as most children rely on the support provided by a range of services. Vulnerable children with complex needs would particularly benefit from the services being linked by a consistent identifier, and a national consistent identifier would also facilitate the transfer of case records when children move to another area.
- Children and their parents would benefit if a consistent identifier meant that the various services they deal with are aware of each other, so they do not have to repeat the 'same story' many times and the risk of 'getting lost' between services is minimised.

In conclusion there seems to be a great deal of support for adopting a consistent child identifier as envisaged by the Health and Social Care Act 2015, because it is seen as key to supporting effective information sharing, and the NHS number seems to be the most obvious choice. While there was also support for using the NHS as a consistent identifier for all services delivered to children, and for supporting the planning and monitoring of these services, this option seems extremely unlikely, if not impossible.

1. Introduction

The Health and Social Care (Safety and Quality) Act 2015 amends Part 9 of the Health and Social Care Act 2012 to give the Secretary of State the power to issue regulations requiring health and adult social care commissioners and providers to use a consistent identifier, defined in the regulations as the NHS number. Section 3 of the Act places a duty on health and adult social care providers to share information about a patient or service user with other relevant persons. Both duties apply when they are likely to facilitate health and social care provision and are in the individual's best interests.

However, the provisions do not currently extend to education and children's services. During the Bill debates, Lord Warner asked why children were being left out of the Bill¹, citing the need for a consistent identifier for children's services, particularly when a child is in need or at risk of harm. There is considerable evidence that information sharing practice within and across different agencies is deficient, inconsistent and, in some cases, has placed children at risk, and the use of a consistent identifier could help to identify children at risk (Munro, 2011). To address these concerns, the DfE commissioned this evidence-gathering exercise to understand the potential impact of using the NHS number as a consistent identifier for children's services, i.e. social care, early years, education and other (mainly Ofsted regulated) services.

1.1 Aims of the study

The study aimed to gather evidence on the possible implications of extending to children's services the Health and Social Care (Safety and Quality) Act 2015 duties to use the NHS number as a unique identifier to share information. The key research questions addressed were:

- Which organisations may be affected if the duties were extended.
- Whether a consistent child identifier is needed to support effective information sharing practice.
- What would be the benefits and challenges of using the NHS number as a consistent child identifier.
- What effects the extension of the duties could have on national policy aims and local practice.

¹ Lords Hansard (6 Feb 2015), col.955.

<http://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/150206-0002.htm#15020642000657>

1.2 Methodology

The study involved:

- A mapping of the range of organisations that would be affected by the extension of the duties based on information available in the public domain.
- A review of evidence on information sharing principles and practice, which looked at a range of issues relating to the introduction of a consistent identifier for children (e.g. consent, system security, data processes, proportionality, communication issues). The review focused on evidence published in 2010-15, supplemented by a review of materials relating to the development of ContactPoint, the universal information sharing index on children that was decommissioned in 2010.
- Interviews with 28 government officials and stakeholders from the education and children's sectors, and a consultation with the DfE Star Chamber – the body that scrutinises requests to gather information from local authorities and schools.

1.3 Service mapping

As discussed, the Health and Social Care (Safety and Quality) Act 2015 places a duty on providers of publicly funded health services and adult social care in England to include a consistent identifier (the NHS number), that health and adult social care commissioners and providers must use when processing information about a patient or service user.

Young people who transition from children to adult services - for example, young people with disabilities, long-term health or mental health needs, or care leavers - would be covered by the new duties when they reach 18. Currently the duties do not extend to children's services in social care, early years or education. If the duties were to apply to the service areas for which the Department for Education (DfE) has responsibility, a wide range of commissioners and providers would be drawn into the remit of the Act as shown in Box 1.1. A full list of the relevant legislative basis for each, as well as an overview of whom each service is for, is available in Annex 1.

Box 1.1 outlines the agencies that could be affected by the extension of the duties. One would need to consider if all these agencies should be asked to adopt a consistent identifier or only some, depending on the benefits and challenges of introducing a common identifier in different contexts.

Box 1.1 Services, settings and providers which could be affected by the application of the Health and Social Care (Safety and Quality) Act duties to children’s social care, early years and education services

Local authority children’s social care – community, voluntary, private

- Adoption; fostering; private foster care; residential care (children’s homes, secure children’s homes, independent hospitals, residential special schools that are also registered as children’s homes); residential family centres; holiday schemes for disabled children; Local Safeguarding Children Boards; housing /accommodation for children in need, care leavers and homeless young people

Local authority early childhood services – domestic, non-domestic, home based; private, voluntary, independent (PVI)

- Childminders, nursery classes, nursery schools, infant classes, children’s centres
- Family Information Services

Local authority education functions – state funded

- Maintained schools; academies/free schools; maintained boarding schools; residential special schools; Pupil Referral Units/alternative education; sixth form & FE colleges

Independent schools

Like adult health and social care, the education and children’s services landscape is extremely complex (Caldicott, 2013; Law Commission, 2014). Commissioning bodies can include a single local authority, a group of local authorities, or local authorities working in partnership with other service areas like health or the police. Many, like schools, academies and colleges, children’s centres or youth clubs, are both commissioner and provider. The public service itself can be delivered ‘in-house’ by the local authority, or by voluntary and community organisations, private sector agencies, or social enterprises.

Each will use its own data systems to record information on the children and families with whom they work and each will retain the information they need to know in order to fulfil their statutory functions or contractual obligations. How and when they share that information is often dependent on the ethos within which they operate.

2. Why information sharing matters

Section 3 of the Health and Social Care (Safety and Quality) Act 2015 Act places a duty on health and adult social care providers to share information about a patient or service user with other relevant persons, when this is likely to facilitate health and social care provision and is in the individual's best interests. Therefore, the question of whether a consistent identifier should be used by agencies providing services to children must be considered within the wider question of why information sharing matters, and current legislation and guidance in relation to information sharing.

In this chapter, we provide an overview of the English legal framework for information sharing. We then specifically discuss information sharing in children's services and to safeguard children.

2.1 An overview of the legal framework in England

Restrictions on how and when an individual's personal information can be shared are set out in data protection law, as well as laws and policies protecting an individual's right to privacy. The Data Protection Act 1998 sets out the parameters for sharing personal information appropriately and safely (see Annex 2 for details). The Information Commissioner's Office has issued a range of statutory guidance and advice that clarifies the law on data sharing, data security and privacy, and provides service-specific guidance to organisations in education, health, charities and local government.²

The sharing of information in child and adult health and social care is guided by the Caldicott principles (Caldicott, 1997 and 2013 - see Annex 2 for details), which in their original form influenced the data protection principles. NHS organisations and local authority social services are required to have Caldicott Guardians: senior people who are responsible for promoting information governance, protecting patient/service-user confidentiality, and advising on lawful and ethical information sharing. The Government has also announced its intention to create a National Data Guardian for health and social care in the future (Department of Health, 2015), the consultation findings are still being considered so it is unclear as yet, whether it will cover both child and adult services.

The Government has issued non-statutory guidance on information sharing in relation to safeguarding children (HM Government, 2015a). This guidance, which provides the detailed instruction that supplements the Government's core, statutory, *Working Together* guidance (HM Government, 2015b), provides a list of principles for sharing information about children and young people which is based on the legal requirements outlined in the Data Protection Act (see Box 2.1).

² A list of guidance for organisations is at <https://ico.org.uk/for-organisations/guidance-index/data-protection-and-privacy-and-electronic-communications/>

Box 2.1 Principles for sharing information about children and young people

- **Necessary and proportionate** - Any information shared must be proportionate to the need and level of risk
- **Relevant** - Only information that is relevant to the purposes should be shared with those who need it
- **Adequate** - Information should be adequate for its purpose, and of the right quality to ensure that it can be understood and relied upon
- **Accurate** - Information should be accurate and up to date and should clearly distinguish between fact and opinion. If the information is historical then this should be explained
- **Timely** - Information should be shared in a timely fashion to reduce the risk of harm, particularly in emergency situations. In these cases, it may not be appropriate to seek consent if it could cause delays and therefore harm a child
- **Secure** - Wherever possible, information should be shared in an appropriate, secure way. Practitioners must always follow their organisation's policy on security for handling personal information
- **Record** - Whether or not the decision is taken to share, not kept for longer than is necessary, and should be subject to review

See Annex 2 for further details.

Source: HM Government (2015) Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers

Information sharing guidelines are also available on the websites of local authorities, Local Safeguarding Children Boards (LSCBs), and some local multi-agency partnerships such as Multi-Agency Safeguarding Hubs (MASHs) or Multi-Agency Risk Assessment Conferences (MARACs). In addition, a number of professional bodies such as the General Medical Council, Royal College of Paediatrics and Child Health, and the British Association of Social Workers publish guidelines, which deal with information sharing practice for their members, or refer them on to official guidance.

Both the Government and the updated Caldicott principles stress the need to balance an individual's right to privacy - the consistent law duty of confidence - with the need to make sure that information is shared in the best interests of the person(s) affected and that, normally, the information cannot be shared without the person's consent.

Under Article 8 of the European Convention on Human Rights (ECHR), individuals have a right to respect for their private and family life. However, Article 8 is a qualified right,

which means it can be overridden if necessary and in accordance with the law. Any interference must be justified and be for a particular purpose, such as where there is a safeguarding concern. The Article 8 ECHR consideration is supported by the UN Convention on the Rights of the Child (CRC), which outlines rights for children and young people up to age 18, and was ratified by the UK Government in 1991. Under Article 16 of the CRC, children have a right to privacy. Under Article 12 of the CRC, children have a right to have their views taken into account and given due weight when decisions are being made about them. That would include decisions about the sharing of their personal information (see Box 2.2).

Box 2.2 Children, confidentiality and consent

- Children and young people have a **right to confidentiality**. In general, children under 16 who give information in confidence are owed the same legal duty of confidence as adults.
- The **general principles for consent** are the same for children and adults. Children who are **competent** (meaning Gillick competent)³, and young people 16+ who have **capacity** (as defined under the Mental Capacity Act 2005)⁴ should be involved in information sharing decisions. When considering the use of a child's personal information, the Information Commissioner's Office suggests that some form of parental consent would normally be required before collecting personal data from children under 12 but, noting that children of a similar age can have different levels of maturity and understanding, recommends that the use of personal information should be determined on a case by case basis (Information Commissioner's Office, 2011).
- **Informed and explicit consent** - children and young people giving consent need to understand why information needs to be shared, who will see their information, the purpose to which it will be put and the implications of sharing that information. Obtaining explicit consent is good practice. It can be expressed either orally or in writing, although written consent is preferable since that reduces the possibility of subsequent dispute. If verbal consent has been obtained, details must be

³ Children who have sufficient maturity and understanding to enable them fully to understand what is involved are considered to be competent.

⁴ A person lacks capacity in relation to a matter if, at that time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. A person is 'unable to make a decision' for themselves if they are unable to do any one of the following:

- understand information which is relevant to the decision to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (whether by talking, sign language or any other means).

recorded in case notes.

- **Implied consent** – allows information to be shared if the sharing is intrinsic to the activity, and especially if that has been explained at the outset, for example when conducting a consistent assessment or developing an integrated plan.
- **Conflict between a parent/carer and child regarding the use of personal information** – if a child is considered competent or has capacity, their consent should not be overridden. In these cases, decisions should be taken in the best interests of the child, and aim at securing the best outcome for the child.
- **Sharing confidential information without consent** - this can be justified when disclosure is in the public interest, for example, to prevent significant harm to a child, or when there is reasonable cause or evidence that a child has suffered or is suffering significant harm. Decisions must be made on a case by case basis.

Sources: Caldicott, F (2013) Information: To share or not to share? The Information Governance Review. Department of Health.

HM Government (2015) Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers. DfE.

London Safeguarding Children Board (2015) London child protection procedures. 2015 edition. Chapter 4: Sharing information.

2.1 Information sharing in children's services

Public bodies are only permitted to share information when they have a legal power to do so. These powers may be explicit: a legal duty to share information for a specified purpose, and/or with a named public body or provider. More often, however, the legal powers are permissive, creating discretion to share information without requiring the service or provider to do so (Law Commission, 2014).

There is no single piece of legislation that sets out what a duty to share information across education and children's services should comprise - including the use of a consistent identifier for children and young people.

- Part 1 of the Local Government Act 2000 gives local authorities the power to take any steps that they consider would promote the wellbeing of their area and their citizens, including children, young people and families. This can include the sharing of information provided it complies with data protection and other requirements.
- Section 10 of the Children Act 2004 places a reciprocal 'duty to cooperate' to improve the wellbeing of children on local authorities and a list of partners, including the police, probation, Youth Offending Teams, education and training, and health. This section is intended to ensure collaborative working, which can include the sharing of information for strategic purposes (HM Government, 2009).

Although current legislation sets out duties to safeguard and promote the welfare of children, which apply to a wide range of public bodies, there is no explicit duty to share information.

- Section 11 of the Children Act 2004 places a duty on a broad range of services and agencies to safeguard and promote the welfare of children up to 18, both in relation to direct service provision and through their commissioning arrangements. The list of public services includes: the local authority; health (NHS England, Clinical Commissioning Groups, NHS Trusts and Foundation Trusts); local police and the British Transport Police Authority; youth justice (Youth Offending Teams, the National Probation Service and Community Rehabilitation Companies); prisons (young offender institutions, secure training centres); and services that provide information and advice to young people on education and training.
- Section 175 of the Education Act 2002 places a similar duty on the local [education] authority, governing bodies of maintained schools, and institutions in the further education sector. Section 157 of the same Act extends the duty to proprietors of independent schools (including academies and free schools) and, separately, non-maintained special schools, with details in regulations.^{5 6}
- Section 1 of the Childcare Act 2006 places a duty on local authorities both to improve the wellbeing of young children and to reduce inequalities between young children in their area. In order to achieve this, local authorities must work in partnership with the NHS and Jobcentre Plus. Under section 3(3), the local authority must also identify parents and prospective parents in order to encourage them to take advantage of early childhood services, which could be of benefit to themselves and their children.
- Section 55 of the Borders, Citizenship and Immigration Act 2009 places a duty to safeguard and promote the welfare of children on the Home Secretary when exercising immigration, asylum, nationality and customs functions. In practice, these functions are discharged by UK Visas and Immigration (UKVI), Immigration Enforcement and the Border Force.

Each of these duties requires effective inter- and multi-agency partnership working. Many public bodies have developed information sharing protocols that should set out why information sharing is important, how it will be shared, how it supports the functioning of the partnership, and how it will work in specific policy or service contexts (Information Commissioner's Office, 2011; Centre of Excellence for Information Sharing, 2015b).

In addition, public services often prioritise practice issues highlighted by the regulatory bodies and within inspection frameworks. With the exception of some independent

⁵ Education (Independent School Standards) Regulations 2014

⁶ Education (Non-Maintained Special Schools) (England) Regulations 2011

schools, Ofsted is the regulatory body for children's services (see Annex 1). Information sharing is a clear priority in the framework for the inspection of children in need, looked after children, leaving care and child protection services (Ofsted, 2015e), but is not referred to in the framework for the inspection of early years, education and skills (Ofsted, 2015d). If the information sharing duty under the Health and Social Care (Safety and Quality) Act was to be extended to cover children and young people under 18, for the first time all public bodies providing services to children would come under an explicit duty to share information.

2.3 Information sharing and safeguarding children

Despite having laws in place that permit the sharing of information in order to support and protect children, failures to do so continue to be cited (Bunting and others, 2010; Munro, 2011). Two recent studies of Serious Case Reviews in England and Child Practice Reviews in Wales (Brandon and others, 2012; NSPCC, 2015) found that a clear majority of the reviews examined included recommendations to improve record keeping and information sharing within and across agencies, and across geographical boundaries. The 'inability' to share information has also been identified as a key barrier to safeguarding children from sexual exploitation (Berelowitz et al., 2013).

Section 27 of the Children Act 1989 permits local authority children's services to request help from health, education and housing agencies in discharging safeguarding duties, and requires those bodies to comply with the request if it is compatible with their own statutory duties and obligations. Section 47 of the same Act requires local authorities to investigate when they have reasonable cause to suspect that a child is at risk of significant harm. If asked to assist in these investigations - for example, by sharing information - other local authorities, education, housing, health and other public bodies specified in the cross-government statutory *Working Together* guidance (HM Government, 2015b) must provide that assistance. Local authorities can also request help from these public bodies when providing other types of support, including section 17 children in need support.

Under section 14B of the Children Act 2004, a Local Safeguarding Children Board (LSCB) has the power to request information from any individual or body in order to enable or assist it to perform its functions.

Statutory safeguarding guidance for the education sector (Department for Education, 2015g) states that schools and colleges should work with social care, the police, health services and other services to promote the welfare of children and protect them from harm.

2.3.1 Information sharing to support specific groups

Information sharing is often seen as through a safeguarding lens, but is critical in ensuring that services work together for the benefit of specific groups of children and young people. For example:

- **Young children** - Local authorities do not as a matter of course receive birth registration data to support their strategic planning, and to alert early childhood services such as children's centres to identify, contact and provide support to new parents (Abdinasir and Capron, 2014; Action for Children, 2015; Gross, 2013b). For individual children receiving an early childhood service, statutory guidance recommends that early year's practitioners share information and work with health visitors to enable them to identify any developmental delays as well as a child's particular strengths (Department for Education, 2014a). The Integrated Review⁷ involving early education and health offers an opportunity to ensure the smooth sharing of information in order to assess and report to the parent or carer on the progress their child is making (Blades and others, 2014).
- **Children and young people with special educational needs and disabilities (SEND)** - The statutory SEND Code of Practice emphasises the need for local authorities and their partners to have information sharing protocols in place, and for agencies to work together to inform SEND provision at both a strategic and individual level. It also recommends a 'tell us once' approach to sharing information to save children, young people and their families from having to repeat the same information to different practitioners or agencies (Department for Education/ Department of Health, 2015).
- **Children with medical needs** - Educational factors such as school attendance are indicators of good health care, but cannot currently be linked to care plans for children with health needs (Low and others, 2015). Statutory guidance for schools and academies stresses the need for educational institutions to work with health and other support services to meet the needs of children with medical conditions in terms of both physical and mental health. This would require school governors or academy proprietors to ensure information is shared appropriately (Department for Education, 2014b).
- **Children with mental health problems** - Departmental advice for schools on the mental health of pupils also refers to the potential to be alert to changes in behaviour that may indicate a problem, and be ready to refer or share information with the child's GP and/or local Child and Adolescent Mental Health Service (CAMHS) (Department for Education, 2015h).

⁷ From September 2015, the Integrated Review brings together the Healthy Child Programme Review at age 2 to 2½, and the Early Years Foundation Stage progress check at age 2.

- **Young carers** - The Care Act 2014 requires different services to cooperate, including children and adult services. This means, where appropriate and as assessed on a case by case basis, local authorities and their partners should share information about young carers. Children and adult services should also share information about young people who are transitioning to adult services (Department of Health, 2014).

3. Is a consistent child identifier needed?

In this chapter, we consider whether a consistent child identifier is needed to support effective information sharing practice. We first briefly review recent developments in relation to integrating systems to facilitate information sharing when delivering and planning services for children. We then consider possible consistent identifiers for children and report views on the benefits of using the NHS number as a consistent identifier.

3.1 Integrating, or linking, information systems

Since the decommissioning of ContactPoint in 2010,⁸ there appears to have been a move away from integrating every child's personal information into a single record system. ContactPoint was an online directory of the public services used by every child in England: universal services (education, GP practice, health visitor), targeted services (SEND, social workers) and sensitive services (substance misuse treatment, sexual health services, CAMHS, youth justice). Due to its universal coverage, and presumably its set-up and operating costs, it was considered by the Coalition Government to be *disproportionate and unjustifiable* (Loughton, 2010) and closed down.

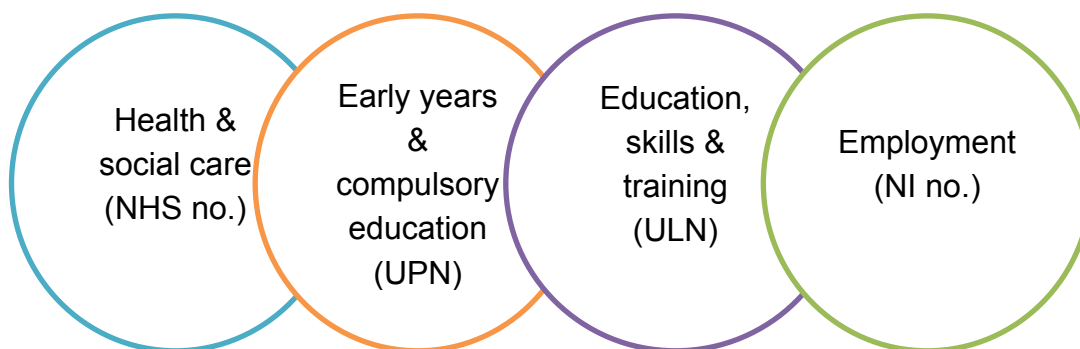
A wholly integrated single record system can be developed to serve the purpose of promoting greater multi-agency working, but it also risks conflating the universal with more targeted services, and the child's needs with the family's or carer's (Wilson and others, 2011). It complicates the issue of consent: when a number of agencies are involved in populating a child's record, which is responsible for seeking the child's consent to share that information? It also raises security concerns: in its privacy principles, the Scottish Government suggests that using a consistent identifier to draw together personal information held on different systems and/or by different agencies presents a lower risk than storing personal information in a single place (Scottish Government, 2014). Public confidence in these systems is essential.

The question is whether an integrated data system, or better ways of linking separate data systems, can improve information sharing in practice. The evidence is that better data linkage can facilitate communication, and may help bridge 'cultural differences' between professions. And, in general, better information sharing can improve care pathways; evidence the impact of different programmes, interventions and services/providers; support the examination of new or innovative developments in service provision; and inform spending decisions (Atherton and others, 2015).

⁸ The Children Act 2004 Information Database (England) (Revocation) Regulations 2012

The rationale for having a consistent child identifier is to ensure that the data that is collected by a number of public bodies and providers can be collated and cross-referenced to provide better care and support on an individual case basis, and to inform regional or national research and strategic planning (McGhee and others, 2011). The consistent identifier does not necessarily supersede those already in use, but acts as a link number between the different service areas. Using a link identifier enables services to share information more efficiently and accurately in the knowledge that they are talking about the same individual (Children and Young People’s Health Outcomes Forum, 2015). It helps to overcome the challenge of trying to pull out and assemble information from incompatible systems.

The Information Standards Board (ISB), which is supported by the Department for Education (DfE) and the Department for Business, Innovation and Skills (BIS), has published a strategy that aims to make improvements to the identifiers used in education and children’s services (Information Standards Board, 2015). The ISB has grouped the identifiers most commonly used by: local authorities for early years, children in need and children’s social care; maintained schools and academies; 14 to 19 education providers; and the Department for Work and Pensions (DWP) and HMRC in relation to the data they hold on learner outcomes and receipt of benefits. The ISB does not propose that all service areas should use the same consistent identifier, but suggests widening the scope of existing identifiers and consolidating these into four broader service areas, or ‘islands’. Within each island, the specified number is universal, but not exclusive; other identifiers may also be used. They believe that having a core set of universal numbers should simplify and expedite data exchange within and between the services.



Source: Diagram (Information Standards Board, 2015)

An alternative proposal is to have a single link identifier. In its 2012 information strategy, the Department of Health outlined its ambition to see ‘connected information for integrated care’ (Department of Health, 2012a), with the NHS number used to connect health and adult social care records across the system. The core aim was ‘interoperability’: electronic records held in secure IT systems that are required to meet a set of consistent standards, and that can ‘talk’ to one another.

3.2 Possible consistent identifiers

Child identifiers currently used include:

- **NHS number** - a lifetime identifier allocated from birth, or when a person registers with the NHS.
- **Local authority child ID** - allocated to children receiving a children in need service.
- **Unique Pupil Number (UPN)** - automatically allocated to each child attending a maintained school or academy. Children who attend an independent school or who are being home educated will not always have a UPN.
- **Unique Learner Number (ULN)** - used to access the personal learning record of young people 14 and up. After this, ULNs are retained throughout a person's life.
- **Child Benefit (CB) number** - allocated to parents/carers who apply for Child Benefit and are responsible for a child under 16, or up to 19 if they are in approved education or training. One number is allocated to each eligible child. Since new benefit and taxation laws came into force in 2013, higher earners can opt out of receiving CB. In August 2014, 475,000 families responsible for 819,000 children opted out (HMRC, 2015).
- **National Insurance number** - allocated to young people when they reach 16, or available to people 16 and over who are eligible to work or study in the UK.

3.3 A consistent identifier and the Health and Social Care Act 2015

As it has been noted elsewhere (Low et al, 2015):

- A consistent identifier is a code, which confirms a person's identity and enables, with consent and information sharing agreements, appropriate and proportionate information to be shared within the purposes of the Act.
- Its use or presence does not mean that information would be shared and that the information shared is sensitive.
- It enables complete confidence that two or more agencies are exchanging information about the same individual.
- The information to be shared using a consistent identifier would be underpinned by governance and confidentiality agreements.

3.4 The NHS number as a consistent identifier

In the literature and among the stakeholders we consulted, there seems to be a growing consensus that of the range of possible identifiers, the NHS number is the most 'universal', and therefore most suitable as a consistent identifier, as it is not dependent on age, situation or citizenship. It is also already widely used in the largest of our public services: in a 2014 survey, 97.6% of NHS Trusts in England reported using the NHS number as a primary id in clinical correspondence, though its reported use was lower in mental health, ambulance and community trusts (NHS England, 2014b).

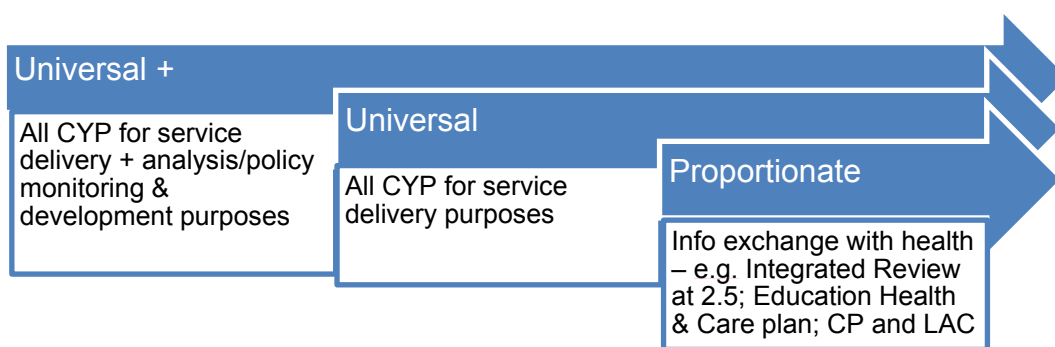
In its advice to the Government on the NHS reforms, the NHS Future Forum recommended the universal adoption of the NHS number to facilitate better care, as currently poor information sharing is a key barrier to people receiving a 'safe, effective, joined-up service', particularly those with complex needs and long-term conditions. (Haslam and others, 2011).

The Children and Young People's Health Outcomes Forum has since picked up the recommendation to adopt the NHS number (2012, 2015), as have two major reports exploring how the Integrated Review for 2 to 2½ year olds will work (Gross, 2013b; Blades and others, 2014). In addition, local government organisations such as SOLACE (Society of Local Authority Chief Executives) have noted the benefits that the use of the NHS number as a unique identifier could have (2014).

In our consultation, we also identified examples of how a lack of a consistent identifier could undermine effective service delivery and planning. For example, as there is no consistent identifier in early years services, it is very time consuming to identify children entitled to targeted support (e.g. the early years premium, free early education for disadvantaged two year olds, additional free childcare for three and four year olds from working families). Similarly it was reported that not having the NHS number from the start of the Education Health and Care Plan (EHC) assessment process, created delays and inefficiencies in communication between children's social care and health. Lack of a consistent identifier also made it very difficult, if not impossible, to carry out the kind of data linkage required for local service planning purposes, for example, to monitor the needs of disabled children, trends in service take-up and likely future needs. Monitoring outcomes for looked after children and linking these to the support they receive was also seen as a huge evidence gap that could be partly filled if data from different agencies could be linked using a consistent identifier. A lack of a consistent identifier was also seen as contributing to the difficulties in relation to policy monitoring and analysis at the national level. While a huge amount of information is collected by different government departments and agencies (e.g. on employment, income, benefits, education, health), without a consistent identifier linking data from these different sources is very time consuming, expensive and sometimes simply not possible.

Given the reported difficulties created by a lack of a consistent identifier, it was not surprising to find that views on the possible use of the NHS number among those we consulted were typically, but not universally, positive. Views fell into three broad groups:

- **Proportionate:** those who believe that the NHS number should be used by education and children’s services to exchange information with health to support current information exchange requirements and practices. For example, the NHS number could be used in Education, Health and Care plans and early years Integrated Reviews, as well as for looked after children and in child protection cases as currently envisaged by the Child Protection Information Sharing Project.
- **Universal:** others believe that the use of the NHS number should not be limited to information exchanges with health, but that it should become the consistent identifier for all services delivered to children, alongside other identifiers services may use. This option emerged as particularly attractive to services, which, unlike education, do not currently have a national identifier for children (i.e. early years and social care). Furthermore, it seems that planning around the use of the NHS number in adult social care and the Child Protection Information Sharing system means that local authority children’s social care has already accepted this as an inevitable, as well as a positive, move.
- **Universal+:** a third group believe that the NHS number should become consistent identifier for children not only for service delivery purposes, but also for local service planning and national policy development. This option could help to deal with current service planning difficulties caused by a lack of a consistent identifier and to fill big evidence gaps discussed above.



While there was support for the ‘Universal’ options, we were told these options are extremely unlikely, if not impossible. The Department for Health has given an undertaking to the Information Commissioner that the NHS number will be used for health and social care only, in response to the Information Commissioner’s concerns about the NHS number being used for other purposes.

4. Learning from current practice

In the literature review (Children and Young People's Health Outcomes Forum, 2015; Low and others, 2015; McGhee and others, 2011) and in our consultation the rationale for having a consistent identifier (and the NHS number as this identifier) is twofold:

- To enable different services to share information more efficiently and accurately in the knowledge that they are talking about the same child, overcoming the challenge of trying to pull out and assemble information from incompatible systems. In turn more effective information sharing between agencies is seen as helping to improve take-up of services and care pathways, reduce risks and help bridge 'cultural differences' between professions (Atherton and others, 2015).
- To ensure that the data that is collected by a number of public bodies and providers can be collated and cross-referenced to: inform local and national policy analysis, strategic planning and spending decisions; establish the impact of different programmes and services; examine new or innovative developments; and support service redesign.

In the rest of this chapter, we provide some examples of initiatives involving a consistent identifier, which was introduced to improve service delivery, and planning.

Box 4.1 Swindon

Swindon uses the NHS number as a link or key identifier to support the provision of integrated services to children. Wherever possible, they are creating a single core demographic record for each child.

The perceived benefits include:

- Allowing access to records from across health, social care and early help services. The database is used to develop a single record for each child, with practitioners able to access and record case information, aiding multi-agency work.
- Better communication with NHS organisations.
- The flow of child level records, from birth notification through to universal and targeted early help services, is faster.
- Data entry and record maintenance are more efficient, aiding data accuracy.
- Being able to match health and social care records and benefit from the tracing of children using the national Personal Demographics Service. Extensive data cleansing and validation is routinely undertaken leading to a reduction in duplicates and improvements in overall data quality.
- Data matching also helps with the identification of sibling groups.

Risks that need to be managed include:

- Concerns around confidentiality and potential loss of client trust, particularly around perceived data protection issues in terms of an integrated child record.
- Concerns around consent. This has been addressed through privacy notices and data sharing arrangements with third party organisations, which make the consent points clear and are held within the Children’s Strategic Partnership Information Sharing Agreement.

Source: Children and Young People’s Health Outcomes Forum (2015) Report of the Children and Young People’s Health Outcomes Forum 2014/15 - Information Sharing Theme Group.

Box 4.2 Scotland

The Scottish Government’s national information strategy notes the importance of correctly identifying people when sharing or proposing to share information about them, normally through the use of an identifier. In Scotland, the NHS uses the Community Health Index (CHI) number. However, advice from the Information Commissioner’s Office is that non-health service bodies may only use the CHI number as a secondary identifier in interaction with a health service body (Scottish Government, 2013).

Scotland’s digital strategy advocates greater use of another identity number, the Unique Citizen Reference Number (UCRN), which can be linked to the CHI number via a service provided by the NHS Central Register. The national information strategy recommends that all systems being developed to share personal information in child and adult health and care should use either the CHI number or the UCRN to facilitate data sharing.

Source: Scottish Government (2015) Health & Social Care Information Sharing – A Strategic Framework: 2014-2020.

Box 4.3 Leeds

Leeds have moved to improve data management, data reliability and information sharing, especially between health and social care services. Using the NHS number is seen as the best way to achieve these improvements and three initiatives are currently underway.

Children under 5

Under a local agreement with the NHS, the LA is provided with quarterly data for all children under 5, including new births. Originally introduced to assist with planning (e.g. to estimate number of school places), the system is now used for service delivery to individuals. For example, if a child turns up at a children's centre, staff can check if they are already on the system. Authorised children's centre staff can only amend personal details, such as name, address and DoB, but on their own Children's Centre Management System, which uses its own identifier. The NHS number is a hidden field, and data collected by the children's centre does not amend the NHS data. In other words children's centre staff cannot alter anything about the NHS number.

The Leeds Care Record (LCR)

Up to now LCR has been used mainly for adults and currently covers all local hospitals, primary care, including GPs, mental health trusts and adult social care. Extensions to ambulance services, hospices and pharmacies are under discussion. The LCR includes the NHS number, some personal data, plus certain health care details (e.g. GP, referrals made, date of hospital discharge, discharge letters, prescriptions, and dates of future healthcare appointments). Any professional looking at LCR can see other professionals or agencies involved and can contact them if they have any queries. The 'social care view' is more limited than what health professionals can access, and social care staff cannot input any details. Only health can update LCR (indirectly), but even so not all of a person's clinical records are visible.

The LCR is currently being trialled with children with long-term complex disabilities in residential homes, children with special needs and disabilities, getting short breaks in residential homes, and care leavers. The aim is to enhance and coordinate the sharing of health information. The groups and numbers were deliberately limited to see how well the system works. For each client group, the relevant professional, e.g. the LAC nurse can only access the records of the children they are responsible for and can only see their 'relevant' information. E.g. social care practitioners do not see blood results or x-rays, as these would be meaningless and unnecessary. However, they are able to see a discharge letter or schedule of appointments and lists of allergies. Education is not currently covered by the LCR. While it was easy to demonstrate the legitimate and proportionate need for social care staff to see the health records, the same arguments were believed to be weaker as regards all pupils and with 265 local schools, and there are logistical challenges. However children with SEND and long term health conditions will still benefit from this system.

CP-IS

Leeds is also one of the areas piloting CP-IS for looked after children or those under child protection. Information provided by social services is used to add a CP 'flag' on the NHS spine. If children present at A&E the hospital staff will know of their CP status and the council's social care case management system will automatically be sent a message. A reported shortcoming is that the information coming back to children's social care is possibly not detailed enough to assist safeguarding that much. They would like to know more than the fact that the child attended A&E, e.g. why, and who best to contact for more information.

Source: fieldwork carried out for the study

Box 4.4 The Child Protection Information Sharing (CP-IS) system

In November 2014, Homerton University Hospital in the London borough of Hackney became the first hospital in England to implement CP-IS, which connects social services' and unscheduled care IT systems to support early identification and intervention for children considered to be vulnerable or at risk. The implementation of CP-IS was facilitated by a number of factors:

- The hospital already had electronic patient records when CP-IS was introduced.
- Support from a very good System Integration Manager who understood users' requirements. Adapting the system to include the CP-IS, improved the system rather than making it more difficult to use.
- The introduction of CP-IS was 'painless', it did not require extensive training, so clinicians could see the benefits of having access to additional safeguarding information, without the difficulties often associated when new systems are introduced.

The case study below illustrates the benefits for children of introducing CP-IS at the hospital.

Anne (not her real name) arrived at Homerton's adult emergency department with a friend one evening. She complained of pain in her lower back and right leg, with occasional shooting pains and numbness. She found it difficult to move. There were no other injuries. The previous day, Anne and her friend had accepted a lift home from a friend. While in the car, the driver started to spin the car round and reversed it into another vehicle. Anne felt a jolt but managed to climb out. As her friend drove away, she grabbed the door handle, but could not hold on. Her friend was still inside. Anne's consultant diagnosed back strain, prescribed analgesia and referred Anne for physiotherapy. As the consultant discharged Anne, he noted a flag on Anne's patient record. The consultant completed the safeguarding alert form and called the Duty Social Worker. Anne was a looked after child (LAC) placed in Hackney by Tower Hamlets Social Services. Her GP was based in Ilford. Anne had already attended the minor injuries department. Without CP-IS, the consultant may not have had access to information about Anne's LAC status and may have discharged her without follow-up. The Duty Social Worker contacted the supported accommodation where Anne lived to ensure she was there and safe. He also contacted Anne's Social Worker and School Nurse and sent them the discharge summary. A red flag was also placed on Anne's record in case she returned to A&E.

'The flag alerted me to potential safeguarding issues. I was quickly able to contact the Duty Social Worker and inform them of Anne's attendance. The Social Worker was prompt to reply and provide a plan of action.' Consultant

'If you don't have this background information, children could be seen and sent home and no-one is the wiser.' Reggie Medina-Rios former Named Nurse for Safeguarding Children, Homerton Hospital

Source: fieldwork for the study and the Health and Social Care Information Centre
<https://systems.hscic.gov.uk/cpis>

5. Implementation issues

This chapter sets out how the NHS number is created and governed; the formal and informal methods for getting the number; the information governance and data protection matters which need to be addressed if use of the NHS number were to be extended to education and children's services, and as part of that, whether the NHS number is used as a primary identifier, or merely linked to other identifiers used by that service.

5.1 NHS number generation and 'ownership'

The NHS number is a ten-digit number, generated, allocated and managed by the Personal Demographics Service (PDS), part of the NHS Spine, which is owned and operated for the Department of Health by the Health and Social Care Information Centre (HSCIC). The number is randomly generated and does not contain any other identity information per se, such as date of birth, or otherwise allow any other identify information to be inferred or derived. The current number format and allocation has been in place since 1996. The first nine digits are the identifier and the tenth helps the number test its own validity.

The NHS number is initially created and allocated on a person's first contact with the NHS, ordinarily when their birth is registered, or when they first register with a GP. As a result, nearly everyone has an NHS number. The NHS number remains the same for life, other than in certain exceptional circumstances such as (at present) for children who are adopted, who currently will be issued with a new number on adoption.

5.2 Formal methods to get the NHS number from HSCIC

We identified a number of approved and informal methods to get the number for the first time, and to check the accuracy of numbers already on file. Information governance is relevant whatever the method. These are divided into: methods which allow direct connection to the NHS Spine; the Batch systems; and informal routes.

5.2.1 Direct synchronisation with the NHS spine

Most NHS services are able to connect directly to the full NHS database: the NHS 'Spine', which holds an electronic record for all patients in England. The Spine comprises central summary records of personal details such as name, address and date of birth, and important medical details, such as current medication. Connections to the Spine are said to be extremely secure, as they use the NHS 'private network' currently called 'N3'. Access is limited to approved personnel, who must use a smart-card to log into the Spine. Specified NHS professionals, such as a GP can input data as well as check and retrieve it, and start the process for a new patient to get their NHS number. This route permits the approved professional to search for the NHS number or other data for a

patient or for groups of people; update their personal details if inaccurate; and correct any mistakes or discrepancies.

The 'Summary Care Record application' allows an approved professional (normally those working in a clinical health situation) to look up a record on the PDS, while the 'Spine Mini Service' can be used to enable lookups from systems that are not connected directly to the Spine, to access certain details. Each can only be used for one patient at a time and were said to be typically used by an NHS professional working in a remote clinical situation, such as health visitor working in a children's centre.

In addition, for a small proportion of local authorities, bespoke software has been developed to enable their Case Management Systems to connect directly to PDS. These have to be approved by HSCIC and meet technical and stringent information governance specifications.

5.2.2 Batch services provided by PDS

Currently the method most used by local authorities to obtain or check NHS numbers is called the 'batch' system, which is also used for CP-IS, and by many health agencies. A local authority submits a set of records for a group of people, with whatever personal details they already hold (e.g. name, address) via the 'Demographics Batch Service' (DBS) to PDS. In return, they get the correct personal information and NHS numbers for each person, as available. This is an iterative process: over time, by repeated re-submission, the accuracy of local records is increased.

The Batch Service can be seen as a one-way flow of information. In other words as it does not allow a direct synchronisation with the NHS Spine, the end user gets information from, but does not directly change the information on, the Spine. Installing DBS requires a secure connection and therefore comes with specific information governance compliance requirements. It is fast, aiming to provide results within 24 hours.

For agencies without N3 connections and the associated ICT and information governance provisions, or possibly unable to satisfy the information governance requirements for Batch services, HSCIC provides a 'DBS Bureau Service' whereby the submission files can be sent to be processed by a team at HSCIC.

Up until 2016, many local authorities and CP-IS used the Migration Analysis & Cleansing Service (MACS) batch method. This linked to an older database, which is not linked directly to the Spine, and as a result, the information governance requirements were easier for local councils. MACs is being decommissioned in 2016. Table 5.1 below provides a brief overview of the main formal methods. Broadly, the distinctions between them fall into:

- Is there a direct connection to the NHS Spine?

- If so, is this to all of the Spine or just to one record?
- Does the method create a two-way flow or synchronisation, or can the end user simply see the NHS number, or name and address?
- The time taken to get the (updated) information.

Table 5.1 Formal methods available to get the NHS number from PDS for individuals or groups

Method	How it works	Security and IG	Timing	Who uses this option
Local records system integrated with Personal Demographics Service (PDS)	Two-way information flow, synchronisation with NHS 'Spine'	Very Strict IG. Secure connection required. Approved personnel only, using Role Based Access Control (RBAC) through smartcards.	Interactive -immediate	Mainly authorised NHS settings and professionals only.
Summary Care Record Application (SCRa)	Can trace/ check the number for one person at a time, and see limited demographic details - not shown a full clinical account.		Immediate	Health mainly.
An approved LA system, e.g. 'LiquidLogic'	Bespoke software designed to allow an LA to connect directly to the Spine	Very strict IG criteria agreed with HSCIC.	Immediate	LAs only
Demographic Batch Service (DBS)	Submit a batch of names to PDS, to get their NHS numbers and check the accuracy of, or update, personal details on file.	Very strict IG criteria agreed with HSCIC.	Aim is 24-hours turn-around	Health, CP-IS & LAs
Spine Mini Service	'Read only' access, one person at a time; only 'simple' traces possible. Must be an exact match (i.e. cannot do random searching). Tracing and results can be integrated into local record system	IG criteria still strict, but based on system access and controls, rather than individuals using smartcards etc	Immediate	Health mainly e.g. a Health Visitor working remotely on a laptop.
Local partnership between LA and NHS Trust/CCG	Parties agree what data to share, how and when.	Agreements cover IG.	Unknown	LAs
MACS Batch system (Discontinued 2016)	Submit a batch of people's names. Get NHS numbers & check accuracy of personal details held locally.	IG least onerous	Slowest because 2 systems – typically 5 days	LAs and CP-IS (if not using PDS).

At present approximately 28 local authorities have DBS registrations to use the DBS Batch systems, but we were told that at least 121 councils had applied and at least two-thirds are understood to have the facility to use the batch system. Numbers will no doubt increase as CP-IS rolls out further. A small number of councils use the SCRa endpoints and the Spine Mini Service, but mostly in addition to batch services. It is unclear at the point of writing, which methods councils and CP-IS will opt for once the MACs system is discontinued (by January 2016, 31 local authorities had applied to use the now de-commissioned MACS system just for CP-IS). It is anticipated that some may take advantage of the DBS bureau service.

The direction of travel, possibly as early as 2017, is to make access to PDS more straightforward for local authorities and other non-NHS services to use, while upholding standards of security and information governance. With the development of the new Health and Social Care Network⁹ which is currently underway, the requirement to have special 'N3' connections will be removed. Access will nonetheless be protected by information governance and security criteria.

5.3 Informal routes to get a person's NHS number

Informal methods were reported to be routinely used by non-health services to get the NHS number, as a result of drives to improve information sharing and coordination of health and children's social care, such as the 'Better Care fund' (BCF)¹⁰; Integrated Care Pilots (Rand, Ernst & Young, 2012), and Integrated Reviews for toddlers. All are predicated on some degree of joint assessment across health, children's services and others, which can be facilitated by the use of a consistent identifier. Interviewees could not quantify the level of use of the NHS number in these initiatives, but the general belief was that the number would be available somewhere within the files even if it was not used as the only, or main, identifier.

The most frequently mentioned methods of informal sharing were:

- **Asking** a local GP, or CCG, or health professional to supply the number.
- **Co-location.** For example where social care or early years' practitioners work alongside health care professionals and are expected to work jointly (e.g. in children's centres). It was reported that the NHS number may be simply 'floating around' in these circumstance, for instance on letters and communication, as well as on the records maintained by health staff.
- **Multi-agency work.** Fora such as Multi-agency Safeguarding Hubs (MASH), Local Safeguarding Children's Boards (LSCBs), or Multi-Agency Risk Assessment

⁹ <http://systems.hscic.gov.uk/hscn/about>

¹⁰ <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

Conferences (MARAC, which discuss domestic violence), Troubled Families, Education and Health Care Plans involve a number of professionals from different agencies meeting and exchanging a range of information about families and children. Along with other data, the NHS number may be disclosed or shared in meetings and communications.

- **Copying** the NHS number from health correspondence, or a child's Red Book, appointment cards, etc; or asking **parents** to supply the number, for example when children first register at a school or with an early years' provider. This was said to be common, but we do not know the extent.

The account above indicates that in reality the NHS number is already being widely sought and used by local authorities and others, in more or less formal ways. While, this may indicate that agencies or professionals have identified some inherent utility, it is unknown how much it is used as the main identifier to underpin joint work.

The indications are that it is more being stored in addition to, but not used instead of, those services' own internal identifiers. Informal access seems to be widespread, making the number visible and accessible to many staff, in a range of agencies.

5.4 Information governance

Information governance will be fundamental to the implementation of a scheme aimed to make the NHS number accessible to non-health agencies. Here, 'information governance' (IG) means all the technical requirements, rules, best practice policies and procedures which are expected to be followed when handling data. Data protection issues are discussed separately in 5.5 below.

The HSCIC set out an IG framework which they expect all users and handlers of the NHS number to follow. This framework covers data protection and confidentiality; information security; information quality; and health or care records management¹¹¹². Moreover, HSCIC and the Information Governance Alliance¹³ are available to provide advice to agencies, in this instance around the IG considerations, technical systems and processes related to employing the NHS number and already work extensively with local authorities on this:

'At its heart, Information Governance is about setting a high standard for the handling of information and giving organisations the tools to achieve that standard. The ultimate aim is to demonstrate that an organisation can be trusted to maintain the confidentiality and

¹¹ <http://systems.hscic.gov.uk/infogov>

¹² <http://webarchive.nationalarchives.gov.uk/+http://www.isb.nhs.uk/documents/isb-0149/amd-136-2010/index.html>

¹³ <http://systems.hscic.gov.uk/infogov/iga>

*security of personal information, by helping individuals to practice good information governance and to be consistent in the way they handle personal and corporate information.*¹⁴

Demonstrating IG compliance

Any agency wanting to systematically obtain, hold or use the NHS number has to satisfy the HSCIC that they can comply with the IG framework. As would be expected, the greater the degree of connectivity and access to the NHS system, the higher the security concerns, and in turn IG specifications. Hence, IG is most stringent if there is access to the NHS Spine. As the current MACS system did not entail any direct access to the spine, it had simpler IG requirements, a reason offered for its popularity with local authorities.

Another dimension emerging is that whilst the organisations who formally apply for and are allowed to use the NHS number must demonstrate their IG compliance, the agencies accessing the number through informal methods may be unaware of the IG considerations. Moreover, compliance is very difficult to monitor if it is unknown which agencies are using the number or how.

In the rest of this section, we highlight the most significant IG concerns emerging during our consultation, namely: using the NHS number for agreed purposes; data security and confidentiality; data quality and accuracy; IT systems; and monitoring and oversight.

Purpose and legitimate use of the number

Meeting the purpose rule is central to an organisation being issued with an individual's NHS number, or being allowed to use the various PDS systems mentioned above. As it stands, the purpose set out in the Health and Social Care (Safety and Quality Act) 2015 is that using the number must be '*likely to facilitate the provision of health services or social care*', and is in the '*individual's best interests*'. If the Act is amended to include children, the wording may or may not be exactly the same.

It was believed that as it stands, meeting the purpose rule would be easy enough for children's social care or disability services wanting to use the NHS number in respect of a child or group of children. In contrast, the purpose rule might be harder to justify for every pupil, as the need would likely be largely hypothetical (e.g. in case of a medical emergency).

The purpose rule would also come into question if the NHS number was to be used by non-health agencies for service planning and policy analysis and monitoring as discussed in previous chapters.

¹⁴ <http://systems.hscic.gov.uk/infogov/igfaqs>

Another question relating to purpose is whether the 2015 Act would enable the NHS number to be used by non-health agencies to exchange information without the involvement of health agencies. As discussed earlier, services, such as early years and social care, that do not currently have a national child identifier, and would like to adopt the NHS number as the consistent child identifier for all their information exchanges (e.g. internal, to use with non-health agencies as well as health agencies).

Data security

Data security exercised a number of interviewees, in particular how the number would be stored in local systems, who had access to it and what other data could be accessed by using the NHS number. Central to this is whether the NHS number was visible or not. At present in some systems, it is in the background as a hidden field. So at most, the professional would know that the person had a number, but could not see what it was. Instead, another identifier was used for that service. If use of the NHS number were to be expanded, guidance would be required about who would have access to it and to any linked information and in what circumstances. In the NHS for example, access is currently limited to designated professionals, for example who hold 'smart cards'.

The NHS was generally considered to have very secure systems for transferring data (NHS England, 2014). Local authorities use the Public Services Network (PSN) system,¹⁵ but some smaller organisations commissioned to provide services were reported to not meet, or being unable to afford to meet, the PSN security standards (Law Commission, 2013). On the whole, interviewees believed that local authority systems were variable and not as secure as those of the NHS, and that security reduced further for smaller, commissioned agencies. A move to cloud computing brings additional data ownership and security concerns (Caldicott, 2013; Law Commission, 2014).

Although much of the discourse about data security relates to computer databases and recording, it was stressed that the people handling the data are central to keeping it secure, and paper files and other documents also needed the same attention to security, if they held the NHS number.

Data quality and accuracy

The HSCIC systems outlined above enable organisations to submit and re-submit the number and any associated personal information on a regular basis to check that it is accurate. A hospital clinic or GP practice might do this daily, while the batch systems used by most local authorities check and return information over a longer period. As this is an iterative programme, over time the accuracy and thus quality of the data is improved. Indeed being able to verify the reliability of the number and personal details on record, such as the name, date of birth or address, were seen as the chief benefits of

¹⁵ <https://www.gov.uk/guidance/public-services-network-psn-compliance>

using the NHS number and would enhance agencies' compliance with data protection law. No difficulties were seen for local authorities signing up to HSCIC for e.g. children's social care functions, as it is already a tried and tested system on their adult side and any learning can likely be shared. However, other local authority services (e.g. education and early years) are not accustomed to this process and may take some time to get up to speed.

Reliability issues are possibly more likely to emerge where other, generally smaller, agencies get the NHS number 'second-hand', in other words without linking to HSCIC, and for example make mistakes in transcription, or entering it in their systems, or do not keep people's details up to date. Without some mechanism for checking accuracy at this level, these agencies may continue to hold inaccurate versions of the number or other personal information, such as variations in spelling names, previous names, or old addresses. In other words, the best system to ensure accuracy of the number and of the personal details that go with it is by connection with HSCIC.

IT systems and ensuring compatibility

On a practical front, the number is only useful on an IT system if it is traceable and if a member of staff can search for a person using the NHS number. However, it would be important to ensure that a professional could access the system and provide the relevant service, even if the NHS number is unknown, or is incorrect, or the child does not yet have a number.

Rather than replacing existing identifiers currently used by agencies, it was considered preferable to use the NHS number alongside any existing service user numbers, such as a child's UPN, or a local service identifier, and to create an extra field for the NHS number. This would enable it to be a 'consistent' identifier, but would not make it the only identifier for services, and also help address certain data protection concerns and minimise some IT issues. In other words the number would be stored in the background but hidden; it would be linked to the other identifiers used by that service for the individual, but run in parallel and not be the primary identifier used; and only limited personal would need or have any access to it, e.g. to validate it.

Views differed somewhat as to how major an IT challenge would be involved in adding the NHS number as an additional field to existing systems. A small number of IT system providers were said to currently design and supply systems to local authorities and schools. If so, this could facilitate development, mutual compatibility and communication across authorities.

However amending IT systems to include the NHS number as an identifier across all children and education services would bring cost implications, as would maintaining a continuous overview and the routine cleaning of data. Local authority case management systems used in social care are believed to be already able to insert and use the NHS number. However ensuring that all agencies are using the NHS number in a compatible way, are able to 'talk to each other', and are up to speed at approximately the same time

will be important for an extension to children's services to be effective in enhancing service delivery. Many interviewees stressed that if the NHS number were to be adopted as the consistent child identifier, a business case, outlining the cost burden, is needed and all 152 councils would need help to prioritise this initiative. Otherwise, implementation would be fragmentary. In other words, there is a risk that if each council, school, or other local children's service designed and developed their own IT solution independently, over different timescales, there may be multiple different systems. We were told that limited numbers of IT development companies operate in each sphere, for example in local authorities or in education services. If so, that may simplify matters to some extent, but nonetheless implementation needs to be synchronised and development coordinated.

Monitoring and oversight

Local authorities already have systems and personnel in place to monitor and ensure their own IG standards and compliance and compliance with HSCIC requirements. However use of the NHS number by subsidiary or commissioned agencies may require the local authority or some other local body overseeing IG compliance, and possibly maintaining a 'master' copy and ensuring the data is 'clean', accurate and reliable.

'Where it becomes difficult is in matching ... It's not unknown for there to be duplicates and it does become an issue then as to whose data is the master record and correct and therefore there would need to be some overhead of brokerage, and then you may have some level of dirty data ...'

On the social care front, contracting out services can make it difficult to identify all the relevant bodies in contact with and delivering services to a child, or family. It is equally challenging to ascertain what information they may hold (Wilson and Gray, 2013; Law Commission, 2014). The Information Governance Alliance provide guidance on these situations and feel that the commissioning agencies have a role to play in supporting small voluntary and charitable bodies to understand and comply with information governance requirements.

If the number was being used by schools, the question emerges as to whether the local education authority could have role in overseeing IG and ensure the reliability of the data held, or if each school would be responsible for ensuring compliance directly with HSCIC. It is also unclear, especially in the longer term, how much local authorities can oversee the use of the number by academies, free schools or independent schools and if not, which body would have oversight.

Any extension of the use of the number into children's social care would appear to fall under the auspices of the local Caldicott Guardian¹⁶. Clarification is needed however

¹⁶ [Caldicott Guardians](#)

about whether this would extend to ensuring the reliability of numbers and other data in use by local services and if the Guardian's jurisdiction would also apply to education establishments.

In conclusion

A requirement to use the NHS number, alongside the drives for great inter-agency cooperation, will bring into sharp focus any disparities around the compatibility of IT systems, IG policies or procedures, or indeed interpretations of the law and thresholds. Technical solutions will be needed to help match the data from different agencies. Arguably, any challenges highlighted because of the extended use of the NHS number existed in any case, but may provide an impetus for these to be addressed by the IGA and others.

5.5 Data protection issues relating to using the NHS number in children's and education services

The handling, storage or transmission of 'personal' or 'sensitive' information about a child, either by paper or electronically, fall under data protection rules. Below we discuss the discrete data protection issues which come into play if the NHS number is to be used in children's social care and educational services, especially what type of data the number is and the application of general data protection principles, not least confidentiality and consent.

In the literature, data protection is normally discussed in the realm of wider information sharing, rather than just the use of a consistent identifier. Similarly, in our interviews, the issue of broader information sharing nearly always arose, and sometimes the two were conflated. It was stressed that using a consistent identifier would primarily help service delivery by ensuring that two services were talking about the right child. After that, any subsequent sharing of information, for example about a child's situation or needs was already underpinned by existing legislation. For example, child protection rules encourage professionals to share information to help safeguard a child. While using a consistent identifier may lead to and facilitate such information sharing, the two aspects, or steps, of data sharing need to be seen as distinct.

As much as possible the discussion here focusses on the particular data protection issues arising from using the NHS number.

5.5.1 Is it just a number, or 'personal' or 'sensitive' data?

This question exercised many interviewees and is of utmost importance in terms of how data protection issues relate to if and how the NHS number can be used to access different types of data.

‘Personal data’ is defined by the Information Commissioner as information which would identify a person. So a child’s name, address or date of birth are all personal data. ‘Sensitive’ data includes a child’s physical or mental health status, ethnic origin and religion¹⁷.

The broad consensus across our interviewees was that at most the NHS number might count as ‘personal data’, as it might enable a professional to access identity details, such as name and date of birth, but that it is not ‘sensitive data’, as it does not any details about health status, diagnosis, or treatment, per se. In other words, while the intention of the Health and Social Care (Safety and Quality) Act is to use the NHS number as a consistent identifier between health and non-health agencies, to facilitate a person’s care, the number in itself does not convey any information about that health or care. If and when a professional uses the NHS number to access a child’s medical records, electronically or on paper, or discuss their needs, they would then, at that point, be accessing and possibly processing ‘sensitive’ data. As outlined above, such access is tightly protected and limited to certain, generally NHS, personnel.

5.5.2 Protecting confidentiality

Interviewees were quite concerned about protecting confidentiality and if using the NHS number would undermine this. Again, there was overlap in the discourse between using a consistent identifier and wider information sharing points. It was generally believed that the appreciation and adherence to data protection rules, especially confidentiality, were highest among NHS agencies and professionals, but was less strong in children’s services and education, decreased progressively as agencies became more ‘arms-length’, and was quite low in small-scale private outfits, such as nurseries. For example, front-line staff in education and early years services may be unaware of the parent’s right to be asked to consent to information about their child being shared with health.

Furthermore, this could be seen in the context of how well data protection rules are generally understood and applied in: as is evident in Chapter 2, the laws around data protection in general, and confidentiality and consent in particular, are not well understood on the whole. Practitioners across the board are reported to be unclear about which personal information can or should be shared, when and in what circumstances (NSPCC, 2013); and health workers’ concern to protect patient confidentiality, can sometimes override sharing information with children’s services (Gross, 2013b). The development of two sets of official guidance (Caldicott and HM Government (2015b) on top of the original legislation, underlines the message from the literature that the legal

¹⁷[ICO online guidance on data-protection definitions](#)

framework can be confusing and difficult to navigate, and that the Data Protection Act is sometimes seen as a barrier rather than an enabling piece of legislation (Office for Public Management Ltd, 2008; Information Commissioner's Office, 2013). The 2015b government guidance, referred to above, attempts to overcome this, by providing a framework and a flow chart to assist practitioners on information sharing.

5.5.3 Is additional consent needed?

If the NHS number is to be used as a consistent identifier between health, children's services and education, clarification will be needed as to how much additional consent is necessary from parents and children. Whereas emergency, safeguarding or medical situations, or strong public interest reasons are exempted from the consent requirement, most ordinary circumstances are not.

It may be simple enough to add any expanded usage of the NHS number to the initial consent form for new-born babies. However, can it be presumed that whatever initial consent was given when the NHS number was first issued, also applies to all and any subsequent use of the number? If not, then specific consent may need to be requested from children competent to give consent, and from the parents or guardians of those who are not (yet) competent.

Additional details or separate, specific, requests may be necessary for any substantial information sharing beyond exchanging the NHS number.

One of the main challenges identified may be the effective communication to parents and children what the number is (and is not); the desired extension of its use to children's services; why this is considered necessary; and how it could benefit the children and young people. Whether this is done on an opt-in or opt-out basis, the scale is immense. Moreover, to be meaningful, the requests should probably be repeated periodically as the child gets older. Interviewees voiced concerns that parents and children might be suspicious of any request for consent and may find it difficult to engage with or understand the issues involved; combined with agencies' and professionals' lack of familiarity with requesting consent from children, or the rules around competency, as outlined in Chapter 2.

Table 5.2 below provides a summary of the literature on the views collected from children, their parents and practitioners on the issue of information sharing broadly (i.e. not as such about using the consistent identifier). These indicate that children and young people are mainly concerned about proportionality, confidentiality and being allowed some control; while parents put more emphasis on not having to tell the same story afresh to each professional. The views of professionals reported echo earlier points about the lack of clarity on which rules to follow.

Table 5.2: Views of children parents and practitioners on information sharing

Children's views

- Want to be reassured that the information they share is confidential (Freake et al, 2007)
- Want the right to access their files in order to ensure the information held on them is accurate and up to date (Hilton and Mills, 2006; ChildLine Scotland, 2011)
- Are concerned about being labelled and problems escalating as a result of information sharing (Hilton and Mills, 2006)
- Information should only be shared if it would benefit them and if doing so would prevent serious harm to them or others (Hilton and Mills, 2006; Munro and Parton, 2007)
- Want to be involved in assessments of needs and risks where possible, and want to be part of the decision-making process (Hilton and Mills, 2006)
- Teachers and social workers should only be told the personal information they need to do their job with a child or young person (Hilton and Mills, 2006)
- Lack of trust in confidentiality can deter a child from using services (Hilton and Mills, 2006; Munro and Parton, 2007)

Parents' and carers' views

- Want to have to 'tell the story once' (Mitchell and Soper, 2008; Children's and Young People's Health Outcomes Forum, 2015)
- Do not want to get lost between services - appropriate sharing of information should help prevent this (Children's and Young People's Health Outcomes Forum, 2015)
- Are concerned about confidentiality and feeling in control of how, what, why, when and with whom information is being shared (Gross, 2013b; Children and Young People's Health Outcomes Forum, 2015)

Practitioners' views

- What counts as confidential or not is subject to different thresholds in different organisations, which confuses practitioners and the children and young people with whom they are working (ChildLine Scotland, 2011)
- Professionals work in a 'culture of anxiety' based on a lack of understanding of what the law does and does not allow them to do (Thomas and Walport, 2008; Caldicott, 2013). They are concerned about potential criminal liability (Law Commission, 2014)
- Feel they are responding to differing 'cultural norms' of what is acceptable information sharing practice in their profession or organisation (Wilson and Gray, 2013)
- Professional confidence is undermined by insufficient prioritisation of training and continuing support for front-line staff, as well as a lack of practical advice in guidance (Thomas and Walport, 2008; ChildLine Scotland, 2011; NSPCC, 2013)

Adding another set of data will not make decision-making around data protection any easier, but nor can it alone be said to cause a particular confusion. While at present a '*blind eye*' was said to be turned to a degree of information sharing occurring in many multi-agency fora and elsewhere, which may or may not also involve sharing the NHS number, it would be better for everyone to have clarity and guidance about using and sharing the number and any associated data protection implications.

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Annex 1

Table of services, settings & providers which would be affected by the extension of the Health and Social Care (Safety and Quality) Act 2015 duties to children and education services - based on DfE list of persons excluded from the Act

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
Schedule 1 Local Authority Social Services Act 1970 Children Act 1989 Children Act 2004	Local authority	Children's social services functions	Adoption service Childminding & day care Fostering service Private foster care Residential care service LSCB Housing service (homelessness)	Children's homes Residential schools Independent hospitals	Children receiving child protection service Children in care Disabled children Homeless young people	Ofsted
S.1(1) Children and Young Persons Act 2008	Body corporate commissioned by local authority	Looked after children Children leaving care	Provider of social work services ¹⁸	Only those bodies which operate on a not-for-profit basis may discharge these functions	Looked after children Care leavers	Ofsted

¹⁸ The Children and Young Persons Act 2008 (Relevant Care Functions) (England) Regulations 2014

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
S.497A Education Act 1996 ¹⁹	Local authority Person	Education functions	Inspection body Secretary of State power to intervene			Ofsted
Part 1 Childcare Act 2006	Local authority	Early childhood services, meaning: <ul style="list-style-type: none"> • early education and childcare; • social services related to young children and their parents; • health services relevant to young children and their parents (i.e. health visitors, antenatal and postnatal care); • employment services for parents; • Family Information Services 	Private, voluntary, independent (PVI) providers Childminders Independent Schools Maintained Nursery Schools Nursery Classes in Primary Schools Infant Classes in Primary Schools State-funded	Childminders (49,385) ²⁰ Childcare on non-domestic premises (28,154) Childcare on domestic premises (201) Home child carers (11,377) Children's centres (2,192) ²¹	Children up to age 5 and their parents/carers	Ofsted

¹⁹ as applied by section 50(1) of the Children Act 2004, or section 15(3) of the Childcare Act 2006, or section 15(6) of the Local Government Act 1999

²⁰ Ofsted (2015) Childcare inspections and outcomes, Jan to March 2015 (provisional) Table 1.

²¹ Ofsted (2015) Children's centre inspection outcomes, Jan to March 2015 (provisional).

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
			Secondary Schools Special Schools			
S.1 Care Standards Act 2000	Person	Children's home	Community homes (LA run) Voluntary organisations Private sector children's homes Homes for disabled children	Children's homes (2,074) ²² - 473 LA - 1,430 private - 162 voluntary - 9 health authorities 14 are secure children's homes Residential special schools (86 registered as children's homes) ²³	All ages, though most children are over 12	Ofsted

²² Ofsted (2015) Children's social care data in England as at 31 March 2015.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/453325/Childrens_social_care_data_in_England_2015_key_findings.pdf

²³ Ibid

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
S.4 Care Standards Act 2000	Person	Residential family centre	Local authority Voluntary organisations Private sector	Residential family centres (38) ²⁴	Children and their parent(s) or person looking after the child	Ofsted
Residential Holiday Schemes for Disabled Children Regulations 2013²⁵	Person	Holiday scheme for disabled children	Registered person (individual, partnership or organisation)	Holiday or recreational care with accommodation (6) ²⁶	Disabled children	Ofsted
S.4 Care Standards Act 2000	Person	Fostering agency	Independent agency Voluntary organisation	Foster placement (300) ²⁷ - 232 private - 68 voluntary	Foster carers and children placed with them	Ofsted
S.4 Care Standards		Voluntary adoption agency	Voluntary organisation	Voluntary adoption agencies (42) ²⁸	Prospective adopters,	Ofsted

²⁴ Ibid

²⁵ Under s.42(1) Care Standards Act 2000

²⁶ Ofsted (2015) op cit

²⁷ Ofsted (2015) op cit

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
Act 2000					matches them with looked after children	
S.8 Adoption and Children Act 2002	Person	Adoption support agency	Private sector Voluntary organisation	Adoption support agencies (35) ²⁹ - 23 private - 12 voluntary	Adoption support to anyone who needs it	Ofsted
S.20(7) School Standards and Framework Act 1998	Governing body	Maintained school	Community school Foundation school Voluntary school Community or foundation special school	State funded primary school (16,766) ³⁰ State funded secondary school (3,381) State funded special school (including hospital schools) (971) Residential special schools (168)	All through schools Primary schools, majority of pupils 5 to 11, with some under 5 in infant/nursery classes Secondary schools, majority of students 11 to 16/17	Ofsted

²⁸ Ibid

²⁹ Ibid

³⁰ DfE (2015) Schools, pupils and their characteristics, Jan 2015. Table 2A

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
S.87 Children Act 1989				<ul style="list-style-type: none"> - 49 LA - 15 academies - 26 private sector - 44 voluntary <p>State boarding schools (38)³¹</p>	<p>Special schools, all ages up to 18/19</p> <p>State boarding schools, majority students 11 to 18</p>	
S.22(9) Schools Standards and Framework Act 1998	Governing body	Maintained nursery school	Maintained nursery school	Maintained nursery school (411) ³²	Young children, age 2 to 4	Ofsted
S.5A(4) Childcare Act 2006	Person	Children's centre	Children's centre	Children's centres (2,192) ³³	Parents, prospective parents, young children	Ofsted

³¹ Figure from State Boarding Schools Association (SBSA)

³² Ibid

³³ Ofsted (2015) Children's centre inspection outcomes, Jan to March 2015 (provisional).

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
S.18 Childcare Act 2006 ³⁴	Person	Childcare	Any form of care for a child including education and any supervised activity ³⁵	Early years register (7,816 providers) ³⁶ Compulsory childcare register (166 providers) Voluntary childcare register (13,328 providers)	Young children up to 5 Older children out of school hours	Ofsted
S.463 Education Act 1996 ³⁷	Proprietor	Independent school	Independent school	Independent schools (2,357 of which 1,044 are non-association schools)	All ages up to 19	Independent Schools Inspectorate

³⁴ required, or may apply, to be registered under Part 3 Childcare Act 2006

³⁵ Excludes education (or any other supervised activity) provided in school hours for a registered pupil at a school who is not a young child; health care; care provided by certain individuals (for example, a parent or a relative of a child); care provided in a hospital, care home or family centre; and care provided for children detained in young offender institutions or secure training centres.

³⁶ Ofsted (2015) Childcare inspections and outcomes, Jan to March 2015 (provisional), Table 1.

³⁷ entered on a register of independent schools kept under s.158 Education Act 2002

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
				inspected by Ofsted) ³⁸		School Inspection Service Bridge Schools Inspectorate Ofsted (for non-association independent schools)
S.92(1) Education and Skills Act 2008³⁹	Proprietor	Independent educational institution	Independent school Institution providing part-time education for students of compulsory school age	Independent schools (2,357)	Pupils age 5 to 16	Independent Schools Inspectorate School Inspection Service Bridge Schools

³⁸ Ofsted (2015) Independent schools inspection outcomes, 31 March 2015 [provisional].

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/439256/Independent_schools_inspection_outcomes_September_2014_to_March_2015_provisional.pdf

³⁹ entered on a register of independent educational institutions kept under s.95 Education and Skills Act 2008

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
						<p>Inspectorate</p> <p>Ofsted (for non-association independent schools)</p>
S.342 Education Act 1996	Proprietor	Non-maintained special school	Non-maintained special school	Non-maintained special school (69) ⁴⁰	Majority of pupils 5 to 16, with some up to 19	<p>Independent Schools Inspectorate</p> <p>School Inspection Service</p> <p>Bridge Schools Inspectorate</p> <p>Ofsted (for non-association independent schools)</p>

⁴⁰ DfE (2015) Schools, pupils and their characteristics, Jan 2015. Table 2A

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
S.1A(3) Academies Act 2010	Academy	Academy	Academy Special academy	Primary academies (2,440) ⁴¹ Secondary academies (2,075) Special academies (147)	Primary academies, majority of pupils 5 to 11 Secondary academies, majority of students 11 to 16/17 Special academies, all ages up to 18/19	Ofsted
S.1B(3) Academies Act 2010	Proprietor	16 to 19 academy	16 to 19 academy	16 to 19 academy	Pupils 16 to 19, post-compulsory school age	Ofsted
S.1C(3) Academies Act 2010	Proprietor	Alternative provision academy	Alternative provision academy	Alternative provision academy (60) ⁴²	Pupils age 5 to 16	Ofsted
S.90(1) Further and	Sixth form college	Sixth form college	Sixth form college	Sixth form college	Students 16 to	Ofsted

⁴¹ DfE (2015) Schools, pupils and their characteristics, Jan 2015. Table 2B

⁴² Ibid

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
Higher Education Act 1992	corporation			(93) ⁴³	19	
S.90(1) Further and Higher Education Act 1992	Further education corporation	Further education college	FE college	FE colleges (339), including those that provide accommodation for students under 18 (39) ⁴⁴	Students 14+, majority 16 and over	Ofsted
S.83(2) Children and Families Act 2014	Proprietor	Special post-16 institution		Special post-16 (67) ⁴⁵	Students age 16 to 19	Ofsted
S.19 Education Act 1996	Local authority	Pupil referral units or education provision elsewhere	Alternative provision	PRUs (362) ⁴⁶	Children age 5 to 16/17	Ofsted

⁴³ DfE (2015) Education and training statistics for 2015. Table 2.1

⁴⁴ Ofsted (2015) Children's social care data in England as at 31 March 2015.

⁴⁵ DfE (2015) Independent special institutions with Secretary of State approval

⁴⁶ DfE (2015) Schools, pupils and their characteristics, Jan 2015. Table 2A

Legislative basis	Responsible agency or persons	Type of service	Type of provider	Settings (and numbers of these in England)	Who the service is for	Regulatory body
	Person					
S.29(3) or 29A(1) Education Act 2002⁴⁷	Person Governing body	Alternative education	Alternative provision	Any place outside the school for curriculum purposes	All ages, but majority age 11 to 16/17	Ofsted
S.100 Education and Inspections Act 2006⁴⁸	Person Governing body or proprietor	Providing education under arrangements	Suitable full-time education for pupils on fixed period exclusion	Home School	Majority students age 11 to 15 ⁴⁹	Ofsted

⁴⁷ requirement for pupils to attend at a place outside school premises for instruction, training or education

⁴⁸ duty of governing body or proprietor where pupil excluded for fixed period

⁴⁹ DfE (2015) Permanent and Fixed Period Exclusions in England: 2013 to 2014, Table 4.

Annex 2

Table of official principles for sharing personal information

<p>Data Protection Act 1998 (Schedule 1)</p> <p>National law</p>	<p>Caldicott principles for sharing information in health and social care</p> <p>Used by health services and adult social care</p>	<p>HM Government principles for sharing information for practitioners providing safeguarding services to children, young people, parents and carers</p> <p>Used in children's services</p>
<ul style="list-style-type: none"> • Necessary [and lawful] for the purpose for which it is being shared (Schedule 2 specifies that this requires the subject's consent or, when processing sensitive data under Schedule 3, is necessary to the vital interests of the subject - in other words, when it is critical to preventing serious harm or distress, or in life-threatening situations) • Adequate, relevant and not excessive • Shared only with those who have a need for it • Accurate and up to date • Shared securely and in a timely fashion • Not kept for longer than necessary for the original purpose • Takes appropriate technical and 	<ol style="list-style-type: none"> 1. Justify the purpose(s). 2. Don't use personal confidential data unless it is absolutely necessary. 3. Use the minimum personal confidential data necessary for purpose. 4. Access to personal confidential data should be on a strict need-to-know basis. 5. Everyone with access to personal confidential data should be aware of their responsibilities. 6. Comply with the law. 7. The duty to share information can be as important as the duty to protect patient confidentiality. 	<p>Necessary and proportionate - When taking decisions about what information to share, you should consider how much information you need to release. The Data Protection Act 1998 requires you to consider the impact of disclosing information on the information subject and any third parties. Any information shared must be proportionate to the need and level of risk.</p> <p>Relevant - Only information that is relevant to the purposes should be shared with those who need it. This allows others to do their job effectively and make sound decisions.</p> <p>Adequate - Information should be adequate for its purpose. Information should be of the right quality to ensure that it can be understood and relied upon.</p> <p>Accurate - Information should be accurate and up to date and should clearly distinguish between fact and opinion. If the information is historical then this should be explained.</p> <p>Timely - Information should be shared in a timely</p>

<p>Data Protection Act 1998 (Schedule 1)</p> <p>National law</p>	<p>Caldicott principles for sharing information in health and social care</p> <p>Used by health services and adult social care</p>	<p>HM Government principles for sharing information for practitioners providing safeguarding services to children, young people, parents and carers</p> <p>Used in children's services</p>
<p>organisational measures against unauthorised use or accidental loss, destruction of or damage to personal data</p>		<p>fashion to reduce the risk of harm. Timeliness is key in emergency situations and it may not be appropriate to seek consent for information sharing if it could cause delays and therefore harm to a child. Practitioners should ensure that sufficient information is shared, as well as consider the urgency with which to share it.</p> <p>Secure - Wherever possible, information should be shared in an appropriate, secure way. Practitioners must always follow their organisation's policy on security for handling personal information.</p> <p>Record - Information sharing decisions should be recorded whether or not the decision is taken to share. If the decision is to share, reasons should be cited including what information has been shared and with whom, in line with organisational procedures. If the decision is not to share, it is good practice to record the reasons for this decision and discuss them with the requester. In line with each organisation's own retention policy, the information should not be kept any longer than is necessary. In some circumstances, this may be indefinitely, but if this is the case, there should be a review process.</p>



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