Department
for Education

Improving multi-agency information sharing

Government policy on information sharing and the use of a consistent child identifier

July 2023

Improving multi-agency information sharing

Presented to the House of Parliament by the Secretary of State for Education pursuant to Section 179 of the Health and Care Act 2022

July 2023

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CORRECTION SLIP

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Correction:

Amended a sentence on page 78 of the report to clarify that Home Office funded rather than delivered the national roll out of Operation Encompass scheme (the scheme was rolled out by Operation Encompass, the charity, with Home Office funding).

Text currently reads:

The scheme was rolled out nationally by the Home Office in 2019 and is now active in all 43 police forces across England and Wales'

Text should read:

The scheme was rolled out nationally with the support of Home Office funding in 2019 and is now active in all 43 police forces across England and Wales'

Date of correction: 20 July 2023

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Ministerial foreword

As Minister for Children, Families and Wellbeing within the Department for Education I am aware that poor information sharing between the agencies that work with children and families is often cited as an issue in reviews following the death of or serious injury to a child. The Independent Review of Children's Social Care (Care Review) and the Child Safeguarding Practice Review Panel report – 'Child Protection in England' (both 2022) also highlighted that information sharing needs to be improved upon, to improve outcomes for children and families.

In January 2023 we published our response to the Care Review, 'Stable Homes, Built on Love.' (Referred to as 'Built on Love' in this report). One of the recommendations in the Care Review was to achieve the frictionless sharing of information by 2027 and our work for this report sets out how we aim to move towards this.

We know that there are some great practices in local areas, where agencies are working together to overcome the challenges in information sharing and that with technological advances, we are able to be more ambitious in our thinking. We can learn from the work in local areas, where they are using technology to help information to flow more easily, to identify and manage risk and provide the right support for families.

A cross government approach has been taken to this report, so we can move forward with solving a problem that has been documented for over thirty years. We have worked closely with our partners in the Department for Health and Social Care, NHS England, Home Office, the Department for Levelling Up, Housing and Communities and scientific advisors with expertise in cutting edge technology to understand the views of their workforces and the work they have underway to make things better. Working in this way we have been able to collaborate on solutions to ensure they meet the needs of the different agencies and the children and families we support. I am grateful for the support and resource the other departments have provided to inform the evidence for this report. It has been a successful collaboration and provides a holistic picture of the experiences of practitioners.

This report sets out our intentions to make things better for children, families, and practitioners. We will continue to work with the sector and follow advances in technology to see where they can further improve services.

Claire Coutinho
Minister for Children, Families and Wellbeing, Department for Education.

Acknowledgments

To write this report it was important for us to understand information sharing within the current context that practitioners are working, including their day-to-day practice, the systems that support them and the legislative framework they work within. We would like to thank our colleagues in the Department of Health and Social Care (DHSC) and Home Office (HO) for their commitment to this primary research. The input from social care, education, health and policing frontline staff has been integral to us understanding the barriers in sharing information and in shaping potential solutions.

The research would not have been possible without the time and engagement of those who took part in the one-to-one interviews, focus groups and workshops and we are hugely grateful to everyone that attended. The sessions gave us a great insight into the experiences of those working with children and families and hearing their ideas for how things can improve has been useful in identifying how we can make things better. We appreciate professionals taking time out of their busy day jobs to speak to us and would like to thank local authorities for spending time with us showcasing the improvements they have made locally, answering our questions, and continuing to provide input into the work we are doing.

We have also worked closely with the Information Commissioner's Office, NHS England, the Children's Commissioner's Office, DLUHC and scientific advisors with expertise in technology and would like to thank them for their contributions to the report and their ongoing help to shape the next steps for improving information sharing. We will continue working closely with them, DHSC and HO to move forward with this work.

In addition, we would like to thank the stakeholders who have been an important part of the work completed for the report. Their input has helped to reflect the voices of children and families and been invaluable to help us to understand the potential positive impact of improving information sharing. Members of the Children and Young People's Health Policy Influencing Group (HPIG) and the Child Safeguarding Practice Review Panel have given us their time and input and we are very grateful for this.

Executive summary

The Department for Education (DfE) have worked closely with colleagues in the Department of Health and Social Care (DHSC) and Home Office (HO) to produce this report, highlighting the barriers practitioners working with children and families face when sharing information and investigating potential solutions to this. The information in the report has come from primary research conducted by DfE, HO and DHSC including multi-agency practitioner workshops and a comprehensive literature review. You will also see summarised in Annex A findings from our Data and Digital Solutions Fund project, led by the London Borough of Newham, on potential solutions for overcoming the cultural and behavioural barriers to information sharing.

This report has also been informed by the issues raised with information sharing in the Care Review and the 2022 National Panel report, ‘Child Protection in England.’ We have worked closely with the Children’s Commissioner’s Office who, in their recent Family Review report (December 2022), made recommendations about implementing a consistent child identifier (CCI), to assist with information sharing between agencies.

Why is information sharing important?

Poor information sharing is often cited in reviews following the death of, or serious injury to, a child. Improvements have been made over time, but significant barriers remain. We know that often different professionals working with children and families have information about different aspects of their lives, such as their health issues or educational attainment and attendance, but it is only when information is shared that it is possible to see the full picture of a child’s life. One piece of information in silo may not seem important or relevant, it is only when it is pieced together with information held by others that its relevance becomes apparent. This holistic view can then inform the support the child receives, ensuring it is appropriate and timely.

The barriers to information sharing

The barriers to information sharing identified by our research have been divided into five main areas:

- Systems and processes
- Perceptions about legislation
- Practice confidence
- Leadership and culture
- Capacity and resource

Systems and processes refers to the technological landscape that practitioners work within. Often their systems do not speak to each other, making information sharing a manual and time-consuming process. There is often no way to know who holds information on a child/family and to access this easily. Practitioners also highlighted the difficulties they have with the different thresholds for intervention across local authorities (LAs), meaning there is confusion about what warrants a referral to social care. This can prevent information being shared.

Perceptions about legislation refers to the lack of clarity practitioners have about what the law allows them to share. This makes them uncertain about what they can share, which can lead to information not being shared and risks the child's situation escalating. We were told very clearly that the current information sharing guidance does not support them in their decision-making about sharing information.

Practice confidence refers to practitioners not always being aware of the relevance of the information they hold and therefore not sharing it more widely. This can be because they are not aware of the information known by other agencies, nor which other agencies are involved with a child or family. Information can also be shared which requires interpretation by the person receiving it, this can be time consuming as clarification needs to be sought. It can also undermine the importance of the information being shared.

Leadership and culture refers to the culture between agencies and where there are good working relationships, there appear to be less barriers to sharing information. We were told that where practitioners work closely, such as when co-located in a multi-agency safeguarding hub (MASH) or a similar multi-agency solution, they feel more confident in sharing and seeking information. It is more straightforward and less time-consuming. We found that the differences in the language used by agencies can also be a barrier to sharing information, as there is a lack of understanding about the risks being managed. In addition, it was felt that leaders need to role model closer working with other agencies and find ways to promote this from a strategic level.

Capacity and resource refers to the high demands we know practitioners have on their time. We were told that gathering the information they need can be time-consuming and difficult and that this can impact on their ability to intervene in a timely manner and at the right level. Challenges around recruitment and retention, combined with the increasing number of contacts and referrals to children's social care, can cause information overload.

Technological solutions, including thoughts on a CCI

We have conducted research with numerous LAs who have invested in and developed technology as a means to improve information sharing. These solutions are explored in more detail in the report but tend to have similar properties. Several feature a ‘one-view’ of a child, which pulls in data from other LA departments and agencies such as schools, police, health and in some cases the fire service, to show interactions with a child or family. There is some sharing of information from the LA to other agencies, but this is limited.

We have performed a deep dive into several of these systems to understand the mechanisms they use to bring in the data from other agencies. Six of the seven LA systems are using a mixture of demographic information and identification (ID) numbers for data matching, including the NHS number and the case management system ID number. They use each ID number relative to the data they are matching. E.g., NHS number to link up NHS/health data and the Unique Pupil Number (UPN) for education data. The LAs are seeing great benefits from having these links with other agency systems and they are looking to enhance these further. Whilst the LAs told us that having the use of a consistent number would be a benefit to increase their confidence ability to match children across systems and to do this quickly, it is the interoperability of the systems that enables them to share information.

The debate around using a CCI for children has been ongoing for years. It has been highlighted more recently since the mandating of the use of the NHS number in adult social care. The exclusion of children from this led to the Department commissioning a report on a CCI in 2016. This concluded that a CCI was a possibility to improve information sharing but highlighted the limited evidence to support the benefits of implementation.

It seems that the use of a CCI has clouded the discussion around how we can improve information sharing. Whilst LAs and other stakeholders have stated their wish for a CCI to be implemented, the ability for this to improve information sharing goes beyond the use of a consistent number. Without the links between systems being established, a CCI would not enable information to be shared. Interoperability is the key to this, and we have found that this should be the focus of the next steps for improving information sharing.

- Using the NHS number as a CCI for health and social care will be a small but significant part of the jigsaw required to improve data-sharing across services.
- It is only part of the solution, as having access to the NHS number does not, in itself, provide access to detailed information or provide practitioners with confidence about sharing detailed information.

- There will be implementation challenges, e.g., ensuring LAs and other safeguarding partners have the resource to meet NHS England security requirements; and
- Requiring children's social care providers to use the NHS number as a CCI may need statutory change.

Whilst this is not the panacea, using the NHS number would allow data to be shared more efficiently and accurately. This has been demonstrated for example by the Child Protection Information Sharing service (CP-IS), utilising the NHS number to link and share data on child protection plans/looked after children. However, this efficiency would only be realised once systems have been made more interoperable, making it possible for information to flow between them.

It is also important to note that while the NHS number is one existing mechanism for identifying the right child, it is not proposed to be a mechanism for creating a national ID number or a way to introduce national ID cards or a national database. The government understands that there is no public support for national ID cards or creating a national database and has no plans to introduce either of them in the future.

Next steps

To inform the conclusions of the report we have considered the primary and secondary research conducted. The findings indicate that in order to address the issues with multi-agency information sharing we need:

- Functioning, joined-up systems across agencies that support the right data to be used securely by the right people at the right time
- an accurate and well-maintained 'golden record' about a child/family
- confident practitioners who are clear on their roles and responsibilities for sharing and seeking information and feel they can do so in low-burdensome ways

The focus for the next phase of work is interoperability – how we can link systems together and share information. We need to further understand the landscape of systems used by agencies and how we can bring them together.

Alongside this work, we plan to further investigate the use of the NHS ID as a CCI for children and to seek out legislative opportunities to mandate this as needed. This will include working with DHSC and NHSE to plan and initiate a regional pilot on using the NHS number and better use of NHS Spine data across children's health and social care systems.

In addition to this we plan to work with DHSC and NHS England on CP-IS, to improve the flow of useful health information into the social worker. We aim to complete a six-week deep dive into the scope, feasibility, and ballpark figures of a phase three of transformation of CP-IS, to make the system more beneficial for social workers and increase the number of children the system caters for.

Within the ‘next steps’ section of the report, we have set out a roadmap to achieve this over five years.

The research showed that cultural, behavioural and practice factors were significant barriers in information sharing. With practitioners we have developed the following solutions to overcome these issues, which when supported by the technological solutions, will help to improve practitioner confidence in their ability to share information:

- strengthened guidance to practitioners and better training on information governance, delivered with specific elements relating to safeguarding children
- promoting and spreading good practice using local safeguarding partners to do so
- development of an online platform for practitioners to access materials, such as toolkits, training, and guidance documents, linking this with resources from agencies such as the Information Commissioner’s Office

Whilst progressing this work we also plan to monitor further advances in technology, to see where these may also be able to assist with our long-term ambitions.

The programme of improvement will not take place in a silo and will be part of wider reforms, such as those in ‘Built on Love’. Numerous reforms being planned and tested in children’s social care, such as those that aim to strengthen multi-agency working and to improve data and digital capability, should have a positive impact on future information sharing between agencies.

Chapter 1 – Introduction and scope

The effective and timely sharing of information, appropriately and securely, between agencies is key to a successful system for child protection and the promotion of child welfare. For over twenty years, numerous reports and national guidance have highlighted the importance of robust information sharing in supporting young people and their families and keeping vulnerable children safe.[1] [2] [3] [4] [5] [6] [7] [8] In 2022, the National Child Safeguarding Practice Review Panel report 'Child Protection in England,' along with the Independent Review into Children's Social Care, again highlighted that the problems with sharing, seeking and using information about a child and a family persist and must be tackled.[9] Whilst much has improved, additional approaches are needed to further address the limitations that remain.

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[1] Lord Laming (2003), The Victoria Climbié Inquiry Report (publishing.service.gov.uk)

[2] E Munro (2011), The Munro Review of Child Protection: final report. A child-centred system Munro-Review.pdf (publishing.service.gov.uk)

[3] Children's Commissioner's Office (2013), "If only someone had listened": Inquiry into Child Sexual Exploitation in Gangs and Groups If_only_someone_had_listened (childrenscommissioner.gov.uk)

[4] Centre of Excellence (2016), Information sharing to protect vulnerable children and families, Department for Education (publishing.service.gov.uk)

[5] Department for Education (2018), Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (www.gov.uk)

[6] Department for Education (2018), Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (publishing.service.gov.uk)

[7] Department for Education (2022), Keeping children safe in education: statutory guidance for schools and colleges (publishing.service.gov.uk)

[8] J MacAlister (2022), The Independent Review into Children's Social Care: Final report (www.gov.uk)

[9] The Child Safeguarding Practice Review Panel (2022), Child Protection in England: National Review into the murders of Arthur Labinjo-Hughes and Star Hobson (www.gov.uk)

1.1 Information sharing and the Health and Care Act 2022

This report is written in response to a legislative commitment outlined in section 179 of the Health and Care Act 2022.[10] The Health and Care Act 2022 received Royal Assent on 28 April 2022. Changes were made to the Bill as it progressed through Parliament, including a specific amendment made in the final stages concerning information sharing relating to children. This clause is now section 179 of the Act (figure 1) and came into force on 28 July 2022. It requires the Secretary of State for Education to report on government policy in relation to improving multi-agency information sharing for purposes relating to children's health or social care, or the safeguarding or promotion of the welfare of children, including the potential role of a Consistent Child Identifier (CCI).

This report explores current barriers to effective information sharing and makes recommendations for improvements. This includes consideration of how we can maximise the linking of data across agencies and the changes to systems needed to do so. The use of a CCI to assist with this is also considered.

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[10] Health and Care Act 2022 (legislation.gov.uk)

Section 179 Health and Care Act 2022

(1) The Secretary of State for Education must publish and lay before Parliament a report describing the government’s policy in relation to the sharing of information by or with public authorities in the exercise of relevant functions of those authorities, for purposes relating to:

(a) children’s health or social care, or
(b) the safeguarding or promotion of the welfare of children.

(2) In this section, “relevant functions” means functions relating to children’s health or social care, so far as exercisable in relation to England.

(3) The report must include an explanation of whether or to what extent it is the government’s policy that a consistent identifier should be used for each child, to facilitate the sharing of information.

(4) The report must include a summary of the Secretary of State’s views about implementation of the policy referred to in subsection (1), including any views about steps that should be taken to overcome barriers to implementation.

(5) The report must be published and laid before Parliament within one year beginning with the date on which this section comes into force.

(6) In this section, “child” means a person aged under 18.

Figure 1: Section 179 Health and Care Act 2022

1.2 Scope

Throughout our research we have focused on information sharing for the purposes of local child safeguarding, and the promotion of children’s welfare. This means the secure sharing of person identifiable information between agencies that is needed to support early identification of need, assessment completion and service provision. It does not consider sharing for national purposes, including policy development, resource planning, analytics, and research. Information sharing for these latter purposes is part of wider work being undertaken at the Department for Education (DfE) to improve how and what data is collected. A data strategy, that will set out our long-term goals and plan for children’s social care data, will be published later this year.

This report considers the sharing of information about all children, but it particularly focuses on those referred to children's social care and targeted early help and their family members, carers, or other significant adults. This reflects the expertise of the practitioners that took part in the research. The report's findings and next steps on improving interoperability are expected to have a broad reach for vulnerable children across health and social care.

We have looked at information sharing by the statutory safeguarding agencies and education settings, as they have primary responsibility for the welfare of children. We have not focused on information sharing by other statutory agencies e.g., probation, private and voluntary agencies, or agencies outside England. However, we accept that current and future policy recommendations will impact these wider groups and we will continue to engage them as we move the work forwards. Our focus has been on local practitioners, leaders and support staff involved in safeguarding and promoting the welfare of children, not government or national bodies.

At times in the report, we use the shorthand of 'safeguarding' when we are referring to safeguarding and promoting the welfare of children. This is based on the definition of safeguarding in Working Together which details the broad definition that the term has. The definition is outlined in the box below.

Safeguarding and the promotion of welfare is:

- protecting children from maltreatment
- preventing impairment of children's mental and physical health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

as defined in the statutory guidance 'Working Together to Safeguard Children 2018'.[11]

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[11] Department for Education (2018)

In addition, as a DfE led report we have looked in more detail at the sharing of information between social care and other agencies, often as this is cited as an issue in the reviews described in the introduction. A lot of work has been completed by DHSC for the report and has provided them with further insight into information sharing within health, as well as between health and other agencies.

1.3 Report objectives

This report outlines current government policy in relation to information sharing for the safeguarding and promotion of the welfare of all children. It explores both the barriers and potential enablers to better information sharing. The conclusions and next steps in chapter 8 aim to improve information sharing between the agencies that work with children and families, including health services, LAs, and the police, as well as education settings.

The barriers to timely and effective information sharing are discussed in chapter 4. We believe that the reduction or elimination of the barriers will facilitate the following improvements:

- more seamless, efficient, and secure sharing of the information appropriate for child safeguarding and promotion of welfare, leading to reduced practitioner time spent seeking relevant information
- increased confidence in practitioners knowing when and how to share appropriate information

These improvements will lead to:

- more timely identification and appropriate support and protection for children and families
- more joined-up approaches to information sharing across partner agencies

The overarching goal is to ensure no harm is caused to children due to a lack of or ineffective information sharing.

1.4 Methodology

This report is based on a cross government project led by DfE, working closely with DHSC and HO. It includes the findings and recommendations from several pieces of primary user research, a review of the literature and wider field work. The project has built on evidence presented in previous information sharing reports and explored current user experiences.

Policy advisers from several government departments have worked with data and digital experts and key external stakeholders, to better understand why effective information sharing remains challenging. Opportunities to make improvements were then explored. This included investigating the feasibility and need for a CCI as an enabler to better information sharing, its benefits, and potential challenges.

Chapter 2 – Background

2.1 History of problems

Poor information sharing between professionals working with children and families is a well-documented issue. As far back as 2003, the Victoria Climbié inquiry highlighted repeated failures by professionals working with children and families to collect basic information and share it between agencies and across LA boundaries.

Better information sharing has regularly been part of the debate on how to improve services for children and families and ensure positive outcomes. We know that health, police, education, and children's social care need to work together to identify and manage risks and needs of children and must collaborate to reach a shared and appropriate conclusion or action for a child. It is only when an holistic view of a child's life is visible, that they can be protected and receive the right intervention.[12] When concerns are raised due to a change in a child's presentation or circumstances, which may indicate their basic needs are not being met or that they are at risk, these agencies rely on the information they receive from other professionals, families, and the community. These concerns may relate to a small part of a child's life, and it is only when considered in the context of information known by others, that the best decision can be made about the appropriate action to take and by who.

Far too frequently it is following a tragic event, such as the death of a child, that an investigation or review of practice is undertaken and a raft of recommendations for the different agencies involved are made. These recommendations are regularly duplicated and improving information sharing is a very common theme.

The first child protection memorandum for professionals working with children was issued in 1974, in the wake of the public inquiry into the death of Maria Colwell.[13] The primary focus of early iterations was to make sure that a range of key professionals were familiar with the signs of non-accidental injury to children (and subsequently child abuse) and processes established so that information could be shared between them. Coordination between agencies and professionals in relation to vulnerable children was seen as key for improving practice, and the roles of paediatricians, GPs, health visitors and the police were soon seen as vital.

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[12] Laming (2003)

[13] N Parton (2011), The increasing length and complexity of central government guidance about child abuse in England 1974-2010 http://eprints.hud.ac.uk/id/eprint/9906/

In 1988, more detailed government guidance called ‘Working Together’ was first published. Subsequently revised to include wider safeguarding considerations, this statutory guidance on information sharing has been in place for practitioners since 1999 when it was retitled ‘Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children’. This set out how agencies should work together to promote children’s welfare and protect them from abuse and neglect.

Following the death of Victoria Climbié in 2000, an inquiry was carried out by Lord Laming to look at the system for protecting children and what could be done to improve it. The Lord Laming Report (2003) analysed the interactions of children’s social care, health and police and made recommendations to each agency individually and as a partnership. Lord Laming highlighted the need for sharing information not only where the risk of significant harm was present, but also where children may need support at a lower level. This gives practitioners the opportunity to intervene at an appropriate lower level, provide support and to prevent the escalation of a case to the threshold of significant harm.

Following the Laming Report changes were made to the ways agencies work together, yet the poor findings on information sharing continued. The introduction of Every Child Matters in 2003 and the updated Children Act in 2004, further promoted multi-agency working to practitioners. This placed a statutory duty on agencies to make arrangements to safeguard and promote the welfare of children. This was followed by an updated Working Together to Safeguard Children statutory guidance document, in 2006, setting out the expectations of these agencies.

Working Together has been updated several times since, often in response to a further inquiry or report. Most notably was the review of child protection completed by Professor Eileen Munro (2011). In her primary research with practitioners, she found the *“…*unanimous view of this group was that it is important to continue to have a single set of rules that all organisations, including professional bodies, voluntary and private sector providers and government departments, follow and are clear on their respective roles and responsibilities for protecting children from harm.”[14] Professor Munro also highlighted how the length of the guidance has increased significantly over the years, making it more difficult for practitioners to have in depth knowledge of its content. Since the review, Working Together has been updated and it is currently going through a consultation process for a further update. It remains the primary guidance for practitioners working with children and families and is used to inform policy and practice across the sectors.

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[14] Munro (2011)

The recommendations in the above reports have led to some improvements in information-sharing and ensured it has remained a large part of the discussion regarding working with children and families. The recommendations have encouraged and improved multi-agency working, with changes to legislation and accompanying guidance (Working Together) providing the status of 'safeguarding partners' to LAs, integrated care boards (or previously clinical commissioning groups) and police (chief officer of police) and implementing duties on them.[15] Other reforms implemented by local areas in the last 10 years have further prioritised collaboration, most notably with the expansion of multi-agency safeguarding hubs (MASHs). Safeguarding hubs encourage professionals from different agencies to work together effectively to safeguard children and young people. Professionals from children's services, health services, and police receive referrals and share data in a controlled, structured environment to assess risk and determine next steps for a child's case.

In 2022 there were another three prominent reports published which all made recommendations about information sharing. The Independent Review of Children's Social Care[16] (the Care Review), the National Child Safeguarding Practice Review Panel report 'Child Protection in England,'[17] (the Panel report) and the Children's Commissioner's Family Review[18] all highlight the problems with information sharing between professionals.

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[15] The Children Act 2004 imposes duties on safeguarding partners (s.16E), along with a duty on LAs to make arrangements to promote cooperation with its relevant partners s.10 and the duty to make arrangements to safeguard and promote welfare under s.11.

[16] MacAlister (2022)

[17] The Child Safeguarding Practice Review Panel (2022)

[18] Children's Commissioner (2022), 'Family and its protective effect': Part 1 of the Independent Family Review Family Review | Children's Commissioner (childrenscommissioner.gov.uk)

2.2 Overview of CCI history and debate

Exploring the feasibility of a national children's database to improve information sharing was a recommendation of the Laming inquiry in 2003.[19] The recommendation was accepted and in the Green Paper, Every Child Matters a firm commitment was made to explore a unique identity number; "improving information sharing between agencies to ensure all local authorities have a list of children in their area, the services each child has had contact with, and the contact details of the relevant professionals who work with them. The government will remove the legislative barriers to better information sharing, and the technical barriers to electronic information sharing through developing a single unique identity number, and common data standards on the recording of information". [20]

A pilot scheme followed to explore how information about children could be shared appropriately within and between agencies, and more easily transferred across boundaries. Further policy was developed and in 2007, the ContactPoint system was introduced under section 12 of the Children Act 2004. This national system was designed to enable practitioners across education, health, social care, youth justice and the voluntary sector to find out who else was working with a child or young person so that they could, where appropriate, work together to deliver better coordinated support. It held basic identifying information on all children in England until they reached 18, using the child benefit number as the CCI. By 2010, ContactPoint was fully operational across all local authorities in England. However, concerns around intrusion of personal privacy and civil liberties saw the system decommissioned in 2010.[21] [22] Due to the system being operational for a short time, no formal evaluation was carried out, however, anecdotally practitioners have told us that there were benefits in having such a system.

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[19] Laming (2003)

[20] Government Green Paper (2003), Every Child Matters Every Child Matters 2003

[21] T Loughton (2010), Written ministerial statement on decommissioning ContactPoint Statement by Tim Loughton on decommissioning ContactPoint (www.gov.uk)

[22] The Children Act 2004 Information Database (England) (Revocation) Regulations 2012 Children Act 2004 (legislation.gov.uk)

In 2011 the Munro review of child protection [23] considered the merits of a national signposting approach, as ContactPoint had shown the potential value of a quick and reliable means of discovering whether another professional had worked with a vulnerable child. It explored whether a national database of two categories of children, those who had been, or were, the subject of a child protection plan (CPP) and children who were, or had been, looked after would be advantageous. Based on the evidence at the time the review concluded that "the arguments for and against such a national system are finely balanced and that there is no compelling case to recommend one at this point." It found that the underlying problem was how to facilitate good risk assessment and that having relevant information available to highlight existing problems and concerns was only part of the process. Whilst a lack of information sharing between agencies was often contributing to inaccurate risk assessments,[24] a consistent finding in Serious Case Reviews (SCRs) was that failure in human performance was also a significant factor, rather than an absence of the required framework, process, or procedures for sharing information.

The Munro review was clear that effective communication is not just a matter of moving data from one computer to another; it is 'the process by which information is transferred from one person to another and is understood by them".[25] It reported differing views on the value of knowing that a child was subject to a CPP in improving risk assessment. There was no clear evidence that sharing this information improved outcomes for children and significant concerns were raised that risk assessment could in fact be damaged, with the absence of a CPP giving safeguarding professionals' false reassurance. The fact that 72 per cent of children who were subject to a SCR between 2007-09 had never been the subject of a CPP, led the review to conclude the value of a CPP as a predictive factor was limited. With no compelling case, further exploration of a national system for this group of children was paused and the Munro review instead recommended the system be improved through more efficient 24-hour access to services.

In 2016, following the introduction of the Health and Social Care (Safety and Quality) Act 2015 (the 2015 Act),[26] the government commissioned further research[27] to look at whether the use of a CCI across education and children's services would, with

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[23] Munro (2011)

[24] Ofsted (2010), Learning lessons from serious case reviews 2009–2010 Ofsted publication (publishing.service.gov.uk)

[25] P Reder and S Duncan (2003), 'Understanding communication in child protection networks', Child Abuse Review, 12 (March April), pp82–100

[26] Health and Social Care (Safety and Quality) Act 2015 (legislation.gov.uk)

[27] I La Valle, B Graham and L Payne (2016), A consistent identifier in education and children's services Consistent identifier in education and CSC (publishing.service.gov.uk)

recent wider policy changes, support more effective information sharing practices. The 2015 Act introduced duties on providers of publicly funded health services and adult social care in England to include a single identifier (the NHS number) in information processed about an adult patient or service user, and to share information about an adult patient or service user with other relevant persons, where that would facilitate the provision of care to the individual and is in his or her best interests.

At the time the 2015 Act was introduced, the government's position was that the duties should not apply to schools or any other Ofsted registered body or any commissioner or provider in respect of children's social care. It did however commit to explore the potential impact, risks and burdens of imposing such a duty on these organisations. This research concluded that there was a great deal of support for adopting a consistent identifier in children's education and social care, that it would be useful, and that the NHS number, a unique lifetime identifier allocated from birth, or when a person first registers with the NHS, would be the most suitable number to use as a CCI. Other potential child identifiers discussed in the report were; the local authority child ID (allocated to children receiving a children in need service), the Unique Pupil Number (UPN, automatically allocated to each child attending a maintained school or academy), the Unique Learning Number (ULN, used to access the personal learning record of young people 14 and up), the Child Benefit Number, (CB, 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) and the national insurance number (allocated to young people primarily when they reach 16).

The 2016 report identified three options for the use of the NHS number as the consistent identifier for children. The first option, "proportionate use" considered education and children's services using the NHS number to exchange information with health to support existing exchange requirements and practices. The second option, "universal use" considered the NHS number be used as the consistent identifier for all services delivered to children, not limited to information exchanges with health. The final option, "universal plus" suggested the NHS number be used as a CCI for both service delivery (as for universal) and for local service planning, national policy analysis and monitoring. The report concluded the proportionate option was most feasible and could be introduced by extending the 2015 Act provisions. However, there was limited evidence to prove the benefits of a CCI to deliver more effective information sharing between children's services and health and there were concerns such as protection of privacy, increased regulatory burdens and likely costs of implementation and maintenance.

Despite this, the use of the NHS number to share information was beginning to emerge in a number of LAs and NHS unscheduled care settings, as the Child Protection Information Sharing service (CP-IS) project to protect children who were looked after, or subject of a CPP got underway. This was without the use of the NHS number being mandated and instead using it within its current legal remit. The CP-IS service was planned and put in place as a result of DHSC commissioning the Health and Social Care Information Centre to deliver the service, following extensive consultation with representatives from a wide range of healthcare providers, Royal Colleges, LAs and government departments. CP-IS is now a well-established service and has demonstrated benefits in the ability to share information between health and social care, improving outcomes for children. It covers all LAs in England. There is an opportunity to extend the use of this more widely across the safeguarding system, as part of the government's policy in relation to the sharing of information. More detail on the CP-IS service can be found in chapter 7 and examples of effective practice using the NHS number are explored further in chapter 6.

In 2021, as the Health and Care Bill progressed through Parliament, the debate on the need for and feasibility of introducing a CCI was revisited, resulting in the government's commitment to explore the issue further in this report.

The Independent Review of Children’s Social Care, published in May 2022,[28] supported the debate further. It argues that a consistent identifier is one of two necessary components to achieve a suggested national objective of frictionless sharing of information between public agencies and organisations to keep children safe by 2027. The review states that a consistent identifier is needed “to ensure that data can be easily, quickly and accurately linked. Without one number that links systems, data must be laboriously matched and the scope for true integration is limited”. We have found no evidence that quantifies the scale of the matching limitations alluded to. LAs have reported good matching rates using the demographic information and system IDs they currently use. Based on previous research and the discussions during the passage of the Bill, the Care Review proposed the NHS number as the solution. It concluded that, “unless a compelling reason is found imminently not to do this, government must get on and implement the NHS number as the identifier”.

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[28] MacAlister (2022)

The Office of the Children's Commissioner (OCC) also highlights that practitioners should have quick and direct access to important information from partners and other LAs, which is needed to help them understand a full picture of what is happening to a child and take action to keep them safe. It recommended establishing a consistent unique identifier for children in its 2022 attendance audit stating, "lack of information sharing should never be a barrier to keeping children safe and ensuring they receive a high-quality education." [29] The OCC went on to explore the technical and organisational challenges of adopting a CCI and its potential to improve data linkage.[30] It argued that the use of a single CCI across all services which interact with children "would be a 'golden thread' not just between records held by one agency, but between records held by multiple agencies." Accepting that the presence of a CCI across data sources "is not a panacea" to solve all data sharing challenges, the Children's Commissioner still recommended the NHS number be adopted as a consistent unique identifier and be rolled out across education and child protection services.

Even though the NHS number is already mandated for use as an identifier for health and adult social care we found little evidence that this therefore enabled frictionless information flow between systems. We also heard that, while the NHS number is used in all health settings, this does not mean that information between health systems is able to be shared.

The discussion around implementing a CCI for children has at times included concerns that this is a means to implement national ID cards. This is not the case. The government understands that there is no public support for national ID cards or creating a national database and has no plans to introduce either of them in the future[31].

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[29] Children's Commissioner for England (2022), Voices of England's Missing Children: The findings of the Children's Commissioner's Attendance Audit [Voices of England's Missing Children (childrenscommissioner.gov.uk)]

[30] Children's Commissioner (2022), Utilising data to improve children's outcomes: Annex to *A positive approach to a parenting: Part 2 of the Independent Family* [CC family review utilising data annex]

[31] Cabinet Office/Department for Digital, Culture, Media & Sport (2023), Government response to the digital identity and attributes consultation [(www.gov.uk)]

2.3 Key findings from previous studies

Information sharing is not a new problem, and this is not the first report to attempt to understand the barriers and ideate solutions. This report uses and builds upon previous research, reviews and evaluations that have considered information sharing.

As part of the London Borough of Newham led research, funded by DfE's Data and Digital Solutions Fund (DDSF), the Rees Centre conducted a rapid literature review of recent literature on barriers and solutions to multi-agency information sharing[32]. This review has fed into the findings and solutions of the DDSF research project and into this report more broadly.

The 2016 report from the Centre of Excellence for Information Sharing and DfE identified some of what could be done to support practitioners in understanding what approaches work best in information sharing, and how to overcome real and perceived barriers. It identified three overarching factors crucial to the successful sharing of information by early help and safeguarding partners: "understanding vulnerability and risk" (having an holistic view of a family); providing 'strategic leadership and communication' (clear and consistent vision for information sharing) and developing professional capability (workforce development and training). The findings indicated that 'poor information sharing cannot be diagnosed and treated as a distinct problem that lies outside of professional practice. In fact, information sharing is part of practice'.[33]

Reports by the Child Safeguarding Practice Review Panel have consistently evidenced the barriers to appropriate and timely sharing, seeking and use of information. The reports stress how vital improvements to information sharing are and make recommendations for specific changes.

"The perennial problems of sharing, seeking and using information about a family persist. This must be tackled. We cannot afford to revisit these problems again and again; new approaches are required."[34]

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[32] Rees Centre (2023), Overcoming Behavioural & Cultural Barriers to Multi-agency Information Sharing in Children's Social Care: A rapid review to inform the Newham led project for the DfE Data and Digital Fund

[33] Centre of Excellence (2016)

[34] The Child Safeguarding Practice Review Panel (2022)

Reviews of local practice continually highlight key themes and practices relating to information sharing. Inspection reports, especially findings of Joint Targeted Area Inspections (JTAIs), evidence multi-agency information sharing practices, both those that are strong and those in need of improvement. In all the reports of JTAIs on multi-agency response to identification of initial need and risk (published since January 2022 to date), there is an improvement recommendation for the safeguarding partners related to multi-agency information sharing (Barnsley, Lewisham, Solihull, Walsall and Windsor and Maidenhead). Independent evaluations of innovative models of local practice also provide a helpful evidence base for possible improvements, such as findings from projects of the Children's Social Care Innovation Programme.

“A large majority of the surveyed practitioners (88%) said that Family Safeguarding had improved information sharing and decision making.”[35]

Recent national reviews, as already mentioned, such as the ‘Utilising data to improve children’s outcomes’ (as part of the Family Review) and the Care Review conducted their own research with frontline practitioners on barriers and possible improvements in information sharing. The Care Review categorised three barriers to information sharing based on their research: ‘Knowledge and culture’, ‘Perceived legislative and regulatory barriers’ and ‘Technological barriers’.

“Each of these [barriers] is hard to address and there is no single simple answer. However, there is a risk that complexity leads to inertia, when what is needed is steady and determined action to solve problems step by step and tackle barriers as we come to them.”[36]

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[35] J Roger, T Allan, S Elliott (2020), Family Safeguarding: Evaluation report Hertfordshire Family Safeguarding (publishing.service.gov.uk)

[36] MacAlister (2022)

Research on cultural and behavioural factors influencing information sharing has been conducted by the London Borough of Newham and Social Finance.[37] Secondary literature has complemented their primary research to validate the insights, which are fed into the findings of this report. Recent literature includes Kantar Public's Multi-agency reform: Key behavioural drivers and barriers, that recognises information sharing as a key barrier and outlines possible interventions (2021).[38] Also, the Behavioural Insights Team's examined "what conditions support effective information sharing across organisations?" and identified five conditions for effective information sharing across agencies. The conditions were highlighted in the Panel Report,[39] as:

- trust, shared values and identity: creating a culture of trust and support for colleagues where information sharing is the norm
- a clear information sharing policy: ensuring overarching data sharing agreements are in place where feasible to permit easy and timely sharing
- leadership support: modelling collaborative behaviours and ensuring sufficient resources are available to set up and sustain information sharing across organisations
- regular feedback loops: establishing processes whereby feedback is solicited and provided on a regular basis both internally and across organisations
- systems that minimise the cost of sharing: removing friction costs associated with sharing information

Over recent years, government departments have delivered numerous "discovery" digital projects in areas of children's health and social care. Some have focused on understanding issues of information sharing particularly, or the use, access and storage of data more generally. The findings of the previous 'discovery' projects such as those led by DfE, for example, 'Family Hubs – Growing Up Well', and those led by NHS Digital (now part of NHS England) have shaped the methodology for the primary research detailed in this report and contributed to the report's findings.

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[37] Social Finance & London Borough of Newham (2023), Overcoming Behavioural & Cultural Barriers to Multi-agency Information Sharing in Children's Social Care. Department for Education *(unpublished)*

[38] Kantar Public (2021), Multi-agency reform: Key behavioural drivers and barriers. Department for Education Multi-agency reform (publishing.service.gov.uk)

[39] The Child Safeguarding Practice Review Panel (2022)

3.1 An overview of the current legal framework for information sharing in England

Local agencies are legally obligated to work together and share information to protect children. Key pieces of legislation relevant to the sharing of information for safeguarding and promotion of welfare purposes include:

Children Act 1989 – each LA has a duty to "safeguard and promote the welfare" of children who are assessed as being in need (s.17) and investigate when they have reasonable cause to suspect that a child is at risk of significant harm (s.47). Specified agencies (in particular certain NHS bodies) are required to assist the LA in any s.47 enquiries, including by providing information and advice.

Education Act 2002 – section 175 requires LAs, maintained schools and further education institutions to make arrangements for ensuring that their education functions are exercised with a view to safeguarding and promoting the welfare of children. A similar duty applies to independent schools (including academies/free schools) under the Education (Independent School Standards) Regulations 2014.

Children Act 2004:

Section 10 – requires LAs to make arrangements to promote co-operation with relevant partners (which includes local police, local NHS integrated care boards and schools) and other organisations working with children in their area, to promote the well-being of children in their area.

Section 11 – places a duty on LAs and their partners (which includes local police, NHS bodies and criminal justice agencies) to make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.

Section 16E – requires safeguarding partners to make arrangements for the safeguarding partners and any appropriate relevant agencies[40] to work together to safeguard and promote the welfare of children in their area.

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[40] Relevant agencies are listed in the Schedule to the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

Section 16H – any of the safeguarding partners for a LA area may request information for the purposes of performing functions under s.16E (local arrangements for safeguarding and promoting the welfare of children) and s.16F (local child safeguarding practice reviews).

Data protection legislation

UK Data Protection Legislation ensures appropriate, lawful and secure personal data processing and sharing. The legislation includes but is not limited to the Data Protection Act 2018 (DPA) and the UK GDPR. The principles laid out in the legislation ensures that organisations are transparent and accountable in relation to their use of personalised data.

The UK GDPR sets out principles which put specific obligations on a Data Controller when processing personal data including:

(1) Ensuring the data processing is legal by identifying which of the six lawful basis applies for processing personal data. Each one has different requirements which need to be met and may affect the rights of the data subject.[41] In public sector organisations "public task" or "legal obligation", where a power to process data is created in law, will be the most appropriate lawful basis for processing information. The voluntary or private sectors may process data under "legitimate interest" as a lawful basis where an organisation conducts a balancing test to determine where the needs of an organisation outweigh the individual's interests, rights and freedoms. Consent is not an appropriate lawful basis to use in safeguarding contexts as it can be withdrawn at any time.
(2) Ensuring only the data that is necessary to complete the task is processed and it is only kept for as long as is necessary to complete the specified tasks.
(3) That the data collected is accurate and is kept confidential and the integrity of the data is maintained.
(4) That organisations are accountable for what happens with the data and are transparent with what they do with the information and ensure that any new processing of personal data is compatible with the original purpose.

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[41] Information Commissioner's Office (2018), UK GDPR: Lawful basis for processing [Lawful basis for processing | ICO]

The Data Protection and Digital Information Bill includes changes to the legitimate interest (lawful basis) test. In a few cases, it removes the requirement for individual organisations to balance their interests against the rights and freedoms of data subjects where there is strong public interest in the processing occurring. Safeguarding is listed as a recognised legitimate interest. The Bill is moving at pace and could become law next year.

The common law duty of confidentiality

The common law duty of confidentiality means that when someone shares personal information in confidence, it must not be disclosed without some form of legal authority or justification. The common law duty of confidentiality protects personal information from being shared with someone trusted to keep it in confidence. A breach of that duty would be seen to be a violation of the relationship of trust (e.g., between doctor and patient). Practitioners must balance a duty to share information to safeguard a child, against the duty to protect the confidentiality of the child and their family members. If it is reasonable to believe that information sharing is necessary to protect a child from harm, then the common law duty of confidentiality can generally be set aside. This is because there is an overriding public interest in sharing the information.

Human Rights Act 1998

The Human Rights Act 1998 (HRA) sets out the fundamental rights and freedoms that everyone in the UK is entitled to.[42] The HRA incorporates the ‘Articles’ and ‘Protocols’ which are set out in the European Convention of Human Rights (‘the ECHR’) into domestic law. Article 8 of the ECHR refers to an individual’s right to respect for their private and family life, for their home and for their correspondence. Human rights concerns can sometimes be seen as a barrier to sharing information. However, where disclosure or sharing of personal information complies with data protection legislation, the sharing or disclosure of that information is also likely to comply with the Human Rights Act.

Digital Economy Act 2017

The Digital Economy Act 2017 contains a single, umbrella piece of legislation designed to reduce legal barriers to data sharing and enable public authorities to share information, including personal data for specific purposes. The data sharing provisions are set out in Part 5 to the Digital Economy Act 2017.

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[42] Human Rights Act 1998 (legislation.gov.uk)

The public service delivery data sharing powers enable specified public authorities to share personal data to improve and target public services or facilitate a benefit to individuals and households and improve their well-being.

Data sharing under Digital Economy Act 2017 powers must be carried out in accordance with the underpinning Codes of Practice, data protection legislation including UK GDPR and the ICO's Data Sharing Code of Practice.

An example of data sharing targeted at individuals under the public service delivery powers is carried out at Somerset Council. Somerset Council have registered a Data Sharing Agreement with the DEA as its legal gateway for the following purpose: Providing early intervention opportunities and presenting multi-agency data pertaining to social issues to a range of frontline professionals. The integration and sharing of this joined up data will elicit a deeper and broader understanding of the multiple issues affecting individuals/families. It will reduce duplication and resource for practitioners supporting the family, as it contains headline detail on assessments and current and historic involvement, not just with statutory services, but commissioned providers. It will:

- identify families facing multiple disadvantages
- enable the improvement or targeting of appropriate support to individuals or households
- enable the improvement of the physical, mental, emotional, social or economic wellbeing of individuals and families

3.1.1 Existing legislation, policies or guidance (Home Office)

Police have regular interaction with some children and their families and therefore gather lots of relevant information needed to promote their welfare. Police also gather intelligence on individuals and groups to assist with the detection and prevention of crime. In the management of this information, police officers have to adhere to the codes of practice and guidance set out below. This is in addition to the duties set out in the legislation and guidance above and is specific to policing.

Common Law Police Disclosure

The police possess a common law power to share personal information with third parties where a “pressing social need” can be established. A pressing social need might be the safeguarding, or protection from harm, of an individual, a group of individuals, or society at large. This ensures that where there is a public protection risk, the police can pass on information (for example to an employer or regulatory body) to allow them to act swiftly to mitigate any danger.

Code of practice on the Management of Police Information (MoPI)

The MoPI code of practice is issued by the Home Secretary under section 39 of the Police Act 1996. Its main objective is to improve information management, including the flow of crime intelligence and communication both within and across all police forces. MoPI principles provide a way of balancing the crucial considerations of proportionality and necessity. They also highlight the issues that need to be considered in order to comply with the law and manage risk associated with police information.

Authorised Professional Practice (APP) for Information Management

APP is the body of guidance published by the College of Policing to provide the police service in England and Wales with detailed policy and procedures to follow in respect of a range of topics. The APP for Information Management sets out the procedures for police officers to follow to adhere to the MoPI code of practice.

Child Sex Offender Disclosure Scheme

This scheme allows anyone to request information from the police to find out if someone poses a risk of sexual harm to a named child or children. The Home Office has recently (April 2023) updated guidance to make the Child Sex Offender Disclosure Scheme quicker and easier to use. This includes the introduction of online applications and a significant reduction in the timeframe for disclosure.

Domestic Violence Disclosure Scheme (DVDS) – statutory guidance

This scheme was introduced to set out procedures that could be used by the police to disclose information about previous violent or abusive behaviour, including emotional abuse, controlling or coercive behaviour, or economic abuse by an individual, where this may help protect their partner or ex-partner, and any relevant children, from violent or abusive offending. DVDS guidance was placed on a statutory footing by section 77 of the Domestic Abuse Act 2021.

Serious Violence Duty – statutory guidance

As part of the Serious Violence Duty, Sections 16 and 17 of the Police, Crime, Sentencing and Courts Act 2022 set out specific provisions to support local partners to share information, intelligence and knowledge to prevent and reduce serious violence. These provisions create information sharing gateways to permit disclosure to a specified authority of information held by specified authorities, local policing bodies and educational, prison or youth custody authorities and to enable local policing bodies to request information from partners for the purposes of the duty.

3.2 Current government policy and commitments to improve information sharing across the public sector

There are several existing policies and future initiatives planned across government to support improved multi-agency information sharing. For this report, we have focused on the activities underway in the departments with lead responsibility for the safeguarding and welfare of children; DfE (children's social care and education practitioners), DHSC (health practitioners), and HO (police). We have also included work led by the Department for Levelling Up, Housing and Communities (DLUHC) on data transformation in the Supporting Families Programme. This aligns closely with several of the other policy areas.

3.2.1 Department for Education (DfE)

In February 2023, DfE published 'Built on Love' an implementation strategy and consultation.[43] This strategy document sets out our plans to improve children's social care, in response to the recommendations made by the Independent Review of Children's Social Care.[44]

Backed by £200 million of additional investment over the next two years, the 'Built on Love' strategy sets out six pillars of reform. Each pillar maps to the outcomes and enablers within the draft Children's Social Care National Framework, published alongside the strategy. The pillars are:

- family help providing the right support at the right time so that children can thrive with their families
- a decisive multi-agency child protection system
- unlocking the potential of family networks
- putting love, relationships and a stable home at the heart of being a child in care
- a valued, supported and highly skilled social worker for every child who needs one
- a system that continuously learns and improves and makes better use of evidence and data

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[43] Department for Education (2023), Stable Homes, Built on Love: Implementation Strategy and Consultation – Children's Social Care Reform 2023 (publishing.service.gov.uk)

[44] MacAlister (2022)

Improving information sharing will support ambitions across all six pillars but particularly pillar two, a decisive multi-agency child protection system. The vision is to improve how front-line children's services function so that agencies work together in a much more integrated way. Better information sharing and seeking within and between organisations will help agencies improve how they work together, for the benefit of the children and families they support.

This report is also the first key milestone in response to the Care Review's recommendation to set a target to "achieve frictionless sharing of information between local authority and partner systems by 2027". DfE is also setting up a data and digital expert forum to bring together expertise from inside and outside government to ensure reforms have maximum impact.

Working Together to Safeguard Children

Working Together to Safeguard Children is the core statutory guidance for all organisations, agencies and individuals involved in safeguarding and promoting the welfare of children. It sets out the requirements and processes for multi-agency working, shaping how agencies deliver their duties and responsibilities. It also forms part of the framework against which local authorities are inspected.[45]

'Built on Love' committed DfE to consult on an update to 'Working Together' and publish revised guidance by the end of 2023 and update every year thereafter. The consultation opened on 21 June 2023 and closes on 6 September 2023. This update is a key steppingstone in the children's social care reform journey including strengthening our expectations of statutory safeguarding partners (police, LAs and health) and education providers; support for parents and families including expanding the role of family networks; and greater recognition of harms that take place outside the home.

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[45] Department for Education (2018)

Information sharing advice

In 2018, in addition to ‘Working Together to Safeguard Children’, DfE produced updated non-statutory advice for practitioners working with children and families. The advice outlines the responsibilities of agencies and organisations and the golden rules to promote effective information sharing. It summarises the key responsibilities of professionals who share and process personal information and/or have responsibility for deciding how to process it. The advice also explains the lawful bases that may be most appropriate for sharing personal information in a safeguarding context. It is currently being updated and the consultation opened on 21 June 2023 and closes on 6 September 2023. The latest version is expected to be available by the end of the calendar year.

Safeguarding partners – roles and responsibilities

In response to both the Care Review and National Panel report recommendations, in December 2022 we wrote to all 137 multi-agency safeguarding arrangements (MASA) across England to ask for further details on the current use of information sharing agreements. The survey explored information sharing arrangements within their specific local area, and barriers to sharing more broadly. Responses have helped inform this report and will be considered further as our work to strengthen safeguarding partners develops.

A new cross-government Child Protection Ministerial Group (CPMG) was also established in late 2022. This was in response to another of the National Panel report’s recommendations and a key shared commitment from government departments with responsibility for or an interest in the welfare of children. The group is already helping to join up work at the most senior levels across government, ensuring that children’s welfare is championed at the highest levels and setting the shared direction for child protection, with the aim of improving children’s social care systems and structures to protect the most vulnerable and at-risk children and young people in our communities.

The CPMG is supported by the recently formed Multi-Agency Safeguarding Partner Performance Board, made up of senior civil servants across departments, and the Safeguarding Partner Engagement Group, which brings together a core set of members, as well as other experts from the system to bring more perspectives when needed on specific issues.

As part of the Working Together consultation, we have clarified the roles and responsibilities for statutory safeguarding partners, at both a strategic and operational level. This involves setting out the joint functions of lead safeguarding partners and their delegates, highlighting the need for local leaders to implement effective information sharing arrangements between agencies, including data sharing that facilitates joint analysis. Alongside this we are considering how to strengthen the role of education and childcare settings, which play a vital role in children's day to day lives. In ‘Built on Love’, we set out some of the practical challenges to making education a fourth safeguarding partner but agree with the recommendations from both the Care review and National Panel report, that education needs to play a greater role in multi-agency leadership. The Working Together consultation is the first step in helping us achieve this by strengthening their role as Relevant Agencies; we will then use learning from this to inform proposals on whether and how to make education a fourth safeguarding partner. If necessary, we will consult on these proposals in 2024.

The Families First for Children Pathfinder

In ‘Built on Love’, we set out a mission to “…pathfind a new, more integrated and expert child protection response”. As part of this, we have already outlined our plans to publish National Multi-Agency Child Protection standards later this year, when we revise Working Together. We have also committed to improve front-line child protection practice through delivering a new expert-led, multi-agency child protection response in up to 12 local areas as part of the Families First for Children Pathfinder.

We want to see agencies work together in a much more integrated way to help improve the poor exchange of information, along with improving other areas of front-line child protection practice. We will use the Pathfinder approach to work through key questions with multi-agency partners, to understand how best to develop our vision on the ground. We will test multi-agency child protection teams with skilled practitioners from LAs, police and health, alongside others as appropriate such as probation, working as a team to deliver specific child protection functions. To support smooth information sharing we will consider a variety of joint arrangements such as integrated teams, sharing day to day management and being co-located. Findings from the Pathfinder areas and an evaluation of Multi-Agency Safeguarding Hubs (MASHs) are also due to start in 2023 and will help inform future updates to the National Multi-Agency Child Protection Standards.

Data and Digital Solutions Fund (DDSF)

This fund was launched by DfE in October 2022[46] to drive forward data and digital priorities recommended by the Care Review. The £7million fund will run to the end of March 2024 and includes projects on information sharing, data analytics, improving case management systems in children's social care and data improvement. Two of the projects, led by local authorities were focused on improving information sharing. These are discussed below.

DDSF project: Safeguarding Data Sharing Agreement (DSA) template and guidance

Somerset Council have developed a Safeguarding DSA template and guidance to be used by officers across agencies with safeguarding responsibilities nationally (particularly Data Protection Officers and Service Managers). The documents are to support agencies to create agreements for new or altered arrangements for sharing data locally (or regionally) with partners, or to strengthen existing information governance arrangements across local partnerships. The documents have been developed to be used for any type of data or information sharing arrangement between agencies for child safeguarding and early intervention / prevention purposes. The template and guidance were circulated online for use by agencies in June 2023 and will be tested, reviewed and iterated over a 12-month period.

DDSF project*:* 'Solutions to overcoming the cultural and behavioural barriers to information sharing' – report from project led by the London Borough of Newham

The London Borough of Newham led a primary and secondary research project on the cultural and behavioural barriers to information sharing. The project was a collaboration with Social Finance, the Rees Centre at Oxford University and the London Office for Technology and Innovation (LOTI). The primary research involved interviews, surveys and participatory workshops with professionals in a multi-agency context, including individuals from children's services, health, police and education. The findings and recommendations from this study have contributed to this report.

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[46] Minister Quince (2022), Oral Statement to Parliament on children's social care review Minister Quince Oral Statement - GOV.UK (www.gov.uk)

Innovation Programme

Since 2014, DfE has invested £200m in the Children's Social Care Innovation Programme. The programme has funded a range of projects to help LAs improve outcomes for children through innovative ways of working. As new models developed, those with the greatest potential to make a difference for children and their families were identified and promoted. Using continual evaluation to develop best practice,[47] the programme included several projects that supported better information sharing through co-location including Family Safeguarding in Hertfordshire, the Stockport Family Model and Families First in Durham.

Family Hubs / Growing Up Well

The Family Hubs – Growing Up Well (FH-GUW) project is funded by HM Treasury through the Shared Outcomes Fund until March 2025. The project works across education, health, and social care to improve outcomes for vulnerable and disadvantaged children, young people, and families. Through the FH-GUW project important digital products have been developed that will improve the experience, access and connectivity of professionals and families using Family Hubs.

The project is being delivered through an iterative, agile process that involves working closely with a small number of LAs and across several stages to develop, test, embed and improve digital products. The project worked with Bristol, Lancashire, Suffolk, Redbridge, Salford, and Tower Hamlets to identify user needs and current difficulties, known as pain points. It then worked to develop and test ideas and to build and test the digital products through piloting within these local areas. Partnership working has also been supplemented by a co-design group, which has provided the opportunity to test our concepts, designs and products with a wider group of LAs. It has taken an innovative and user-centred approach to build an evidence-based service that will have impact, is scalable, and will improve outcomes.

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[47] National Audit Office (2022), Evaluating innovation in children's social care National Audit Office (NAO) report

FH-GUW have developed three digital services:

- Find support for your family – to help families find their local family hubs and support services available to them, within their local family hub network. This service will eventually enable families to find and access services provided by their local authority; voluntary, community and faith organisations; and other state and non-state actors. It provides non-stigmatising access to preventative support and will reduce families' needs escalating to statutory support.
- Connect families to support – to help professionals find and connect families to support services available to them within their local family hub network. This service will eventually enable professionals to navigate local services and make a request for support for families. It will also allow professionals to share information about families with service providers more efficiently so that they can save time, make better informed decisions, and help the families they work with to receive the right support at the right time.
- Manage family support services and accounts – to help LAs and the Voluntary, Community and Faith Sector (VCFS) organisations (and other state and non-state service providers) manage the users and services on Find and Connect.

However, these products can only be as good as the data which underpins and powers them. We know that many LAs do not have robust, standardised data systems, and this will act as a barrier to the adoption of our products at scale. The project is therefore investigating embedding the use of a single data standard, such as the Open Referral UK,[48] to make it easier for LAs to engage with our products alongside their own existing Family Information Services (FIS) and Local Offers. This will support efforts to better integrate national and local directories.

The FH-GUW project is playing a central role to reform early help delivery through digital and data innovation and the products we have developed lean towards policy recommendations set out in several national reviews. During the public beta phase, we will continue refining and iterating the digital products and scaling up to wider public roll-out. We will then move into the live phase to continuously improve and support the service in a sustainable way.

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[48] Open Referral UK data standard (endorsed 2022) Open Referral UK

3.2.2 Department of Health and Social Care (DHSC)

The Child Protection Information Sharing Service

The Child Protection Information Sharing service (CP-IS) links IT systems used across health and all local authorities in England, sharing basic safeguarding protection status information between social care and health, covering children with a looked after status, children on a child protection plan (CPP) and pregnant women where an unborn child protection plan is in place.

CP-IS has been in use across NHS unscheduled care settings, such as emergency departments or minor injury units, since 2014. It is currently the only national register of social care status, and the only system to provide information when a child is out of area.

The CP-IS service aims to improve outcomes for vulnerable children, but there are also benefits for healthcare and children's social care teams. Benefits of service use have been demonstrated in the following areas:

- Preventing or reducing future harm.
- Improved safety and care – doing the best when children need help.
- Increased workforce efficiency – doing the most for children with the resources that we have.

In a healthcare setting, knowing the child protection status of the child contributes to a more holistic clinical assessment. As a result, decisions can be made to seek intervention earlier. With instant access to CP-IS information, communication with the appropriate social worker can take place quickly, leading to a better outcome for the child.

The allocated social worker is also notified immediately that a child has presented at a care setting. The social worker has knowledge of the child and family and can assess whether an intervention is required to achieve a good outcome for the child.

As CP-IS is a national system, health staff can see vital information about children based anywhere in England. Social care staff can see if a child in their care attends an unscheduled care setting anywhere in the country. Health and social care staff are provided with each other's contact details, so they are able to work more closely together. Sharing information supports better decision making about a child's care.

Health staff in care settings have more reliable checks and the risk of missing a child who is known to a local authority due to a CPP or being looked after is reduced. In addition, a flagged vulnerable child is more likely to see a senior clinician, ensuring a senior overview of the child's care.

From the research undertaken by DfE we are aware that whilst CP-IS has benefits for health practitioners, social workers and LAs have a different experience of CP-IS and do not see the same level of benefit. This is covered further in chapter 7.

The CP-IS service replaces manual processes, thus freeing up resources to be used elsewhere. The process is automated, and information is updated daily ensuring a child's data is always up to date and current.

In the long term, LAs will not have to collate a child protection list and send it to their local health partners. This will remove the associated costs, time and effort in managing this process. Likewise, NHS Trusts will not have to receive and distribute the child protection list to relevant departments or set up safeguarding flags to alert if a child attends. The following case study demonstrates one of the benefits of using the CP-IS service.

Case study – Protecting children when out of area

Child C was a looked after child who went to visit family in the south of England. Whilst there, Child C presented at an unscheduled care setting with a panic attack which affected their breathing.

On checking the demographic details, a staff member saw that there was a CP-IS alert on Child C’s record. The alert showed that the young person was a looked after child. Knowing this additional information, more probing questions were asked about the cause of the panic attack. At this point, Child C disclosed that the panic attack was brought on as a result of being pushed by a family member. This disclosure resulted in the staff member having a conversation with a social worker and making a safeguarding referral to the local authority.

As Child C had presented at an unscheduled care setting that had implemented CP-IS, an automatic notification was sent to the child's originating local authority.

The child's social worker contacted the unscheduled care setting to find out about the incident and the action that had been taken.

A safeguarding referral was made, and an investigation was initiated by the police (a Section 47 enquiry) with the visited local authority. This not only protected the visiting looked after child from the adult perpetrator, but potentially other children too.

Without CP-IS being in place, this young person may have been seen, treated and discharged without a safeguarding referral being made. The information sharing between the two local authorities may not have happened and appropriate follow up may not have occurred. When contacted by their social worker the family failed to mention the incident.

The fact that the CP-IS automatic notification came from another part of England, combined with the fact that this made the staff member there probe more, meant that the social worker had a more holistic view of Child C’s case.

This example was provided by a Social Care Practice Lead.

Through CP-IS, health and social care colleagues across agencies were better enabled to work together to share information about this young person. This information positively influenced safeguarding practice and enabled a more holistic approach to Child C’s care.

Impact of CP-IS in this scenario:

Having access to CP-IS information promotes the duty of care and is paramount to the child's safety and wellbeing.

Clinical decision-making and outcomes in unscheduled care settings are enhanced because staff can see via CP-IS that a child is subject to a CPP or is a looked-after child.

The safeguarding of vulnerable children when visiting unscheduled healthcare settings outside of their local area is enhanced through better information sharing.

Information is automatically made available to social care staff at the child's home local authority which enables appropriate follow-up.

Further case studies demonstrating benefits of the use of the CP-IS service are available online.[49]

Access to CP-IS is now being extended across the NHS in England, in line with the NHS Long Term Plan milestones for digital technology.[50] Planning is also underway, to look at delivering enhancements and extending access to the service from April 2024.

Work is underway to include the ‘reason why’ a child is on a protection plan, in response to the Independent Inquiry into Child Sexual Abuse (IICSA) recommendations (recommendation 17 – access to records) published in October 2022. Consultation and planning for the delivery of this important safeguarding response is underway.

CP-IS is available through the National Care Records Service (NCRS) and SCRa (until 30/09/23). NCRS is the improved successor to the Summary Care Record application (SCRa). NCRS is a service that allows health and care professionals to access and update a range of patient and safeguarding information across Integrated Care Board (ICB) boundaries. The service is a web-based application and can be accessed regardless of what IT system an organisation is using.

NCRS is available using mobile or desktop devices connected to the internet using WiFi, mobile data or an existing Health and Social Care Network (HSCN) connection and offers multiple access options including biometric authentication or smartcards. Multifactor authentication access has also been approved by the National Data Guardian.

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[49] NHS Digital (2022), Benefits of Child Protection – Information Sharing NHS Digital

[50] NHS (2019), The NHS Long Term Plan NHS Long Term Plan

Digital Personal Child Health Record

NHS England are responsible for the delivery of the Digital Personal Child Health Record (DPCHR) and are working closely with the government's Start for Life unit to ensure the needs and interests of parents, carers and babies are central to its development.

Many parents already have digital access to their child's records. Once the NHS App includes proxy access to records, millions more will have access. There will be a rolling delivery of improvements and further features over the next two years – this will enable NHS England to put the needs and experience of parents and families at the heart of the design process, while integrating the new functionality with the NHS App and electronic patient record programme. The roll-out will be completed by March 2025.

The completed DPCHR will improve data-sharing between different parts of the health system. This will:

- reduce the burden of data collection on frontline staff
- make it easier for them to understand the full picture of a baby's development and identify early warning signs of health issues or abuse

The DPCHR will also improve parents' experiences, limiting the number of times they must re-tell their story to different professionals and giving them one digital record of their baby's development. This will include vaccination records, which play an important role in promoting every baby's health and wellbeing.

Data Strategy / Shared Care Records

DHSC's data strategy, '*Data saves lives: reshaping health and social care with data*' [51] sets out our ambition to ensure health and care staff have the information they need to provide the best possible care.

Shared Care Records (SCR) look to integrate information from across multiple care providers to create a longitudinal view of the interactions between an individual and health and care services. Every Integrated Care Board (ICB) has a basic shared care record, the focus of which is to integrate information from NHS Trusts and general practice. The SCR is currently only routinely used by health and adult social care.

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[51] Department of Health and Social Care (2022), Data saves lives: reshaping health and social care with data (www.gov.uk)

A further enhancement in information sharing is the introduction of the Core Information Standard (CIS) produced by the Professional Records Standards Body. This reflects the recommendations of many clinical professional groups and royal colleges and includes information requirements associated with sharing information in relation to safeguarding.[52] The standard is currently undergoing the process of publication as per the Health and Care Act and therefore is expected to become a statutory requirement for the NHS.

The Education and Child Health Insights from Linked Data (ECHILD) Database

The ECHILD Database is a linkable collection of longitudinal, administrative datasets from the domains of health, education and social care for a whole population-based cohort of children and young people in England. All children and young people (up to age 25 years) in England who were born between 1st September 1995 and 31st August 2020 are included in the ECHILD Database. In total, it contains linked health and education records for approximately 14.7 million individuals. The ECHILD data set was initially created for a University College London (UCL) led project, supported by DfE and DHSC, and funded by ADR-UK (Administrative Data Research – UK). These well-established datasets are a valuable tool for longitudinal research as they contain pseudonymised IDs that allow de-identified records for the same individual to be linked over time. It does not include any information that could be used to identify a person, such as names, addresses, postcodes, dates of birth, Unique Pupil Numbers or NHS numbers.

The ECHILD Database is used to inform research for policymaking. It is currently measuring the impact on children of the pandemic and subsequent lockdowns. The database links:

- The National Pupil Database (NPD), which holds a wide range of information about students who attend schools and colleges in England
- Hospital Episode Statistics (HES), which includes information on hospital admissions, A&E attendances and outpatient appointments in NHS hospitals in England

These two data sources provide information on health and education and the data from each can show how health can impact education and vice versa.

An extension to the original ECHILD has been proposed by DfE under the Data Improvement Across Government (DIAG) programme, which has extended the cohort to those born on or after 1 September 1984 and added to the data already available from a number of additional health data sources, including Mental Health, Community and Maternity Services Datasets.

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[52] Professional Record Standards Body, Core Information Standard Core Information Standard

3.2.3 Home Office

Multi-Agency Public Protection System (MAPPS)

The police maintain a number of databases which hold details of known offenders, including the Violent and Sex Offender Register (ViSOR) Dangerous Persons Database.

The Home Office and the Ministry of Justice have jointly funded a project to create the new Multi-Agency Public Protection System (MAPPS) which will allow ViSOR, which is now outdated, to be decommissioned. MAPPS will have much greater functionality than ViSOR, enabling criminal justice agencies to share information more efficiently, improving the risk assessment and management of offenders. It aims to improve info-sharing between Multi-Agency Public Protection Arrangements responsible authorities and their partner agencies (which includes LAs).

Law Enforcement Data Service (LEDS)

Since 1974, the Police National Computer (PNC) has been the main database of criminal records and is used by front-line officers from all police forces in the UK to understand who they are interacting with. The PNC is also accessed by, or provides data to, many other organisations with a range of restrictions on what they can access.

The PNC is being incrementally replaced by the Law Enforcement Data Service (LEDS). The LEDS will be a modern cloud-based data service that will provide police forces and other law enforcement agencies with the latest, on-demand and joined-up information at the point of need. This will help to prevent crime and better safeguard the public. The LEDS programme remains on track against the overarching roadmap, with all LEDS product development to deliver PNC parity by the first quarter of financial year 2024/2025. Full adoption is to complete by the first quarter of financial year 2025/2026, and PNC decommissioning to commence thereafter, in the second quarter of financial year 2025/2026.

The benefits of the PNC, and soon to be LEDS system for multi-agency information sharing, are that they enable police colleagues to look at a national picture of a person. This can assist in interactions with social care, where police colleagues can assess safeguarding risks based on historic interactions they have had with an individual, no matter where they have lived before. It can assist social care professionals to identify other sources of information, such as another LA that may hold information on a child.

3.2.4 Department for Levelling Up, Housing and Communities

Data transformation in Supporting Families

The Supporting Families programme[53] helps thousands of families across England to get the help they need to address multiple disadvantages through a whole family approach, delivered by keyworkers, working for local authorities and their partners. To achieve this, Supporting Families is committed to strong multi-agency local partnerships in every area, underpinned by mature local and national data systems. DfE and DLUCH are working together closely on the programme with joint governance across the two departments. The Supporting Families programme will be formally moving from DLUHC to DfE from 1 April 2024.

The Supporting Families team have developed a data maturity model for local partnerships. Data maturity is an organisation’s capability to manage data. The results of the 2022 data survey of all 150 upper tier Local Authority areas showed substantial improvements in data sharing and maturity compared to 2021, with an increase of 14 percentage points in the proportion of areas saying they are now using mature data models.

For Supporting Families, transformed or mature data systems have several key elements:

- strong data sharing agreements and regular sharing arrangements in place across local partnerships (including schools, police, health, and voluntary and community agencies)
- the automated bringing together of data to create one view of families and individuals across the local area in one place, such as a data warehouse
- data being available to the front door and the person/team working with the family as soon as they present to services and regularly updated throughout the intervention
- being able to extract quantitative reports on all the issues identified for the whole family and outcomes achieved
- data being used across the partnership to inform strategic decision making to better support families and identify issues at the earliest stage

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[53] Department for Education/Department for Levelling Up, Housing and Communities (2023e), Supporting Families programme Supporting Families

- all the above being driven forward by strong partnership data transformation governance with an appetite for reliable and regular data, as well as children's services using this data at the highest levels of governance to inform decision making

The Supporting Families team regularly share good practice and innovation through:

- their digital showcase programme
- working closely with trade associations providing systems for children's services
- national support and challenge through the delivery team
- two peer support projects, providing targeted support to 20 local authorities in total
- intensive, focused one to one support from the data lead in the national team for the least transformed partnerships
- working on national solutions to facilitate local data sharing

In January 2022, the team provided Structured Query Language (SQL) training to one analyst in every local area.

The Supporting Families Programme and the National Supporting Families Outcome Framework have been at the core of some local LA development of technological solutions for information sharing, such as Bristol, Liverpool and Somerset, discussed in Chapter 5.

3.2.5 Information Commissioner's Office (ICO)

Following a 2022 Public Services Committee session, the ICO agreed to produce a resource to support data sharing by organisations and practitioners involved in safeguarding children. The ICO's focus is very much from a data protection and information rights perspective. However, the ICO intends also to produce overarching guidance on sharing data to safeguard children, and sector-specific guidance featuring an explanation of how sharing personal data for safeguarding purposes fits with other legislation outside data protection. The ICO is currently working on the first part of the guidance, which has been reviewed by stakeholders. It aims to publish the first overarching part of the resource in the summer.

Chapter 4 – Cross-government research on existing barriers

4.1 Research approach

This chapter includes the findings of user research undertaken across DfE, DHSC and the HO. All departments took a similar approach, combining primary qualitative research with a review of previous studies. Participants in the primary research were chosen to reflect the range of practitioners working in roles related to children in different agencies.

Semi-structured interviews with education, social care and police professionals, focused practitioner focus groups / forums (with health professionals and school Designated Safeguarding Leads - DSLs) and multi-agency workshops were conducted. Three workshops were held by DfE which were attended by cross discipline practitioners, senior leaders and system experts. The aim of the workshops was to consider and co-develop potential solutions, to address the identified barriers to information sharing.

DfE also commissioned primary research and a review of secondary literature, focused on the behavioural and cultural barriers to information sharing in a multi-agency context in 2023. This work was facilitated by the London Borough of Newham and delivered by a partnership between the council, Social Finance, the London Office of Technology and Innovation (LOTI) and the Rees Centre (University of Oxford). This work was split into two strands that have fed into the development of this report:

- A literature review and academic-led roundtables, by the Rees Centre[54].
- Primary research supplemented with secondary literature, by Social Finance[55].

In December 2022 an online, voluntary survey was also sent to all multi-agency safeguarding arrangements (137) across England to further capture the barriers experienced across organisations involved in child safeguarding. A response rate of 81% (111) generated valuable insight to both barriers and potential solutions.

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[54] Rees Centre (2023)

[55] Social Finance & London Borough of Newham (2023)

The research took a thorough approach, but has some limitations. For example, the number of social work practitioners involved in the primary research was limited compared to health practitioners. The behavioural and cultural barriers project led by the London Borough of Newham was limited to London authorities' experience. However, many of the barriers identified by them have been reported elsewhere and were corroborated at roundtable discussions with professionals led by academics. Participants agreed that the barriers identified were not confined to London but reflected experiences across England.

The sample of professionals who participated may be biased towards those who are particularly interested and/or expert in information sharing for children, due to our convenience sampling approach, use of focus groups and self-selection bias from asking for volunteers. This means that findings may not be generalisable to all professionals and should be considered within the context of this limitation; we may not capture views of professionals who are less interested in, are less involved in, or do not see challenges with information sharing for children.

At this stage of the work to improve information sharing, we have not sought the input of children and families. As the report aims to scope the issues for practitioners and potential solutions, it was considered that it may be premature to speak to children and families at this stage. However, we recognise this as a limitation of the work to date. In the work following the report and implementation of solutions we plan to involve children and families, so we ensure their views shape the solutions we develop. Recent literature provides insights into the views of children and families, such as the Care Review and Children's Commissioner's Family Review and these have helped to inform the work so far.

DfE will continue to engage with children and families as we implement the reforms to children's social care, as set out in 'Built on Love', giving them the opportunity to be heard and shape the future of the services supporting them.

In addition, DfE has conducted several discovery projects, each exploring relevant aspects of the information sharing landscape.

The projects have helped to identify knowledge gaps and shape further research areas to:

- understand the LA landscape for data and information sharing
- understand how information sharing between agencies works and what could be done to improve this
- explore the use of CP-IS, including barriers and workarounds that people may have
- deepen our understanding of children's social care social workers uses around information sharing

- understand the barriers and enablers around sharing information between agencies
- identify how the systems that support information sharing between agencies could be improved

The outcomes of the discovery projects have been to understand how information sharing can be improved to offer better access to information sharing for social workers and system managers to ensure vulnerable children are not harmed.

Drawing on all the research described above, we identified key themes in poor information sharing. These key themes have been consistent across all agencies and are well supported by evidence in previous literature on information sharing. These are explored in detail below.

Based on all the research, we have identified some potential improvement opportunities. These have been used to shape the report conclusions and next steps outlined in Chapter 8. In parallel, local safeguarding partners are encouraged to consider how they could implement the opportunities for improvement in their areas.

The London Borough of Newham and Social Finance research also identified opportunity areas for change and corresponding recommendations. A summary of their findings can be found in Annex A [56]. These recommendations were discussed and validated by two academic-led roundtable discussions of 43 participants from different professional and organisational groups[57].

4.2 Perceived barriers to information sharing and improvement opportunities

The barriers to timely and effective information sharing were divided into five areas that correspond to key themes of the problem causes. The research findings that relate to each area are discussed below. The five areas are:

- **Systems and processes** – systems and processes for information sharing in safeguarding and promoting welfare of children are fragmented and insufficient.
- **Perceptions about legislation** – the interpretation of legislation can be difficult and is a source of confusion, especially in nuanced cases.

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[56] Social Finance & London Borough of Newham (2023)

[57] Rees Centre (2023)

- **Practice confidence** – some practitioners do not have the confidence in information sharing (i.e., knowledge of what information is required, how to interpret certain information and the skills to share it effectively).
- **Leadership and culture** – organisational culture(s), poor leadership and a lack of relationships between practitioners can create unfavourable conditions for information sharing.
- **Capacity and resource** – practitioners do not have the capacity to share information, due to the intensity of their roles and resource constraints.

4.2.1 Systems and processes

Key findings:

- IT systems are not joined up across agencies and do not assist with the sharing of information.
- Different thresholds and referral forms can be a barrier to practitioners sharing information.
- It is not clear which professionals may have information about a child/family.

Systems

The research has looked at the technological landscape of the agencies working with children and families and has shown that this is complicated and fragmented. Each agency has their own case management system(s) and there is very limited join up. The way information is recorded, and the compulsory elements required varies across the different agencies. There is often information recorded by one agency which would be relevant to another, but there is no way for this to be visible. Practitioners described how they do not know who has information on a child or family, so it can be difficult to know who to approach to find out. This was also cited as an issue within agencies, as well as between them, with some agencies using multiple systems which do not share information between them.

In our survey to multi-agency safeguarding arrangements (MASA), 40% of respondents ranked the barrier “technological systems are fragmented and lack interoperability” as highest from a list of seven possible barriers to timely and effective information.

> “Systems and networks are different and do not interact together so some information on one system may not be recorded or accurate on another.” (MASA survey)
>
> “At an operational level there is no quick way (other than pulling together all partners in a meeting) to pull together information about a child at risk or be able to understand/assess the risk and put appropriate risk management plans in place.” (MASA survey)

> For health practitioners the use of different IT systems within the healthcare system and between health and other agencies can present challenges in accessing relevant information about a child, making it difficult for health professionals to assess safeguarding risks.

This was echoed by police representatives with many IT systems being described as outdated and not very intuitive – “clunky” was a word used by numerous interviewees.

> “It took 2-3 months to find the files… A 15-hour round trip to get the files.” (Social worker)

Some schools use the CPOMs and MyConcern systems within the school to share and manage safeguarding and welfare information. Barriers arise however when information needs to be shared outside of the school. Interviewees told us that information cannot be directly accessed across systems and so it must be requested and either lifted from the system or sent manually to other local agencies which can be time consuming and lead to gaps in the information shared. This becomes a particular problem when it comes to children and issues crossing local boundaries.

If a child moves from one LA to another, or one school to another, any case history that is stored on them is not automatically transferred or accessible. In Keeping Children Safe in Education, expectations are set out that when children leave the school or college (including in year transfers) the DSL should ensure their child protection file is transferred to the new school or college as soon as possible, and within five days for an in-year transfer or within the first five days of the start of a new term. This should be transferred separately from the main pupil file, ensuring secure transit, and confirmation of receipt should be obtained. Receiving schools and colleges should ensure key staff such as designated safeguarding leads and special educational needs co-ordinators (SENCOs) or the named person with oversight for SEND in colleges, are aware as required.

Lack of information about their circumstances can impact on the child’s safety, welfare and educational outcomes. In addition to the child protection file, the DSL should also consider if it would be appropriate to share any additional information with the new school or college in advance of a child leaving to help them put in place the right support to safeguard this child and to help the child thrive in the school or college. For example, information that would allow the new school or college to continue supporting children who have had a social worker and been victims of abuse and have that support in place for when the child arrives.

We heard this process is not always followed through and that there can be inconsistencies in the approach. For example, we interviewed one SEND practitioner that had faced difficulty around student transfers. When a student transferred into their school, the only information that was shared with them around that child was their Education and Health Care Plan (EHCP) via a common transfer file.[58] There was no formal meeting or handover from the old school to the new school. As the case management systems in the two schools did not link up, the only information the new school had was from the EHCP as any information held by the previous school was not shared. They commented that the EHCP itself does not contain rich enough data about the needs of children, meaning additional time is spent in seeking the information from other agencies. This can be difficult to obtain without knowing which agencies may hold information.

Practitioners felt that if the systems between schools were able to link up, then the new school would be able to access the child's file when necessary. This would enable the school to safeguard the child more effectively as they can create a relevant plan to care for them. Historic information on the child is also difficult to transfer or share as each system has a different approach to storing hard copies of information. The lack of uniformity means that even if the information is shared, a different system may not be able to store or read the information correctly. We also found, from our DSL forum, that while some schools can input information onto other systems within the LA, they cannot access any information in return. In Durham, one school could upload information on the Liquid Logic system that is used by social workers, but they could not access any other information that had been uploaded onto the system. This limited the free flow of information to the school and would be alleviated if the systems could link up.

Within a MASH (or similar multi-agency model) there were concerns raised by practitioners about their access to systems, when they are the one representative from an agency. For example, as health has so many different systems, the health lead in the MASH (or similar) may not have direct access to all the different health systems that contain information about the child. The below quote highlights that having a consistent identifier in place does not necessarily mean a practitioner is able to access the information they want need to. They need to have the right links between systems to enable to them to access the relevant information, and the permissions to do so.

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[58] Department for Education (2023), Common Transfer File: CTF 23 specification (publishing.service.gov.uk)

> “A colleague who works in a MASH has to gather information across the whole health economy to inform strategy meetings and is having to log into different systems and is often denied access from some health systems.” (Specialist nurse for safeguarding children)

- “There’s not an easy way working in the MASH to identify which health professional that young person may be known to, to then request that information...Because of the way that health is set up, it may not always be clear who all the people who may be involved with that young person and who may hold information.” (Trust head of safeguarding)

Several participants in the academic-led roundtables, written up in the Rees Centre report, mentioned the potential of greater use of technology to facilitate information sharing[59]. Some gave examples of visualisation tools that allow practitioners to view information from various agencies without the need for ad-hoc communication or lengthy referral processes.

Many practitioners who took part in the research suggested that all safeguarding partners should use or have access to a single national system. There were many references to slow processes or technical difficulties using the systems that are already in place. This was raised by practitioners from the different professions. When broken down, it seemed the focus was on the professional having access to the information they need and it being readily available when, where and how they need it.

> “In an ideal world, I would like information that relates to safeguarding in the broadest sense of Working Together 2018 to be available on one system, and probably a system hosted by the local authority, that can be accessed by the key professionals across all the agencies. So not every frontline practitioner to start with, but it would be key designated professionals who can have a login to that system, they can justify the reason why they're accessing that system.” (Consultant paediatrician and designated doctor for safeguarding children)

Identification of children

Other participants identified scenarios where the process is more challenging, for example where different names have been provided to different services or children frequently move between different addresses. Health professionals explained that sometimes families may not give accurate information about their identity to prevent accurate identification, where there may be a safeguarding concern. This can cause delays and complications.

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[59] Rees Centre (2023)

> “Some of the challenges that may occur, maybe where children have multiple names and the names don’t match, social care have one name or one date of birth, and we have a different name and a different date of birth recorded on our system. We often get those kinds of challenges when we're getting court orders as well.” (Specialist nurse for safeguarding children)

It is in this area that the benefits of a CCI could be most realised. Having a consistent number for children, can overcome the delays caused by systems not having the most up to date address, or having a different spelling or version of a name contained within them. The CCI could potentially help systems to pull information through from each other, being more confident they were talking about the same child. This should make matching rates between systems more reliable and make matches occur quicker. However, in the case of CP-IS, the match of a child across the systems relies on their name, address, date of birth and NHS number being a match on each system.

In the case of the below quote, there is an additional task for LAs to cleanse their data to ensure a child’s information is a match with the information held on CP-IS. This is in addition to the time a social worker needs to spend finding out the detail of a child’s attendance at an unscheduled health setting.

> “There are reports of missing NHS numbers, invalid or non-matching demographic details. Both those things obviously hinder the exchange of information, and we respond to the CP-IS admin team, who pick up the access to service notifications.” (Social worker)

In working to overcome such difficulties and without increasing the time pressures on practitioners, it will be imperative to ensure systems have safeguards within them to cope effectively with missing data. The testing of the use of any identifier prior to implementation will also be essential, so any potential side effects are realised and overcome.

It has been noted during the research that agencies and services across the NHS have the use of the NHS number and yet difficulties remain in the timely, appropriate, and secure sharing of information. When discussed with NHS England they have highlighted how they are constantly learning lessons on information sharing and keeping up to date with technological advancements. They explained that part of the difficulties with information sharing, despite having the NHS number in place, is the technology that sits underneath. Merely having a consistent number does not improve the flow of information. They have found it is necessary to have standards applied, ensuring the different systems in use across the NHS are able to use the NHS number to share information. At present they are looking at how to implement these standards with the case management systems suppliers for adult social care. This mirrors work that is in the development stage in DfE for the case management systems in use in children’s social care. As both adult and children’s social care tend to use the same suppliers, NHS England and DfE can work closely to share learning and develop ideas. This is described further in chapter 8.

Improvement opportunities identified by practitioners:

1. Increasing interoperability of computer systems
2. Enhancing the service provided by CP-IS (this is covered in chapter seven).
3. Exploring the possibilities of Shared Care Records to share information for children.
4. Exploring the possibility of using a consistent child identifier to assist with the sharing of information.

Processes

In relation to processes, there was much discussion in the health focus groups and multi-agency workshops about how unhelpful and inconsistent local information sharing processes can be. Those making a referral to social care often do not receive any feedback on a referral and therefore do not know what has happened with a case. Where there is no further action, they do not get the feedback needed to inform their future practice. Practitioners identified how knowing why a referral was not taken forward would help them to know whether a referral is appropriate in the future. They may also have additional information that would help the referrer, but unless they are contacted, the referrer may not receive that additional information. Therefore, decisions can be made without the complete context around a child.

> "I think feedback would be really, really useful because you hear all the bad news, all the serious case reviews and you feel like this system never works. If you had feedback saying well, because of that information you shared we're doing this, this and this with this family, you could actually see the kind of outcome of it. I think that would be really, really helpful." (Named GP for safeguarding)

The London Borough of Newham and Social Finance research highlighted the barrier that "individuals are not motivated to share information if they do not understand the outcome of their actions". The lack of feedback on referrals, particularly when a referral did not meet the threshold for children's social care, contributed to a lack of confidence in information sharing processes, and hesitancy to share information in the future. This can be compounded when a practitioner feels their working relationship has been undermined by them making the referral, when often they will have informed the family that the referral is being made.

Practitioners also highlighted concerns about the difficulties they have with referring to children's social care, due to differing thresholds across local authorities and the use of different referral forms. This can lead to those making referrals having to navigate multiple different processes.

> “Each local authority will have a different system, different thresholds. So, the midwives then have a number of different processes to follow for different women, which can be a barrier and sometimes may actually stop them from making that referral.” (Designated nurse for safeguarding children and cared-for children)

DSLs in schools told us that dealing with different authorities with different thresholds, different information requirements, and often different contact points makes sharing information and concerns, slower, confusing and significantly less effective. For example, at the DSL forum, one independent school dealt with up to 30 LAs at one time and so was constantly navigating a complex and diverse landscape of thresholds and procedures that increased their workload.

There is a lack of consistency of information-sharing agreements. A lack of clear process within agencies was cited as a common cause of difficulty and delay. Practitioners reported it as “not uncommon” to find requests that separate information sharing agreements were sought for every school and GP surgery within a local authority area. Findings from the MASA survey suggested that there was significant variety in the types and quality of agreements being used by local safeguarding partners.

Improvement opportunities identified by practitioners:

1. National information sharing templates, maintained centrally and accessible to all agencies.
2. Potential for more consistent and digitised referral processes and forms.
3. Better-quality and more timely feedback processes for referrals.

4.2.2 Perceptions about legislation

Key findings:

- Practitioners are unsure how legislation supports the safe sharing of appropriate information.
- Practitioners may give more attention to the risk of breaching data protection legislation when making decisions around sharing information, than to the risk to the child if the information is not shared, which can potentially lead to safeguarding risks escalating.
- Current guidance and training do not sufficiently support practitioners in their decision-making around sharing information.

The research revealed that practitioners have significant difficulties with the legislation governing information sharing. There appears to be a widespread apprehension across all agencies, with some practitioners viewing the law as a barrier to them sharing information. Practitioners described the issues relating to perceptions of data protection legislation and many raised confusions relating to the use of consent as a particular issue.

> "In some situations, the concerns of consequences of breaching GDPR outweighs the importance of sharing information for safeguarding or reviewing practice of safeguarding." (MASA survey)
>
> "Professional disagreement, particularly in relation to the level of risk and threshold and whether consent is needed, and how best to maintain confidentiality, and appropriately share information. The impact of this on practice is that safeguarding decisions may not be made with a collective understanding of risk your picture is not understood. Therefore, impacting appropriate and timely intervention." (MASA survey)

Many participants in the academic-led roundtables, written up in the Rees Centre report, mentioned "legal literacy" about data protection as a potential barrier[60]. Participants felt that anxiety about data protection regulations inhibit the sharing of information, particularly where there was uncertainty about the significance of the information or whether it would meet the threshold for statutory support and intervention.

Practitioners described how their information security training made them focus on the consequences of sharing too much information and makes them wary when asked to share. The language of such training focuses on the negative aspects of information sharing and can contribute to the unease of practitioners. Practitioners suggested that legislation is not user friendly and open to interpretation, so they can be less likely to decide that they can share.

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[60] Rees Centre (2023)

The lack of understanding of data protection legislation leads practitioners to be more cautious in sharing information and to rely on consent from families when this is not usually necessary or appropriate for sharing personal information when safeguarding a child. There are usually more appropriate lawful bases to share information. There can also be differences in views on ethical considerations, such as in health where there has always been a focus on patient confidentiality, or in policing where ongoing investigations rely on confidentiality. It can be more difficult to make a decision about sharing information about family members, rather than the child, if the family member is the person who presents a potential risk to the child. At times it may not be clear to a practitioner holding information that it is relevant to another agency working with the family. Without knowing the whole context for a child, it can be difficult for practitioners to assess risk to the child fully.

Decision making on whether to share information

In balancing the risks about whether to share or not to share, we heard that practitioners can lack understanding of the risks of not sharing information and have difficulty weighing this against the concern of sharing incorrectly.

Practitioners were generally confident in sharing information when there was clear evidence of harm, however in instances where risk was unknown or unclear, practitioners felt much less confident in sharing information with others. The burden of decision-making in such unclear circumstances is challenging, and instances of child abuse or harm may be missed.

Health professionals described how they must consider a range of factors when deciding whether to share information, including whether sharing is proportionate and relevant, whether it complies with statutory frameworks and local information sharing agreements, whether information is confidential, and whether sharing may damage their relationships with families. Professionals may face challenges in understanding data protection requirements and may not feel confident about the appropriate lawful basis to use.

> “No granularity about who you can, can’t share info with.” (Social worker)
>
> “Sometimes we can get a request from children’s social care, but they don't necessarily give you enough information to make that assessment on whether it's relevant, proportionate.” (Designated nurse for safeguarding children)

Under UK GDPR, a lawful basis is required to share personal information. In safeguarding situations, the lawful basis of ‘consent’ is usually not the most appropriate to use. More appropriate lawful bases in safeguarding contexts include ‘public task’, ‘legal obligation’ and ‘legitimate interests’. We found in our research that practitioners and agencies were not confident what lawful basis was most appropriate for use and this caused anxieties and confusion. Practitioners have become risk averse in terms of information sharing due to fears of legal repercussions, which can then have a detrimental impact on the safeguarding of children in their care. Particularly, practitioners are much more reticent to share information when they assume that the case does not meet the statutory threshold. As a result, instances of physical abuse, neglect or child sexual abuse may be missed across the system.

To combat anxieties about information sharing, some schools told us they have begun to seek legal advice to support their information sharing decisions. We have found that this advice can come from in house or across a multi-academy network. In one case we found that a school had a lawyer on standby to advise on any queries around data protection. This slows down the pace and urgency of information sharing as schools can feel they must prioritise the need to justify their actions rather than dealing with the safeguarding issue at hand.

> “Professionals still struggle to understand the laws with regarding to sharing information. They understand about the need to share but are worried about not being legally allowed to share.” (Social worker)
>
> “Some people are scared to share information while others don’t understand what they can share.” (Social worker)
>
> “I would really like them [the government] to be very explicit about the thresholds, the tiers, and what can be shared and what can't and what consent we need and what we don't. That would be the most helpful thing, that we could have is a toolkit to know to share and what not.” (Consultant community paediatrician and designated doctor for safeguarding)

Practitioners regularly told us there was a need for “updated”, “clear”, “simple” and “consistent” national guidance about information sharing for child safeguarding. Updates to guidance was the change most mentioned by multi-agency safeguarding arrangements (MASA) in responses to the survey we circulated as part of our research activity. Practitioners suggested the need for guidance, particularly on information sharing, that may not meet the statutory threshold for action under section 47 of the Children Act 1989.

Training was also often highlighted by practitioners, such as in the below responses to the survey:

> “National eLearning on information sharing in relation to safeguarding.” (MASA survey)

> "Short on-line training to ensure everyone has access to the same messages." (MASA survey)

The need to improve training has been highlighted by the Child Safeguarding Practice Review Panel: "Basic training for all practitioners needs to address a concern that GDPR and data protection regulations limit when information may be shared."[61]

There was also a clear message from the practitioners that the introduction of case studies would be very useful to help them learn and reflect. They want the case studies to reflect the complications that they find in their everyday practice and be based on real-life scenarios. They felt this would help them in a situation where they are unsure about whether they can and should share information with another professional. Practitioners were keen that case studies of positive practice were also made available, alongside less favourable examples. They felt this would help to reduce the unease sometimes felt when making the decision around what to share and with whom. Case studies are often used to highlight poor practice, or cases where there was a distressing outcome.

Improvement opportunities identified by practitioners:

1. Clearer guidance with examples and case studies.
2. Updated and consistent information security training for all practitioners, with a focus on safeguarding elements.
3. Online platform accessible by practitioners from all disciplines, containing training materials, case studies and the guidance detailed in 1 and 2 above.

4.2.3 Practice confidence

Key findings:

- Information shared is not always fit for purpose and requires interpretation by the practitioner receiving it.
- Practitioners are not always aware of the relevance of information they hold for other professionals working with a child/family therefore they do not share.
- Practitioners may not always seek the information that they need.

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[61] The Child Safeguarding Practice Review Panel (2020), Annual Report 2020: Patterns in practice, key messages and 2021 work programme (publishing.service.gov.uk)

The research has shown that beyond the concerns around the legalities of sharing information, there can also be difficulties for practitioners in assessing the relevance of the information they hold on a child/family. Without knowing about the involvement of other professionals and their concerns about a child, it is difficult for a practitioner to measure the importance of the information they hold. This is important when making the decision about sharing it with others. At present, there is no national database or generally other means to check whether a child is known to services, so practitioners need to use their professional knowledge and experience to seek information from others. It can be difficult for a practitioner to be thorough in their information seeking, particularly when a child/family move to a new area. Some local areas have developed solutions to create a more centralised view of a child and the professionals involved, some of these approached are summarised in Chapter 5.

> "…their family go missing or they move away from a local authority area and there's no way almost of tracking them to where they've gone or turned up remains a problem." (Safeguarding practitioner)

Where practitioners have an incomplete picture of a child/family they are unable to respond effectively to their needs. It is therefore difficult to provide oversight or resource plan effectively as the true extent of needs is unknown.

The London Borough of Newham and Social Finance identified that health and education professionals, as well as other professionals who may come across safeguarding concerns for a child, do not feel comfortable sharing information because they lack confidence in their own safeguarding assessment, especially in nuanced situations. Practitioners are more likely to share information when they can discuss a case in confidence with a trusted, skilled and reassuring professional. Practitioners emphasised the value of a consultation line to discuss concerns anonymously with a social worker before deciding whether to share concerns formally, this can support practitioners to feel empowered to share information effectively.

Police officers expressed difficulties they experience due to a widespread lack of understanding from partners of the investigative processes which police are obliged to follow. This can lead to frustrations and impact relationships between professionals. Some felt that children's social care and schools did not always understand the type and amount of information that it was appropriate to request from police, with many requesting more information than they needed or with poor justification e.g. car number plate checks. This demonstrates a lack of understanding that police need to be able to justify each access enquiry on their systems and ensure it is fully auditable.

Examples of poor practice that were described to us included repeated requests for information which had already been provided, and instances of information being shared more widely than the practitioner sharing the information thought it would be. This kind of incident quickly erodes trust between agencies which is then hard to recover.

A further difficulty highlighted was that the quality of information is sometimes not complete or detailed enough for practitioners to act upon. For example, in the case of a referral to children's social care or following an alert from CP-IS to a social worker. In such cases social workers then spend time tracking down the information.

As referenced in chapter 2, Munro was clear that information exchange is not merely the lifting of one piece of information on a computer to another computer. It is ensuring that information and its relevance is understood by the person accessing the information. National Panel have told us that they have seen numerous examples of when practitioners have had the right information at the right time, but it was not recognised as something which they needed to action. Behavioural biases can impact on information sharing and decision making such as:

- Diffusion of responsibility – the tendency for people in groups to fail to act on the assumption that someone else is responsible.
- Source bias – the tendency to interpret information depending on its source not substance.
- Confirmation bias – the tendency to dismiss evidence which does not support your initial position.
- Risk aversion – preference for more certain outcomes even when more uncertain outcomes could be of greater benefit.[62]

Our research with education professionals has shown the importance of the role of the DSLs within each school as the key information sharer. They are responsible for how information comes to the school but also how it is passed to other agencies with regards to safeguarding. The competence and confidence of the DSL is fundamental in ensuring the effectiveness of this arrangement.

Currently the role of the DSL is supported by a role description, set out in statutory guidance. The description states that a DSL has to be a senior member of staff from the school or college leadership team, and they have lead responsibility for safeguarding within the school or college. It describes DSL availability, how to manage referrals, how to work with others, how to share information and when, that they are responsible for raising awareness in a school or college, the training, knowledge, and skills they need to have, how to provide support to staff and understand the views of children, and how to hold and record information. They also should have regular training often offered by the local authority or safeguarding partners specific to their local area.

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[62] The Child Safeguarding Practice Review Panel (2022)

DSLs told us that they found the training that is being accessed is often lacking and at times counter-productive for the role, leading to vast inconsistencies in knowledge and confidence in DSLs. As training is managed at the local level, meaning it is tailored to the needs and ways of working of the area the DSL works within, there can be some difficulties when a school's pupils cross different LA boundaries, where practices can be different.

It is clear from our research that the role of a DSL is strengthened when they are a part of the senior leadership team and have the DSL role as a clear and significant part of their daily role. DSLs need to be in the role for a significant period to develop the relationships and confidence with other agencies to push for information sharing when a matter of safeguarding is concerned. This is a role that cannot be viewed as a short-term developmental opportunity.

Improvement opportunities identified by practitioners:

1. Improved DSL training, particularly around local area practices where these differ across LA boundaries – potential to use the online platform described in the improvement opportunities in 4.3.
2. Use of a consultation line to help front-line professionals confirm and validate the value of the information that they hold.

4.2.4 Leadership and culture

Key findings:

- Information sharing is less problematic when working relationships have been developed between the practitioners sharing and receiving information.
- Differences in language and thresholds for referrals impact how information is sought, shared and used.
- Leaders from across the different agencies need to share a vision for working together, role modelling positive relationships and good practice.

Across all group identities, professionals are concerned their own expertise is devalued or misunderstood by other disciplines. For instance, education professionals can become frustrated when the value of their perspective is not recognised fully by social workers. However, the vital role education professionals play in safeguarding and promoting the welfare of children was broadly acknowledged by research participants. Most professionals involved in the multi-agency workshops thought that education becoming a statutory partner was a positive plan and would strengthen information sharing between education and other statutory partners.

Social workers noted that the data they share holds less weight compared to health professionals: the information they collect and share needs additional context, whereas health information is supported by medical documentation and evidence. Secondary evidence from multiagency contexts suggests that different professional roles are awarded preferential status, with health and the legal professions identified as often having greater power.

Some health professionals also raised that health was sometimes not treated as an equal safeguarding partner and decisions are sometimes taken by children's social care rather than jointly. They felt that other agencies may be reluctant to share information with health, meaning health expertise does not always inform the assessment of risk and threshold decisions.

Some practitioners felt that children's social care and health are not always aligned in their views on the risks facing a child. Relevant health professionals are not always invited to strategy meetings, and when they do attend, they may be expected to represent the perspectives of the whole health system. Many participants felt that MASH structures or similar multi-agency solutions can support decision making, whilst embedded social workers within healthcare providers can help to translate different professional 'languages'. Online strategy meetings have made it easier for the relevant health professionals to attend.

> "As a specialist safeguarding practitioner in MASH...we don't get to see all referrals that come through the front door. They are chosen by the practice manager as to whether they need that information…to determine the outcome of that referral...I was actually part of the MASH pilot looking at the importance of health participating in agreeing the threshold with social care...With the health information that we've got, what may come in at a Level Two…we could then say this actually meets Level Four, especially with health neglect and things like that." (Specialist safeguarding practitioner and MASH professional)

Police practitioners generally reported positive feedback on co-located MASH (or similar multi-agency solution) structures, which help to foster a good collaborative culture, including making discussions and requests easier to deliver (especially if clarification was needed). The co-location of agencies promotes a shared identity and builds trust-based working relationships.

The London Borough of Newham and Social Finance's research recognised the need to align diverse professionals around a shared responsibility and vision for child safeguarding and welfare. Practitioners working in different agencies referenced a lack of shared identity, or shared culture, as a barrier to information sharing. Some practitioners expressed their suspicion regarding assessments conducted by other agencies and their concerns that other agencies may not store information securely. This climate of distrust does not facilitate information sharing. Co-located multi-agency training was suggested as a way of improving relationships between professionals working in different agencies. In-person training may help practitioners to learn about each other's systems and areas of expertise, and build stronger, more collaborative relationships between different professionals.

Participants highlighted challenges in communication between agencies. Communication networks can be disrupted when organisational boundaries change; communication with children's social care about open cases can be slow; and delays getting through to children's social care over the phone can impact timely referrals. Communication between agencies may also rely too heavily on trust, as practitioners report being more likely to share information with those who they have an established relationship with. Telephone communication could be improved by scheduling calls for a specific time; using the GP safeguarding lead as the practice's point of contact for children's social care; or having an on-call duty worker to respond to MASH requests. Actively building relationships with colleagues across disciplines can act as a facilitator for information sharing, such as through meetings between professionals, and through the co-location of teams.

> "If I'm in clinic and I see an injury, I then know that trying to get through to social care could take me at least half an hour…Once you get through to social care, you do have to answer all the basic questions with the administration sometimes…it is really time consuming." (Consultant paediatrician)
>
> "I think, from my point of view, you're more likely to more readily share information with an agency that you've already had an interaction with, and you already know and trust. So, if you've got a call from MASH and you're talking to somebody that you've spoken to before or you're talking to a social worker that you had a conversation with before, you're more likely to share that information." (Named GP for safeguarding)

When discussing these close working relationships, there have been concerns raised about the differences in language and thresholds of the different disciplines. Risks are often assessed differently, not only across agencies, but also across geographical borders. This can be difficult for professionals to navigate and can lead to delays in information being shared and linked. Some practitioners gave examples of things they have put in place locally to help with this, but a more consistent approach would be useful.

Different organisations use different terms and protocols, which can cause miscommunication between agencies. The report from the London Borough of Newham and Social Finance recommends the development of a language tool to enable practitioners to interpret the information they receive more easily. The tool would be mutually beneficial for the referrer and the agency receiving the referral - it could help to guide the referrer on terms that may not be comprehensible to the agency to which they are referring. This tool could also help agencies understand each other's risk thresholds and assessments, as certain words may denote levels of risk differently across organisations. To be effective, the tool would need to be co-produced with practitioners from different agencies, accessible to all, and regularly updated.

There is a clear connection between the lack of cultural alignment between local agencies and the use of different language. Shared organisational cultures across local partnerships reinforces the use of shared language, and vice versa. The promotion of the shared vision and practices by local leaders was highlighted as an improvement opportunity area. Practitioners have been clear that a more joined up approach, where agencies work together and build trust, needs to be sponsored from the senior levels of each organisation. As mentioned earlier, 'Leadership Support' was highlighted as one of the five conditions for effective information sharing across agencies by the Behavioural Insights Team[63]. Leaders should role model behaviours and collaborate with other leaders to develop a shared vision for how their services work together to deliver shared goals.

Improvement opportunities identified by practitioners:

1. An accessible language tool to aid interpretation of frequently used safeguarding and information terms, readily updated and co-produced by partners from across the system.
2. Strengthen use of multi-agency forums and co-located teams.
3. Cross discipline training to build relationships between practitioners from different agencies and to develop understanding of each other's roles.
4. Leaders role modelling positive behaviours of multi-agency working and conveying positive messages that enable information sharing.

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[63] The Child Safeguarding Practice Review Panel (2022)

4.2.5 Capacity and resource

Key findings:

- Practitioners describe sharing information as a time-consuming process, which impacts on their already stretched resource.
- It can take a long time to obtain the whole picture of a child/family, delaying timely intervention.
- Lengthy referral forms can be a barrier to practitioners making referrals to children’s social care.

The research has shown a wide variance in attitudes towards information sharing, and a lack of confidence in some practitioners. This seems to be based on their level of experience and a lack of understanding of the roles and remits of the other practitioners working in the field. There is a reliance in building up trusting working relationships over time, which are then impacted by the high turnover of staff that is seen in certain professions. High turnover can negatively impact on relationship building across different organisations. Interviewees also felt that staff across safeguarding agencies often moved roles too soon, leaving a deficit of experience/knowledge that is difficult and time-consuming to recover.

> “Referrals coming into MASH have increased significantly over the last 5 years. Resourcing across agencies does not appear to have kept pace with this, which means current staffing models are unable to keep up with demand.” (MASA survey)

Workforce capacity pressures were reported to exacerbate the time-consuming nature of triangulating information.

> “It takes an awful long time to get the whole picture. And in the middle of that, we have a child who's getting abused and so by having disjointed systems, the biggest risk is just ongoing harm to that child.” (Community paediatrician and named doctor for safeguarding)

Participants in academic-led roundtables discussed the issues of high turnover and demand pressures[64]. Participants referenced the high turnover of staff in schools driving a shortage of experienced safeguarding lead practitioners and an ongoing need for training, highlighting the difficulties this leads to in embedding institutional learning and expertise in this area. Many participants also mentioned the impact of demand pressures on information flows and capacity to analyse the significance of information received. The large number of contacts and referrals to children's social care, combined with challenges around recruitment and retention, were leading to information overload and making it harder to identify children who needed help and protection.

Throughout the research practitioners have displayed their passion for wanting to perform their role in safeguarding and promoting the welfare of children well. Across each discipline caseloads are high, and the demand on resources is increasing. To assist practitioners in their roles, we must promote methods to make information sharing more straightforward and less time-consuming. Referral forms were discussed in the systems and processes section but were again discussed in relation to capacity. The forms can be lengthy and when practitioners are short on time, the quality of the referrals can suffer.

> "We have a very cumbersome and difficult system and the area I work in…sits in the middle of [a number of] local authorities. There's not a one-size-fits-all referral process…a lot of the time, the safeguarding team themselves have to put that referral in because we have paper methods, we have telephone methods, and we have online referral processes all sitting around us." (Associate director for safeguarding)

Health professionals identified CP-IS as a valuable tool which alerts them when a child is on a CPP. Some participants suggested there would be value in improving data flows so health professionals can see why a child is protected or adding further flags. This work is in progress.

A further suggestion was to enhance the notifications social workers receive, such as from CP-IS, to reduce the time they spend seeking further information. Receiving numerous notifications can de-sensitise workers to their importance.

> "It would be a very positive introduction in making sure we're not overwhelmed with the number of contacts." (Social worker)
>
> "Sometimes they get multiple notifications in a short period of time, which adds a lot of noise to the system." (Social worker)

There are plans to seek improvements in this area and these are covered in chapters 7 and 8.

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[64] Rees Centre (2023)

Improvement opportunities identified by practitioners:

1. Potential for technological solutions to free up practitioner time and allow automatic sharing of key information.
2. Enhancements to CP-IS to manage notifications and provide further, relevant information.
3. Introduction of referral templates – stored on an online platform.

4.3 Additional issues highlighted relating to information sharing

4.3.1 Information sharing for adults

Whilst not directly linked to the identification of barriers to information sharing, a topic that came up in the research that warrants inclusion is the need for professionals to share and seek information about the adults in children's lives. Practitioners highlighted that to assess the risks to and needs of a child, and to intervene appropriately, they need to understand the context within which the child is living. For this, better links with adult agencies such as probation and adult social care were suggested as ways to improve this. For social workers in particular, information from such agencies can identify issues such as mental health, domestic abuse, substance misuse and prison sentences, all of which can have a varied impact on a child's life. It can also show where a child is in the position of caring for an adult in their life. This is important not only for the adults involved in the care of the children, but also to help to assess the risk and protective factors the adults may present to children directly.

Whilst having the police as a safeguarding partner is useful in understanding some of the context of crime within a family and ongoing investigations, probation is also important as they carry out risk assessments of offenders. They may have information on the person's mental health issues, substance use and links with other offenders, in addition to their history of offending and compliance with the courts. In a similar way youth justice gather and risk assess many different areas of a child's life, to make recommendations for their sentence to the courts. This includes their health, education, peers, family life and offending behaviour. This can all be relevant to a social worker trying to understand a child's needs and the best way to support the child and their family. As noted earlier in this chapter, we have found some instances of LAs using technology to pull through information from agencies, to show who is working with a child/family. We have seen examples where youth justice services are included, but not probation so far.

The awareness of extra-familial harms, those from outside the family environment, has increased significantly over time and we now understand better the ways organised crime groups act to exploit children for sexual and criminal purposes. County lines is an example of this, where children are taken to a town away from their own and used by gangs to carry and sell drugs. Going across LA and police force borders can reduce the possibility of the activity being discovered, due to the lack of join up between areas. Names of offenders may not trigger any concern in one area, but in another there may be flags that they are involved in criminal activity. To tackle such issues, a more joined up approach and national picture of interactions with agencies is needed.

The introduction of the National County Lines Coordination Centre, involving experts from police forces and the National Crime Agency, demonstrates that a more national approach is beneficial to tackle such issues.

4.3.2 Siloed LAs

In the sections above we have focused on information sharing between agencies across local areas, but it was also made clear in the research conducted that within children's social care there are difficulties sharing information between LAs. They each operate in silos, where their systems do not communicate, despite many of them using the same case management system. It is therefore difficult for social care practitioners to know which other LAs may have interacted with a child or family before and there is no way to access those records. Presently, to access records elsewhere practitioners often have to travel to the other LA and manually read files on the system. This can lead to important information being missed and therefore not transferred across.

We know some LAs have developed local solutions using systems to share information and this is explored further in chapter 5. Many of them have focused their efforts on creating a 'view' of a child/family, so they can see which other agencies are involved with them and may therefore hold relevant information. It would be useful to explore the opportunities for a similar system on a more national basis, which could help to inform a 'golden record' of a child/family, that shows where information is held. In this instance the term 'golden record' means a complete, accurate and well-maintained record with the necessary information to assist practitioners to assess need, risk, and the most appropriate intervention at the right time.

4.4 Summary

Throughout our research, front line professionals raised the same issues with information sharing that have been recorded and persisted for too many years. Problems with systems and processes, misunderstood legislation and guidance, practice competence, organisational culture and capacity and resource continue to contribute to poor information sharing across all agencies.

In this chapter, we have highlighted several improvement opportunities which could help alleviate the problems, but a collective effort is needed across the safeguarding community to really grip those issues that can be resolved through stronger working relationships and a focus on culture. Guidance has been in place for several years, but practitioners remain confused and unsure. We can, and will, strengthen the guidance and look at other process issues in the round. However, we believe harnessing technology to make it easier to share and remove the ambiguity of whether and what to share will deliver a step change. Chapters 6 and 7 begin to explore what might be possible in this space.

Chapter 5 – Exploration of current innovations and practice

5.1 Examples of local practice and innovation

Reviews of relevant secondary literature and our primary research activity have highlighted promising practices and innovations that are supporting improvements in information sharing in local areas. This section provides an overview of some practices and innovations by theme. It provides insights into some of the key principles and factors that can support good information sharing practices in local areas. It is only a short summary of some examples; we are aware there are many more examples of promising practice.

Multi-agency teams

Multi-agency safeguarding hubs (MASHs) are designed to facilitate information-sharing between agencies. In our MASA survey of January 2023, MASAs referenced their MASH (or similar local multi-agency solution) most commonly as a "local system that enables timely and effective information sharing."

Ofsted inspection reports evidence mature and well-functioning MASHs (or similar) enable effective information sharing between local agencies. For example:

- "Mature partnership arrangements in the MASH help to ensure that relevant information is shared swiftly." (Torbay Council, rated 'Good' by Ofsted)
- "The co-location with children's social workers of many other professionals, for example the contextual safeguarding specialist, the early help coordinators and police and health colleagues, enables highly effective collaboration and timely information-sharing, leading to appropriate and timely interventions." (Merton Council, rated 'Outstanding' by Ofsted)
- "Enquiries in the multi-agency safeguarding hub routinely feature information sharing meetings between agencies, providing genuine depth and rigour to initial multi-agency risk assessments. This means that decisions are closely aligned with children's vulnerabilities, any additional needs and the children's ages." (West Berkshire Council, rated 'Good' by Ofsted)

Joint Targeted Area Inspections (JTAIs) assess how LAs, the police, health, probation and youth offending services work together in an area to identify, support and protect vulnerable children and young people. Recent JTAIs of the multi-agency response to the identification of initial need and risk demonstrate strengths and weaknesses of information sharing at the "front door". All JTAI reports (published since January 2022) for this type of inspection have made an improvement recommendation related to information sharing, however, many have mixed findings.

For example, findings from the Lewisham Safeguarding Children Partnership (LSCP) JTAI included:

- “Diligent and collaborative work undertaken by co-located MASH professionals is highly valued across the LSCP and leads to effective and timely information-sharing and child-centred decisions.”
- However, the report finds “what needs to improve” is “internal and external information-sharing systems in all agencies, so that appropriate individuals and organisations receive the correct reports and decisions following the outcome of referrals, strategy meetings, child protection investigations and assessments”.

One of the discovery projects feeding into this report focused on the safeguarding referral process and the “front door.” Research with social workers evidenced “pain points” in this part of the system. From our general research activity with LAs and analysis of inspection reports, the features in a MASH (or similar local multi-agency solution) that can enable effective information sharing include shared databases / systems, digitalised and consistent referral forms, robust feedback processes, use of meetings (eg. daily meetings), strong leadership and a shared partnership culture.

North Yorkshire’s multi-agency safeguarding team (MAST) was described as “highly efficient and effective” by Ofsted. When we engaged with the MAST manager and other managers from the local authority, some reasons for strong information sharing in the MAST were highlighted, including:

- robust policies and procedures which give practitioners the confidence that they are sharing information in a way that is well considered, thought through and tested
- a “single view of a child” which brings together key information from across partners into one report on the system
- An embedded and mature practice model
- open and transparent culture that empowers and supports practitioners to share information
- established information governance documentation and arrangements

The findings from our research can feed into the more targeted research on MASHs led by DfE, working with HO and DHSC, who are commissioning a joint evaluation of MASHs due to start in 2023. This work will support reforms, set out in ‘Built on Love’, on the help provided to families and the child protection system.

Research suggests that co-location of professionals supports communication, discussion and analysis of information, enabling them to build trusting relationships and easily share information or access advice. [65] [66] [67]MASHs are one example of this, however there are other practice models that include multi-disciplinary teams or embedded professionals that may support improvements to the sharing of information, for example:

- **Family safeguarding**

  The evaluation of the Family Safeguarding Model developed in Hertfordshire evidenced improvements in information sharing. The co-located multi-disciplinary teams and the use of the electronic workbook (method for case recording) aid information sharing, with 88% of surveyed practitioners agreeing there had been improvements to information sharing and decision making.[68]

- **Parental alcohol misuse (innovation pilot project (IPP))**

  Findings of the family-based model pilot that brought together support for adults and children stated, 'at the systems level, the genuine multi-agency approach was supported by professionals being seconded into the IPP project team, working from a shared location, and using a shared case management system to record interactions, which enabled communication between practitioners to take place freely'.[69]

- **Contextual safeguarding**

  The evaluation of the contextual safeguarding model in Hackney evidenced improved approaches to multi-agency information sharing. The Child Exploitation Referral Form and MACE meetings are some of the methods used to enable sharing of information on child exploitation.[70]

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[65] L Bostock et al (2018), Diffusion theory and multi-disciplinary working in children's services. Journal of Integrated Care, 26:2, pp. 120-129 (openrepository.com)

[66] Collyer et al, H. (2021), Strengthening Families, Protecting Children: Family Safeguarding – Pilot Evaluation Report Cambridgeshire What Works for Children's Social Care (whatworks-csc.org.uk)

[67] A Crawford, X L'Hoiry (2017), Boundary crossing: networked policing and emergent 'communities of practice' in safeguarding children. Policing and Society, 27:6, pp. 636-654 (tandfonline.com)

[68] Roger et al (2020)

[69] H Alderson et al (2022), An Innovative Approach to Delivering a Family-Based Intervention to Address Parental Alcohol Misuse: Qualitative Findings from a Pilot Project. Int J Environ Res Public Health, 19:1, pp. 80-86 PubMed (nih.gov)

[70] M Lefevre et al (2020), Evaluation of the implementation of a Contextual Safeguarding system in the London Borough of Hackney Tackling Child Exploitation (researchinpractice.org.uk)

Some LAs who engaged in our research discussed their approaches to extra-familial harm that supported multi-agency information sharing. Some discussed the use of operational and strategic forums and risk assessment tools that were supporting sharing information across partnerships on exploitation.

The Youth Endowment Fund is testing specialist multi-disciplinary teams embedded in neighbourhoods to support children who are at risk of experiencing violence or criminal exploitation from outside the home, in a pilot being delivered through their Agency Collaboration Fund.

Operation Encompass

Operation Encompass is an innovative scheme that facilitates information sharing between the police and schools to provide emotional and practical support to children affected by domestic abuse. When officers attend a domestic abuse incident, police share the information with a school's Key Adult (DSL or safeguarding officer) before the start of the next school day, so that appropriate support can be given at the earliest possible opportunity. The scheme was rolled out nationally by the Home Office in 2019 and is now active in all 43 police forces across England and Wales.[71]

In addition, the Home Office has funded the Operation Encompass National Specialist Teachers' Helpline since its launch in 2020.[72] The helpline provides free access for teachers to confidential and immediate access to support and guidance from experienced clinical and educational psychologists, enabling teachers to provide appropriate emotional and practical support to children affected by domestic abuse.

As part of the research activity for this report on current information sharing practices and processes beneficial to schools and their pupils, Operation Encompass was a key and reoccurring theme raised by the participating DSLs.

Through HM Treasury's Shared Outcomes Fund, the Home Office are undertaking an evaluation of the Operation Encompass scheme to ensure that the most effective interventions are in place for children who have been affected by domestic abuse. This will evaluate the current scheme, the ongoing pilot for early years settings and the applicability of the model to other harm types. To support this research a review of frontline officers' responses to domestic abuse incidents involving children is also being conducted.

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[71] The Operation Encompass notification scheme is also in use in Ministry of Defence schools in Germany and Cyprus and is now used on a statutory footing in Northern Ireland and Gibraltar.

[72] DfE also provided funding to the helpline between January and March 2021 to extend the helpline hours.

Information governance frameworks

Our research has highlighted the importance of local information governance frameworks that support the sharing of information across safeguarding partners, education settings and other relevant agencies. Lack of frameworks can limit or block local digital and data innovations and negatively impact collaborative approaches to working more generally. Frameworks are therefore necessary foundations for successful approaches to multi-agency information sharing.

The maturity of information governance frameworks across local multi-agency safeguarding arrangements is diverse. The use of information sharing agreements particularly is inconsistent and varied, as evidenced in the MASA survey.

The Pan London Data Sharing Agreements Project delivered by London Office of Technology & Innovation (LOTI) with the London Safeguarding Children Partnership has successfully signed up all London boroughs to a ‘London Multi-Agency Safeguarding Data Sharing Agreement for Safeguarding and Promoting the Welfare of Children’. The benefits of this agreement are yet to be fully understood, however the London borough responses to the MASA survey suggested some early positive impacts, including:

- “Consistency of approach and a reduction in multiple formal agreements that run the risk of creating confusion.”
- “Builds good working relationships and gives confidence to all professionals.”
- “Reliable framework. Efficiency of process.”

Some local authorities are developing innovative information sharing frameworks to support sharing of information for safeguarding and promotion of welfare purposes. The local authority one-view systems discussed later in this chapter have all required the creation of mature information governance frameworks that enable sharing. The DDSF project to develop a safeguarding data sharing agreement template and accompanying guidance, led by Somerset Council, should support more local areas to improve information and data sharing arrangements.

The use of the CP-IS service is underpinned by a national information governance and legal framework and data sharing agreements between all 152 local authorities and health. Using this framework, data sharing agreements will be put in place with all Integrated Care Boards, to support the integration of the CP-IS service with Shared Care Records.

Building data maturity

Some local areas have utilised funding streams to develop data flows and maturity across partners agencies, to support improvements to local support for children and families. Below are just a few examples of schemes.

Data accelerator programme

This Local Data Accelerator Fund (2021 -23) was one strand of a wider Data Improvement Across Government programme. Ten LAs were funded to work more closely with police forces, local NHS services and schools to share data to ensure children and families receive the right help at the right time. Examples of projects included those data modelling to identify families that require early help and support from services, with a focus on financial problems and homelessness (Nottingham and Leicestershire). Also, London boroughs, the Metropolitan Police and NHS London are using data to plan and manage child social care placements (Pan-London). The final outputs of the projects have not yet been formally evaluated.

Thames Valley Together

Thames Valley's Violence Reduction Unit (VRU) is at the forefront in sharing and utilising data safely to prevent serious violence. Thames Valley VRU has developed the Thames Valley Together (TVT) programme, which is a promising innovative approach to the way local data and information streams are managed. Thames Valley is one of 20 VRUs that are funded by HO, where they bring relevant partners and data together to understand and tackle the drivers of serious violence in their area.

TVT involves a single data platform which has the ability to collate hundreds of live data feeds from across local partners in policing, local authority, education, youth offending, health and criminal justice. It enables the creation of tailored, accessible visualisation of data and analytics. TVT is underpinned by a commitment to shifting efforts towards earlier intervention and prevention, addressing the causes of serious violence and away from costly enforcement measures.

A Better Start Programme

A Better Start (ABS) is a ten-year (2015-2025) programme set-up by The National Lottery Community Fund. ABS partnerships (Blackpool, Bradford, Lambeth, Nottingham, and Southend) are "supporting families to give their babies and very young children the best possible start in life" and are using "data-informed decision making".[73]

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[73] The National Lottery Community Fund (2022), Data-informed decision making: A Better Start Programme (tnlcommunityfund.org.uk)

Several of the partnerships are working with local organisations to integrate data through data linkage projects, meaning that each has access to the bigger picture in terms of outcomes for the local population, and for individual children and families. Across the partnerships, data is being used in a variety of ways, including identifying patterns of usage for services, identifying those families who are not using the service and demonstrating overall impact of services on children and families. An evaluation of the programme has highlighted that the introduction of a CCI is “essential to deliver more integrated support and improve health and care outcomes, as well as to help safeguard the most vulnerable children”.

5.2 Deep dive into local technological innovations

Overview of current LA technological practices against aims and user needs

Through working with the sector to gather evidence for this report, it is clear that some LAs are using technology to improve how they share information. There are different examples of how they have done this and what information it now enables them to share. These have been developed in local areas and link social care with various other agencies. We have explored some of them in detail, to understand how the systems are linked, who with and what information it allows them to share. There are some similarities across the systems, which we highlight, and differences where they are tailored to the specific needs of the area.

We engaged with around a third of LAs in England to understand what systems and processes they have in place for information sharing in relation to child safeguarding. We found lots of similarities in approach and have completed a ‘deep dive’ into seven local authority systems. We compared each system against the needs identified throughout the research. These are summarised in the boxes below. Where systems are similar, we have provided an overview of the type of system, rather than outline each one, leading to six case studies.

Our research with the LAs has identified that their progress in this area has been largely supported by government grants, the engagement of consultants and investing in increasing their data maturity. Data maturity is the amount to which an organisation can process and use the data that they generate. To enable information to be shared from elsewhere, an agency needs to be at a sufficient level of data maturity, otherwise they will not be able to make use of the information they receive. Their systems need to able to cope with and understand the information coming in.

Think Family Database (TFD) – Bristol

Overview

The Think Family Database (TFD) is a centralised information repository to provide a comprehensive view of a child or vulnerable person's situation by consolidating information from 35 different social issue datasets to provide a more comprehensive view of families within the LA. Data streams include the police, housing, NHS, DWP, GP registrations and schools. The system uses the NHS number, Unique Pupil Number and Liquid Logic ID to data match and group people into family units and assigns a family ID to them, allowing safeguarding professionals across the council to access a single view of a family's situation.

System aims

To improve the effectiveness of the council's safeguarding efforts by providing practitioners with comprehensive information about a family's situation, including risk indexing to support practitioners to identify vulnerabilities and aid early intervention. In addition, providing data on how interventions are affecting school attendance and long-term outcomes.

Key features

- Integration of data from various sources: The TFD integrates data from various sources, providing practitioners with a comprehensive view of a family's situation.
- Family unit grouping: The system assigns a family ID to group individuals into family units, making it easier to view information about a family as a whole. To reflect the different ways families are made up, the system presents practitioners with several ways to view the ‘family.’ Such as, those in the same address, those with a known relationship and linking them to other addresses where they have a significant relationship – for example, if parents live separately.
- Contact information for partner agencies: The TFD provides practitioners with contact information for named workers in partner agencies to facilitate information sharing and referral.
- Notifications: The system sends notifications to practitioners connected to open family cases when new crime information is received from the police. This has received positive feedback.
- Feedback and development: The council actively solicits feedback from users, which is incorporated into ongoing development efforts to improve the system.

Users

The system is used by social workers when a referral comes in. They search for the child in the system and review the details and use the contact details to contact anyone who has been in contact with the child/family. The social worker uses the system's risk rating as a guide. The system also notifies any professionals who are connected to an open family case when new crime information is received from the police.

Impact

Since its implementation, the TFD has been used by approximately 1,000 active users from 140 different teams. There have been over 200,000 searches carried out, and the system has had a significant impact on improving the effectiveness of safeguarding efforts by providing practitioners with comprehensive information about a family's situation.

Considerations

One of the main considerations with the TFD is the challenge of balancing the need to protect individuals' privacy with the council's responsibility to promote the health and wellbeing of children. There is also resistance from practitioners towards relying on the Data Protection Act's 'public task' provision, which permits the sharing of information without explicit consent. Broader data sets such as information about probation or health could enhance the 'complete picture' provided to a social worker, but this must be balanced with ensuring proportionality of processing sensitive personal data in line with UK GDPR. Feedback on the system is collected through monthly email updates sent to super users and frontline workers, and any feedback received is added to the list of development tasks to be addressed iteratively.

Multi-Agency Safeguarding Tracker (MAST) – Walsall

Overview

MAST is a system that matches datasets from local authorities (both adults and children's social care), police, fire and rescue, and NHS data from the LA's health partner on a daily basis. The system was developed by Policy in Practice in partnership with Walsall council and CC2i and is designed to share headline data with stakeholders to help them see where there has been contact with other agencies, so they can contact partners and make more effective safeguarding decisions. MAST allows for searching by address and person, with views available on person and household level. The system is accessible to officers with a statutory safeguarding responsibility, such as social workers and the police. Other safeguarding practitioners are currently involved in gaining access to the system. The system uses unique identifiers such as the NHS number, and non-sensitive personal identifiable information such as name, date of birth, street name and postcode to join up the data.

System aims

MAST aims to provide a comprehensive and efficient data sharing system for safeguarding professionals. It aims to make data sharing faster, more effective and easier for agencies involved in safeguarding, resulting in better outcomes for vulnerable individuals. MAST seeks to facilitate easier collaboration and coordination amongst safeguarding agencies to improve the speed and quality of decision-making, without replacing the need for professional curiosity from safeguarding professionals.

Key features

- MAST contains datasets from LAs, police, fire and rescue, and the NHS. The system is used to share headline data of individuals and addresses with safeguarding stakeholders. No sensitive case information is shared. Social workers can search by name or street address. Matching is deterministic where a unique reference ID (e.g., NHS number) exists, and probabilistic (e.g., by name, date of birth, address/postcode) where it does not, with the system calibrated to avoid false positives.

- Search results are returned within seconds. The system shows who is in charge of the case and shows all incidents that have occurred with the child. It also shows the email or telephone number of the person or team who dealt with the incident.

- Education, probation, and district nurse data is not currently available but may be included in future development.

- The system gets overnight daily feeds from partner agencies and can allow for searches within and across safeguarding partnerships, to help with county line related problems.

Users

The system is used by social workers and others within the fire, police and health services with a statutory safeguarding responsibility. For example, the police can search for a child or family to see if any other agencies have been involved with the child or family. This helps them to identify any safeguarding needs and make an appropriate referral.

Impact

MAST has significantly improved lateral checks for safeguarding purposes and has reportedly saved hundreds of hours in gathering information. The system aims to reduce assessment delays with a 24-hour turnaround target. MAST also provides an avenue for easy collaboration and coordination among safeguarding agencies, leading to better outcomes for vulnerable individuals.

Considerations

The MAST team has identified the minimum data set that can be shared across all partners with the mandatory responsibility for safeguarding, without the need to share operational or case level information.

It does not currently include data from education, probation, and district nurse services, but future development intends to address this. The system's success depends on effective data sharing agreements between agencies and the ability to overcome differences in culture and ways of working. Additionally, there is a need to establish a clear business case and commercial model for MAST to ensure its sustainability and viability.

The team established an information governance foundation first, and the MAST technical platform has been built on top of that. There is room to develop MAST further. The key limitation to scaling MAST faster is in co-ordinating its rollout across multiple stakeholders.

The Family Context tool – Stockport

Overview

The Family Context tool aggregates data from at least six data streams, including education, adult and children’s social care, housing, school nursing (via email) and health visitor details (via email) to provide a comprehensive view of service involvement and essential information related to individuals connected to a child's welfare. The tool facilitates communication between social workers and lead practitioners from various services. It aims to improve the support provided to families and to safeguard children. The system matches the data by ‘fuzzy matching’ the first name, family name, date of birth, age, gender and address, and records it against their case management system (Liquid Logic) ID. The system does not include the NHS number due to the manual processes involved in obtaining the number from the NHS.

System aims

The system aims to save time, provide more opportunities for joint work with other services, and build a more complete picture of the family's needs and risks to make more informed decisions. It facilitates communication between social workers and lead practitioners from various services, improving the support provided to families and safeguarding children.

Key features

- The tool aggregates data from various sources and presents it in a single searchable view and provides essential information.
- Social workers can search for individuals using their name or Liquid Logic Children System ID. They can access summary details, including relevant service involvement and contact details.

Users

Social workers access Family Context using their case management system login details (in this case Liquid Logic). They then search for adults or children using their name or Liquid Logic Children System ID. The results page shows any matched individual records. The social worker then selects the correct person and can choose to open a 'drop down' to view relevant service involvement and contact details.

Impact

We were told that the Family Context tool has saved social workers an average of over two hours for each new referral, with most searches taking only 20 minutes using the tool. The system has facilitated communication between social workers and lead practitioners from various services, improving the support provided to families and safeguarding children.

Considerations

The system is currently only used by social workers, but there have been requests to open it up to other agencies such as GPs and early help workers. The capacity of the system has not been verified through testing, and currently there are some limitations and challenges in the data streams being used, including progress being slow in bringing in additional data streams and difficulties in accessing other data sets to undertake basic person matching.

Care Director – Swindon

Overview

Care Director is a case management system that is used by the whole safeguarding team (social care, police, health colleagues and education) to share information. The system displays summaries of involvement for all disciplines. Social workers cannot see the detail of health involvement but can see if there is a health history involved with a child and the name of the worker to contact. The system has a homepage for each child that displays their demographics, identifying information like NHS number, name, date of birth, all the case information including who is involved in the social care case and family relationships. It also has a field for other involved services. As the system does not receive data from other systems/agencies there is no data matching or a need for IDs to match the data. Nevertheless, users record the NHS number on the system (taken from the NHS Spine).

System aims

The aim of the system is to allow the LA's safeguarding teams to share information between them.

Key features

- The full safeguarding team have access to the system.
- The system displays one view of a child.
- Each child has a homepage showing their demographics, name, date of birth and system ID number, NHS number, all the case information and family relationships.
- The system has a 'professionals' module which contains name, organisation, profession type (i.e., GP, teacher), address, phone number, email, notes box for free text of any other relevant information and within this module users can link practitioners, for example, GPs, to an organisation provider, such as their GP surgery.
- There is a 'providers' module which holds information about whole organisations which links individual professionals to that organisation.

Users

- LA users who record information on the system.
- Health and education colleagues record their checks directly onto the system.
- The police have read only access so they can see any safeguarding concerns and who is working with the child and family.

- Practitioners from internal early help services within the council (this includes youth services, youth counselling, family support work) use Care Director as their case recording system, so social workers can view their recordings if appropriate and send them direct messages within the system that are logged on the child’s file (known as a task in the system).

Impact

The system has enabled the whole safeguarding team to share information between all the safeguarding agencies.

Considerations

The system does not receive data from other systems/agencies. It relies on safeguarding users manually recording information in the system.

OneView – London Borough of Barking and Dagenham and Thurrock

Overview

OneView is integrated into the LA case management system (CMS) or is accessible through a web-based portal where social workers with appropriate Information Governance permissions can access a case summary of a child. OneView has over 80 data streams from multiple source systems including DWP, Council Debt, criminal justice partners, education, housing and housing associations, adult's social care, children's social care, VCS organisations and limited health data including GPs. This information is analysed and there is a matching process which creates single views of children and wider family / household members. Match data quality reporting is used to support clients address data quality issues in their source systems. Once matched the data is used to create case summaries for social workers – with data sharing rules ensuring data included is proportionate to the social worker role. The system flags up any cases that need to be investigated and social workers can see a chronology of events that have taken place and any safeguarding risks that have been flagged. It also has a text analytics engine that runs on unstructured case notes, extracting all the risk factors and generates natural language sentences for front line officers.

System aims

The operational aim of OneView is to present an holistic view of risks and risk trajectories to assist social workers with the assessment and identification of safeguarding issues, this includes an analysis of risks as well as event chronologies. At a strategic and commissioning level OneView provides aggregate insights into demand drivers and intervention / service efficacy.

Key features

- Shows a case summary of a whole family and contact details for the family and key professionals who are engaged with them.
- Has the ability to identify cohorts of people who may be of concern or may have escalating needs.
- Displays a chronology of events that have taken place across the multi-agency partnership systems.
- Creates a corporate data sharing platform that is governed by data sharing protocols and defined legal basis that govern who can view what data and when.
- Pseudonymises data and has role-based access.

- Supports the early intervention and prevention agenda across CSC, Family Hubs and all people-based services.

Users

Social workers use the OneView system either; when a child is referred and users can generate a 'OneView' case summary for that child and their family, directly from their CMS (any updates to data in the CMS), or they can access a cohort of children and families from the OneView case management system (can be configured to capture data about the proactive contact). In this case the target cohort is generated by OneView based on analytics agreed with the LA. For both approaches, a case summary shows a chronology of events and interventions from all partners that have taken place and any safeguarding risks that have been flagged.

Impact

The system processes 30 million records per month. In addition to reducing the effort and accelerating assessment processes, the tool also increases the richness and quality of data presented to social workers. The tool is used to build identify discrete population cohorts (including Supporting Families) which can then be offered additional support. Additionally, the tool uses predictive analytics to identify risk patterns and risk trajectories to provide strategic insights into demand and service efficacy.

Considerations

The system is built on a cloud computing infrastructure that supports multiple clients. Implementation uses templated technical assets to accelerate deployment and allows clients to share assets with one another. The tool is being used by clients to support vulnerable groups across adult social care, youth offending, financial exclusion and homelessness, in addition to children’s social care.

Family Build System – Liverpool

Overview

The Family Build system takes in data from 72 data streams including DWP benefit data, housing benefit, medical Information (Medicare, GP data), NHS Spine, youth crime and anti-social behaviour, police (arrests, Intelligence data, victim of crime, police call out), education (attendance, exclusions, school family support), family intervention, missing from home and early help and stores them in a data lake. The system provides a combined view of all this information about the child in a single view including family relationships via BI reports. The BI Report includes a risk score which helps the social worker judge the level risk for a child. The system uses a mixture of IDs from Liquid Logic ID, NHS number, police ref number and schools UPN for data matching.

System aims

- To use data to better help and support families by gaining an understanding of what complexities and vulnerabilities exist for young people.
- To understand what the LA vulnerabilities are, what the LA cohorts look like and identify as many issues as possible using a big data approach as well as to deliver a lot more qualitative practitioner data.
- To develop a crisis identification system to be able to link identified healthcare data, economic data, domestic abuse data both on an individual and family basis and to be able to identify multiple needs across the system and across services.

Key features

- 72 data streams which includes any interactions with the police, housing, DWP benefit data at the address, GPs and schools attendance data.
- Shows a single view of a child, including family relationships.
- Displays a risk score.

Users

This system is used by social care staff. There are different access levels for different users with social workers having full access. They search for a child by their name, date of birth, and identification numbers, such as a Liquid Logic Identifier or NHS number and are given either a direct match or close matches from which to choose. Users do not record any data on this system, instead they use their own CMS.

Impact

Information from adult mental health services provides a list of individuals of adults accessing mental health support monthly. That information then links to families and helps to understand which of the families have got complex issues and may require support. The system helps to highlight any potential issues with regards to a family.

There is scope to embed a data science approach to rigorously interrogate the dataset, identifying serious life affecting issues earlier, and using machine learning and AI to identify any commonality in life events across population cohorts to effectively target resources earlier with the intention of preventing issues that affect children and families from becoming more serious life damaging events.

Considerations

The data is currently displayed by the creation of BI reports but there are plans to display the information using web portals and the user role will dictate what data is visible. The service presently is mainly around adults but with plans to replicate it for children.

Transform Data View – Somerset

Overview

Somerset’s Transform Data View (TDV) is a portal that consolidates data from different case management systems. It includes social care data, early help data, educational attendance data, police and other data from various external organisations including the VCFSE. It provides a single view of a child's situation and their family.

System aims

The aim of TDV is to provide an holistic system view of vulnerabilities and involvements, to help practitioners support families with a data driven insight. It also provides a case analysis tool from social care and early help systems.

Key features

- Consolidation of data from different case management systems and external organisations.
- A case analysis tool.
- Engagement history, attendance data and assessments completed for the individual and their family.
- Advanced matching techniques to connect individuals across different systems.
- Identification of the family's vulnerabilities, and display of relevant agencies with quick access to their contact information.

Users

Practitioners use the system when a child is referred, or they have concerns for the safeguarding of the child. They search for the child in TDV, and this shows a chronology of events that have taken place and any safeguarding risks that have been flagged. The system links the child with family members and people they may have connections with. Practitioners do not record any information onto TDV, instead they record it on their CMS.

Impact

It is effective at joining up the early help system and has over 500 practitioners. It reduces resource for front line practitioners in identifying key professionals involved with the family and reduces duplication.

Considerations

The system is built on a cloud computing infrastructure, requiring technical skills and resources to implement. It requires effective partnership relations and robust information governance and like a plug in it must be integrated into a base system.

5.3 Comparison of LA technological innovations

The seven LA systems summarised in section 5.2 were benchmarked against the user needs shown in table 1 below. The user needs were developed based on primary user interviews, workshops with stakeholders and previous research.

No.	User need
1	I need to promptly access accurate information about children and families held by other safeguarding agencies, so that I do not encounter delays in making informed safeguarding decisions.
2	I need to interpret and assess information from other agencies, so that I can make a risk assessment and decide outcomes.
3	I need to feel confident that I can share information with other agencies, so that the appropriate safeguarding action can be taken.

Figure 2: User needs identified during primary research

The LA systems vary in their ability to meet the various user needs. Three of the LA systems have advanced practices for accessing information about children and families through MASH efforts (User need 1), while two of the LAs have better capabilities for producing risk assessments and indexing against children and families from information gathered from safeguarding agencies (User need 2). However, there is low confidence across practitioners about what information can or cannot be shared with other agencies (User need 3).

All the LA systems are siloed and do not communicate with other LAs.

To overcome the siloed systems, but not the issue of different geographical areas not being able to communicate via their systems, MASH teams tend to be co-located. This allows for better sharing of information without the impact of siloed systems, as the practitioners can access the system immediately for colleagues as appropriate. This model of a co-located MASH team could be explored further and potentially replicated in other LAs to improve communication and collaboration between teams. However, it does not overcome the issues with LA systems being siloed to their local area.

Based on these findings, it may be useful for the LAs to explore ways to improve communication and interoperability between their systems to better meet the user needs. Additionally, it may be beneficial for the LAs to work on increasing confidence among practitioners in what information can be shared with other statutory safeguarding partners and relevant agencies to improve collaboration and information sharing. Overall, an holistic approach that addresses both the technical and organisational aspects of the systems should be considered to meet all the user needs effectively.

Of the seven LAs whose systems we reviewed, three of them pull data in from several different data sources to provide a single view of a child and family. Only three of the seven LAs are currently sharing information with external agencies. One LA shares with the police, one with their schools and some of their voluntary community sector organisations and one LA shares their CMS with the full safeguarding team, which they use to share information. One LA's system displays headline data only which sits above the LA's other systems and because it's only headline data, it reduces the potential challenges of wider information governance requirements and does not impact on existing systems.

In addition to the systems summarised in section 5.2, our research included technical discussions with four LAs in the process of building new systems and that do not currently have a system in place that meets all their needs. These discussions are summarised below.

Lancashire has multiple case management systems holding information about individuals. To address this issue, the LA has implemented a MASH and a children's services support hub, which provides access to different sets of information. However, this system can become a bottleneck, and staff can only access information by contacting the MASH. The LA is developing a tool called Family Hubs Information Sharing Service (FHISS), which is a digital tool to improve information sharing and decision-making for safeguarding practitioners.

Staffordshire currently uses a data warehouse (which uses data from their three CMS'), a system called Fido and an IS Log for information sharing. IS Log is used by the LA, police, and other agencies. All agencies view the info on the log and submit their feedback for the next steps for the child. The LA is currently working on implementing a new system which requires new information governance.

Nottingham City is working to automate its primary systems, including social care, housing, and finance, into a database. The LA aims to understand the totality of a person or household and integrate external sources to support families. By making the system real-time and gluing together different datasets, they hope to provide more targeted and effective support to individuals and families.

North Yorkshire currently uses two CMSs: Liquid Logic and EHM. It does not currently have a system in place for information sharing and is at the very start of building a new system which will be based on an Azure data lake.

One of the major issues all the LAs mentioned is information governance and the legal gateways to share data for safeguarding. LAs had similar challenges related to information governance, however some had different approaches. All have limited the amount of data accessible on the system to ensure it is relevant and proportionate and have limited access of the systems only to practitioners in relevant roles. For example, the MAST system displays headline data such as the number of police visits or number of attendances at A&E. The Care Director system is used by the LA's whole safeguarding team as their system.

One LA reported information governance as the primary cause of difficulty: "What I've learned from information sharing is probably the biggest headache in all of this. The digital technology is not the headache. There's plenty of systems out there that can sing and dance and do everything that you want them to do and more. But the actual governance, are you allowed to do it? The lawful basis (UK GDPR) behind it is one of the sticking points and I think one of the things that I have identified through the work that I've done is that strategic leaders aren't confident in the ability to share information."

Six of the LAs are using a mixture of IDs for data matching, from the NHS number to Liquid Logic ID. They use each one relative to the data they're matching. E.g., NHS number to link up NHS/Health data, Liquid Logic ID for their case management data and UPN) for education data. One LA does not use any IDs. Instead, it performs fuzzy matching on first name, family name, date of birth and address, it then creates a unique system ID for the child and family, which is used by the system and is not shown to the users. The LA reports that this is a good method for matching data, but they feel having the NHS number as a CCI would enhance the matching rates and build confidence that information was being shared on the right child.

LA systems which give a single view of a child

Four LAs have systems that provide a single view of a child (Think Family Database (TFD), Transform Data View (TDV), OneView and Family Context). They receive data from several sources through various methods, including SFTP (Secure File Transfer Protocol), direct database query, APIs (Application Programming Interfaces), and Excel. The views are read only, with updates being recorded on the underlying systems and feeding through but not in real time. Three of the systems were built by the LAs and one is an off the shelf package called OneView which is integrated into the LAs CMS. The systems link the data from the various sources by routines called 'Fuzzy matching' typically using the child's first name, family name, address, date of birth and an ID used by the supplying system, which could be the NHS number, UPN, Unique Property Reference Number (UPRN), CMS ID or police reference number. These single views are not shared with external agencies except for TDV, which is shared with schools and some of the LAs voluntary community sector organisations.

Although the Care Director system does not take data in from other agencies or partners, the full LA's safeguarding team use it as their one system to share information. Each child has a homepage that shows their demographic identifying information like child name, date of birth, system ID and NHS number and it shows all the case information and family relationships as real-time information.

To share the data the systems pull through, the LAs have information sharing agreements with the other agencies, detailing the governance of the information they collect and store.

5.4 Summary

This chapter shows the amount of work already being done to try and join up the agencies working with children and families, both in the non-technological and technological areas. This is ongoing, with plans for further development and evaluation. Despite these improvements, we know there is more that needs to be done and this work provides an excellent foundation.

An important next step in the technological area is to understand more about the interactions between systems across social care, health, police, and education in the first instance. By fully mapping all data systems across all agencies to include the points at which there are already linkages or potential for join, we will see where advances have been made and where these can be built upon. It would also be beneficial for us to understand the levels of data maturity across the agencies' systems, so we know what information they are able to receive, send and process. This is one of the recommendations in chapter 8. Beyond this we would like to understand more about the potential for interactions between other agencies such as probation and youth justice.

Chapter 6 – Exploration of the use of a Consistent Child Identifier (CCI)

In this chapter we look in more detail at how the introduction of a CCI could help change the way information is shared. We also consider the system challenges that would need to be addressed to fully realise the potential benefits of a CCI.

6.1 Overview of the use of a CCI

What is a CCI?

A ”consistent identifier” is defined in the Health and Social Care Act 2012 as any identifier (such as a number or a code) that relates to an individual and forms part of a set of similar identifiers that is of general application. This report considers the possible use of a consistent identifier specifically in relation to children.[74]

As noted in La Valle et al 2016[75] in their exploration of the use of a consistent identifier:

- its use or presence does not mean that information would be shared, and that the information shared is sensitive
- the information to be shared using a consistent identifier would be supported by governance and confidentiality agreements

What format could a CCI take?

When looking at which number would be suitable, the NHS number is the front-runner. This is a lifetime identifier allocated from birth, or when a person registers with the NHS for the first time.

Other identifiers have been considered and discounted due to their reach, remit and the work that would be needed to use them for the purposes of information sharing. The suitability of these identifiers is summarised in table 2.

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[74] Health and Social Care (Safety and Quality) Act 2015 - In this document, a child is defined as anyone who has not yet reached their 18th birthday. ‘Children’ therefore means ‘children and young people’ throughout.

[75] La Valle et al (2016)

It should be noted that the changes to systems and processes needed to implement a CCI have both financial and time costs. It has to be considered whether the implementation of a CCI is the best use of that money and time when there would still need to be work carried out on the interoperability of systems to improve information sharing.

Figure 3: Suitability of existing identifiers as a CCI

Identifier	Scope of data includes	Scope of data excludes	Is it suitable ?	Comments
NHS Number	Cradle-to-Grave (England, Isle of Man and Wales)	- Unborn children - Persons that have not registered with the NHS - Northern Ireland and Scotland though when patients transfer in from Scotland/NI or to Scotland/NI, NHS can transfer in their medical history by using their Scotland or NI NHS no.	Yes, for health and social care purposes with work required to mandate	Number considered ‘most universal.’ Widest data coverage with known quality Possible legal barriers
Unique Learner Number (ULN)	Young people 14 and up	Young people below 14	No	Excludes all children under 14

Identifier	Scope of data includes	Scope of data excludes	Is it suitable ?	Comments
Unique Pupil Number (UPN)	Automatically allocated to each child attending a maintained school or academy	Children who attend independent school or who are being home educated will not always have a UPN	No	Local Authority Owned Is not unique (multiple UPNs may be assigned to the same child)
Local Authority (LA) Identifier	Young people known to a specific LA	Specific and relevant within the specific LA	No	Lacks consistency across all LAs
National Insurance (NI) Number	People 16 and over who are eligible to work in UK	- Young people below 16 - Persons that have not registered	No	Excludes a majority of young people (everyone under 16)
Child Benefit Number	Allocated to parents/carers of children up to the age of 16 (or 19, if in education)	People who opt out	No	In August 2014 475,000 families, responsible for 819,000 children opted out.

The NHS number is already used to help match data for CP-IS. However, currently obtaining the number is a very manual and burdensome process for social care colleagues. Using this as part of the solution for improving information sharing will involve the development of a more automated, less burdensome process for obtaining the number. There is an automated NHS system called ‘PDS’ (Personal Demographics Service) that is also used by adult social care. There is the potential that this could be used by children’s social care if standardised protocols were put in place.

Why might a CCI help?

A CCI has long been cited as a way to improve information sharing between agencies. It most recently featured in the recommendations in the Independent Review of Children's Social Care and the Children's Commissioner's Family Review, with both describing it as being able "…to ensure that data can be easily, quickly and accurately linked".[76] A commonly held view is that without a consistent number, data has to be matched on other variable identifiers which takes time, could lead to mismatches and limits the scope for complete integration. As others have previously suggested,[77] the Care Review also highlights the additional benefit of a consistent identifier would be to "…improve our ability to link data and make better use of the data that already exists." Previous reports suggest a consistent identifier would not necessarily supersede identifiers already in use but act 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.[78] In this way it could help to overcome the challenge of trying to pull out and assemble information from incompatible systems.

Interoperability is the ability of different systems to seamlessly communicate and process data in a way that does not require any involvement from the end user. We are aware that there are good examples of partner agencies sharing information using a variety of systems and several forms of interoperability. Only one of these systems, CP-IS, uses a consistent identifier (the NHS number). However, despite both the NHS and LA systems having the NHS number contained within them, in order for information to be matched on CP-IS, more of the information stored on a child must be identical – their given name, surname and date of birth.

A CCI, along with data standards and integration frameworks, could assist with the sharing of safeguarding information across disparate datasets with different identifiers. However, we have shown in Chapter 5 that several LAs are doing this successfully without the use of a CCI, linking with a variety of different partner agencies.

The use of the NHS number could prevent delays and inefficiencies in communication between children's social care and health. For example, we know from previous research that not having the NHS number from the start of the Education Health and Care Plan (EHCP) assessment process, can create delays and inefficiencies in communication between children's social care and health.[79]

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[76] MacAlister (2022)

[77] J McGhee et al (2011), Meeting children's need for care and protection (ed.ac.uk)

[78] G Baird, L David (2015), Report of the Children and Young People's Health Outcomes Forum 2014/15 – Information Sharing Theme Group (publishing.service.gov.uk)

[79] La Valle et al (2016)

Our research with some of the LAs who are using technology to share information has explored whether there may be additional benefits to their systems, if the NHS number was implemented as a CCI. They all told us that it would provide them with an additional confidence that information is being shared on the right child. Their thinking is based upon the uniqueness of a CCI, compared with the other data fields that are used to match data, such as name and address. If there are differences in how they are recorded, such as a shortened first name rather than full name, matches may not be made. As noted above, any work on the implementation of a CCI would need to include a testing phase. We know that there will always be potential errors and gaps in systems, and it is important to assess whether a CCI helps to address or reduce these.

The LAs spoken with felt there were potentials for the NHS number to increase the speed of matching data. They referred to the additional checks systems go through when trying to match names and addresses, for example, having an alias checker as another process to go through before confirming a name is a match. For addresses, LAs often take an address, match it against a gazetteer, and then utilise a code for that address as an identifier as opposed to the address directly. This takes further time to make the match.

When considering whether the use of the NHS number as a CCI would lead to benefits for improving the matching for children who are vulnerable, LAs believed this was true if the number was used to pull information through from other agencies. It would enable them to see where information on a child is held and to then seek that information. It may also be possible for that information to be shared directly.

6.2 Current position of the NHS number and its use

The NHS number is a ten-digit number, generated, allocated and managed by the PDS, part of the NHS Spine. 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 system that generates the number has processes in place to ensure two people with very similar demographic data (eg. name, date of birth) do not have close NHS numbers. This mitigates the risk of mixing up patients. The NHS number has been prescribed as a consistent identifier for the purposes of health and adult social care[80] [81].

There are various methods for safeguarding agencies to get the number for the first time, as well as check the accuracy of numbers already on file.

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[80] Health and Social Care Act 2012, 251A - 251C (legislation.gov.uk)

[81] Health and Social Care Act 2012 (Consistent Identifier) Regulations 2015 (legislation.gov.uk)

Birth

The NHS number is initially created and allocated on a person’s first contact with the NHS, ordinarily when they are born, generally in a maternity unit or under medical supervision, or when they first register with a GP. Otherwise, they are given their NHS number when the birth is registered. The 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. Practitioners are encouraged to merge pre- and post-adoptive records to ensure continuity of records, while recognising data sensitivity and the need for confidentiality.

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 has the unique advantage of being a national and universal identifier which is ‘for life’.

Batch services provided by PDS

Currently the method most used by local authorities to obtain or check NHS numbers is called the ‘batch’ system. 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 the 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 resubmission, the accuracy of local records is increased. The batch service can be seen as a one-way flow of information. In other words, the end user gets information from, but does not directly change the information on, the Spine (see below). 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. A new strategic service, Master Patient Trace, is currently being implemented. The function is largely similar, although the quality of the trace is higher, and it performs more quickly. Any new integrations developed to improve information sharing should use MPT.

Direct synchronisation with the NHS Spine

Most NHS services can connect directly to the NHS Spine, which holds an electronic record for all patients in England. The Spine comprises of 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 extremely secure, as they use the NHS ‘private network’ currently called HSCN. 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.

In addition, for a small proportion of local authorities, bespoke software has been developed to enable their CMS to connect directly to the PDS. These have to be approved by the Health and Social Care Network and meet technical and stringent information governance specifications.

6.3 Current legal basis for information sharing in children's social care

As stated in chapter 3, there is no single piece of legislation that imposes a general duty to share information for the purposes of safeguarding and promoting the welfare of children, nor is there any legislation specifying that a particular consistent identifier should be used for children and young people. However, LAs and other agencies are under various statutory duties in relation to safeguarding and promoting the welfare of children. These include:

Section 10 of the Children Act 2004 requires local authorities to make arrangements to promote co-operation with relevant partners (which includes local police, local NHS integrated care boards and schools) and other organisations working with children in their area, to promote the well-being of children in their area.

Section 11 of the Children Act 2004 places a duty on local authorities and their partners (which includes local police, NHS bodies, criminal justice agencies) to make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.

Section 17 of the Children's Act 1989 imposes a general duty on LAs to safeguard and promote the welfare of children in their area who are in need.

Section 47 of the Children's Act also places a positive duty on LAs to investigate when it has reasonable cause to suspect that a child is or is likely to suffer significant harm and specified persons (including certain NHS bodies) are required to assist an LA in their enquiries.

Section 16H of the Children Act 2004 which provides that safeguarding partners may request a person or body to provide information for the purpose of enabling the performance of the safeguarding partner's functions under sections 16E (local arrangements for safeguarding and promotion of welfare of children) or 16F (local child safeguarding practice reviews).

LAs currently use the NHS number to a limited extent within existing legal frameworks.

As outlined in chapter 3, when sharing personal information or data there is also a requirement to comply with UKGDPR and DPA 2018. This includes complying with the Article 5 data processing principles which include, in summary, a requirement to only process data in a way which is fair, necessary, proportionate, relevant, accurate, timely and secure. The organisation processing data must also be accountable and must be able to demonstrate that accountability. These are ongoing requirements and apply to both data controllers and processors. Any sharing of a child's NHS number – and hence access to any personal information via that route – must be compliant with the data protection legislation.

Expanding the use of the NHS number

As outlined above, the NHS number is currently used to a limited extent by some LAs in the exercise of their children's social care functions. This is possible due to the NHS number's current remit being for use for health and social care purposes. We know that some LAs are hesitant to use the NHS number without it being set out to them that they can do so and in what ways. It would be useful for guidance to be issued to address this, so LAs can continue to develop the technological solutions they have implemented to improve information sharing. This is included in the recommendations in chapter 8.

To mandate the use of the NHS number as a consistent identifier to be used for the purposes of safeguarding and promoting the welfare of children, it would be necessary to make provision for this in legislation. Options could potentially include amending the Health and Social Care Act 2012 and associated Regulations (which set out the framework for use of the NHS number as a consistent identifier and sharing of information in health and adult social care services) or making separate provision in children's social care and possibly education legislation. Further consideration would need to be given to the types of bodies/agencies any duty to use the NHS number as a CCI should apply to (for example, whether it should extend to police and schools) and the specific purposes for which the CCI is be used.

6.4 Technical and legal considerations for implementing the NHS number as a CCI

NHS England sets out an Information Governance (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 management. In addition to this, the use of the NHS number will also need to comply with data protection legislation.

Purpose and legitimate use of the number

Meeting the purpose rule is central to an organisation being issued with an individual’s NHS number. As it stands, the purpose set out in the Health and Social Care Act 2012 is that using the number must be “likely to facilitate the provision of health services or adult social care in England” and is in the “individual’s best interests”. If the Act is amended to include children, the wording may or may not be the same. As it stands, we consider meeting the purpose rule would be relatively straightforward 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 in education, 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. However, when looking at safeguarding and promoting the welfare of children, the NHS number would only be used for a child for those purposes.

IT systems and ensuring compatibility

Amending IT systems to include the NHS number as an identifier across all children and education services will need to be a key consideration, as would maintaining a continuous overview and the routine cleaning of data. Local authority case management systems are believed to already be able to insert and use the NHS number. However, ensuring that all agencies are using the NHS number in a compatible way is a key requirement. This can be done over time, with those on board realising the benefits. It is thought to be less of a challenge to use the NHS number for this, than to create and implement a new number.

Legal implications of broadening the use of the NHS number

In accordance with the public sector equality duty, it would be necessary to think through any equality implications of mandating the use of the NHS number as a CCI. For example, it may be that particular groups would be dissuaded from accessing health or social care services due to concerns that their NHS number and other personal data could be shared with other agencies. This would need to form part of any broader policy analysis on the potential impact of the proposal and consideration of any unintended consequences.

It would also be necessary to look in further detail at any specific data protection requirements that would apply to a widespread sharing of children’s NHS numbers across children’s social care. Sharing the NHS number on its own does not necessarily require any other personal data to be shared, but any changes to the NHS number’s remit would have to be clearly defined. This would include any changes to the processing of the NHS number that need to be made once statutory safeguarding provisions no longer apply, such as when the child becomes an adult.

It would be important to work with the Information Commissioner's Office, the National Data Guardian, stakeholders and other relevant government departments in order to ensure that the legal and policy implications of mandating the NHS number as a CCI in children's social care were fully considered and consistent with existing data protection requirements.

Data security

If use of the NHS number were to be expanded, guidance would be required about who would have access to the number, how the number would be stored in local systems, and what other data could be accessed by using the NHS number. Central to this is whether the NHS number is visible or not to the user, or whether it is used by the system in the background to make links. Guidance would need to address data security and data protection considerations on the use and access of the NHS number. At present in some systems, it is in the background as a hidden field. Currently, most LAs use the Public Services Network (PSN) system, but some smaller organisations commissioned to provide services were reported to not meet, or being unable to afford to meet, the PSN security standards[82]. It must be noted that LA systems may not be as secure as NHS systems, which means that security is reduced further for smaller, commissioned agencies. Although much of the discourse about data security relates to computer databases and recording, it is important to note that the people handling the data are central to keeping it secure, and paper files and other documents also need the same level of security if they are to hold the NHS number.

Monitoring and oversight

In children's social care, because some services are contracted out, it can be difficult to identify all the relevant bodies in contact with and delivering services to a child, or family. The use of the NHS number by subsidiary or commissioned agencies may require the LA or some other local body overseeing information governance compliance, and possibly maintaining a 'master' copy and ensuring the data is 'clean', accurate and reliable. Arguably, 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, information governance policies or procedures, or indeed interpretations of the law and thresholds. Technical solutions will be needed to help match the data from different agencies.

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[82] Law Commission (2013), Annual Report 2012-13 (publishing.service.gov.uk)

6.5 Cost for implementing a CCI

To calculate the potential costs of linking the NHS number to other identifiers, more detailed models will be needed. Data architects from NHS England will then need to work with data architects in the relevant departments to ensure all system requirements are included.

Costs for these would need to be explored as part of a fuller cost benefit analysis of implementing a CCI. It is, however, known to be significantly less expensive than establishing and maintaining a new standalone CCI. The costs of establishing and maintaining a new CCI (excluding integration costs to agency systems) are estimated at £12-18million over 3 years, based on the experience of NHS England in establishing and maintaining the NHS number. These ballpark figures were provided to us by DHSC to assist with the work for this report.

The costs of implementing the NHS as a CCI would need to account for:

- setting in place the legal and policy framework to enable use of the NHS number
- onboarding agency systems to MPT and the Spine
- capturing the NHS number in each agency system and linking to existing child records
- maintaining a data quality procedure for issues with the NHS number to be raised and resolved (NHS England has a template for this already)

6.6 LAs currently using the NHS number as a CCI

During our research we have spoken to two LAs that are already using the NHS number in an innovative way. As discussed in Chapter 5, we also spoke to several who are using technology to share information without the use of a CCI.

Swindon

Swindon uses the NHS number as a key identifier to support the provision of integrated services to children. They have created a single core demographic record for each child within the local authority. The benefits include:

- allowing access to records from across health, social care and early help services – their current systems and databases are used to develop a single record for each child, which allows practitioners to access and record case information, aiding multi-agency work
- using the NHS number aiding better communication with other NHS organisations, as they are familiar with the number and its use within health settings

- the flow of child level records, from birth notification through to universal and targeted early help services, becoming faster due to direct working between health visitors and the local council
- data entry and record maintenance becoming more efficient, aiding data accuracy
- being able to match health and social care records and benefit from the tracing of children using the national PDS – extensive data cleansing and validation is routinely undertaken leading to a reduction in duplicates and improvements in overall data quality

Swindon reported both one off and ongoing administrative costs to the implementation of the NHS number as a CCI. The administrative costs were for the use of the DBS whereas the one-off costs were towards the implementation of their supporting systems. A third-party vendor was used to support the setting up of databases and systems.

Other costs mentioned include access to the NHS Mini Spine services as well as the demographic batch systems that allow the use of the NHS number where the information is not available within the LA.

Liverpool

As part of the COVID response within Liverpool City Council in 2020, the NHS number was introduced as a CCI to link family data and identify families to understand the complexity and need of the population during the pandemic. They introduced this under Section 4 of the Health Service Control of Patient Information (COPI) Regulations.[83] This was interim legislation.

Children's social care, the City Council and NHS partners quickly recognised a need to develop a crisis identification system to be able to link identified healthcare data, economic data, domestic abuse data both on an individual and family. However, the legislation was revoked at the end of June 2022. For Liverpool, the use of the NHS number as a CCI meant having access to the NHS Spine data and primary care health information for Liverpool's shielding population (60,000 residents) that gave invaluable insight into the potential needs of that cohort during the pandemic and allowing the city council to plan for any direct care response during if required.

Since the revocation of the COPI notice, access to data has been reduced. The children's social care team has since then sent a proposal to its Integrated Care Board to allow the use of the NHS number as an identifier under the Supporting Families Programme[84] which aims to link data for families with children aged under 17.

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[83] The Health Service (Control of Patient Information) Regulations (2002), Regulation 3

[84] Department for Education/Department for Levelling Up, Housing and Communities (2023e)

Part of the proposal is to take advantage of the current legal gateways that allow the use of the NHS number within the adult care services such as using Article 9(2)(h) of the GDPR Regulations.

The appetite to mandate the use of the NHS number across children's social care was strong in Liverpool. The LA mentioned that the greatest enabler to their work will be to unlock the legal barriers when it comes to data legislation. One benefit that they have found was not only does using the NHS number act as a CCI but also, it matches data between the various systems with certainty where the number has been used, taking away the complexity of capturing duplicate information.

6.7 Summary

We know holding information on different systems that lack connectivity makes it difficult to triangulate information and get an accurate picture of a family and levels of risk. Frontline staff often cannot access information they need (inc. professionals involved, history of interventions/support etc). These fragmented journeys and lack of system join up hamper information sharing. Implementing a CCI within systems that cannot easily talk to each other will still leave practitioners without the information they need.

Our research has found that introducing a CCI is one piece in the puzzle of improving information sharing across agencies. Done badly or seeking to implement a CCI before systems and relationships are mature enough, risks being a time-consuming and expensive exercise that detracts focus away from higher priority activity.

Improving interoperability and improving data standards/quality needs to be the priority

That is why, while we believe in the benefits of introducing a CCI to enhance matching rates/confidence when identifying children across systems and enable better information sharing, it should only be introduced alongside other improvements to ensure the benefits of a CCI are realised. Alone, it will not increase the ability of systems to share information and there are errors and gaps we need to know more about to overcome. We think that there are three strands/themes that need to be addressed to improve multi-agency information sharing:

- a functioning set of case management systems, across agencies, sending the right data securely to the right people at the right time
- well-informed and confident users of that information who are clear on their roles and responsibilities for sharing information and feel they can do so in low-burden ways
- high-quality data matching and maintenance of the 'golden record' about the child/family

A CCI can only help with the third of these – and local implementations would evidence the benefits that were hinted at in the Care Review. An interoperable network supporting children's social care would work more effectively with the NHS number and associated 'best in class' demographic information within the NHS Spine running through it than one without it. Indeed, moving towards it would signal intent and itself help with confidence within the associated workforces.

LAs have told us that the implementation of the NHS number as a CCI would further enhance the systems they have developed for information sharing across agencies. It has the potential to increase the matching rate and speed, meaning practitioners can be confident information is being shared on the right child, more quickly.

But implementing a CCI is not the area that is most needing of our immediate attention to reduce information sharing risks and burdens.

To develop a multi-agency roadmap towards interoperability of systems relevant to safeguarding data, NHS-ID / Spine adoption as part of a strand to maximise data linkage efficiency has potential merit. A quantification of the costs and impact needs to be completed, based upon a more defined and targeted list of systems/data movements, before a conclusion on the impact can be made.

Options for how to best do this both through legislation and non-legislative options need to be explored, but we believe we need to develop a fuller picture of the system development costs (to NHS and others) associated with implementing a mandated use of NHS number (& Spine data) across a well-defined scope of systems, to properly present a cost/benefit analysis.

In parallel, there would need to be a wider programme of work to improve system interoperability and practitioner confidence & competence. This would include a cross-government programme to develop more consistent and comprehensive guidance, training, and tools for information sharing.

Chapter 7 – Enhancements to CP-IS

7.1 CP-IS: current state

The Child Protection Information Sharing (CP-IS) service is an information exchange service between social care and health practitioners that support the health and wellbeing of looked after children and those subject to a CPP, including unborn children. CP-IS in its current state enables limited communication between health and social care professionals about these children. Information within the system can follow the child, wherever they appear across England.

Social workers in LAs enter the protection plan or looked after status details into their case management systems and key facts are loaded securely with NHS via the NHS Spine. If that child attends an NHS unscheduled care setting, such as accident and emergency:

- healthcare professionals are aware of their status with the LA and can make informed contextual decisions
- health practitioners have access to contact details for the social care team
- the social care team is automatically notified that the child has attended the unscheduled health care setting via an Access to Service Notification (ASN) – one ASN is triggered every 24 hours per episode of care
- both practitioners (health and social care) can see details of the child's previous 25 visits to unscheduled care settings in England

This means that health and social care staff have a more complete picture of a child's interactions with health and social care services, supporting professional curiosity, and enables them to provide better care and earlier interventions for children who are considered vulnerable and at risk.

In our discovery project from April to July 2022, we carried out some user research with social workers to understand their experiences of CP-IS. The overall findings of this were that while CP-IS is a valuable service that supports the coordination of care between two critical safeguarding agencies, social care practitioners would like to see enhancements and improvements to the quality of data being shared back from health, when a child presents at a specific care setting, to ensure that they are getting the same benefits as health practitioners from system use.

A key requirement is to increase the amount of information being shared back from health to LAs.

While CP-IS provides a channel for sharing information, there are concerns that the information being shared is not always comprehensive enough and that it can hinder effective decision-making, even though the use of the system is not intended to replace existing safeguarding referral processes or the role of the MASH. To support professional curiosity and effective decision making by social workers, more information relating to the reasons why a child has presented at a healthcare setting would be of benefit. The information shared with LAs when a child's record is accessed on CP-IS by health workers is minimal and consists of "the name and job title of the person accessing the record, the organisation code and name where the record was accessed from, and the NHS number of the record accessed". This information is provided to support professional curiosity over a child's pattern of engagement with health. This is viewed by some social workers as being overly generic and hindering effective decision making. Time is spent following up with health to understand why the child has presented at this setting.

Social workers are already under significant pressure to manage high caseloads and make complex decisions in a timely manner. Including information about why a child has presented at a health setting and the outcome of their attendance will help with this.

CP-IS uses various data points to match children across the health and social care case management systems. In order to find a match, a child's given name, surname, date of birth, and NHS number must all be a perfect match. Where there is only a close match, these are flagged so that health and social care can update those fields to ensure they align. This is an additional burden on the teams in LAs and health and finding ways to reduce this should be a part of any work programme going forward.

This join up between health and all LAs is a great achievement and provides reassurance that technology can help us in our aims to improve information sharing for practitioners. However, while CP-IS can provide valuable benefits, it is important that efforts are made to address these limitations to ensure that it can be used effectively to support the protection of children. NHS England has considered ways to enhance the service provided by CP-IS and to address some of the limitations. The extended use of the service across the NHS and enhancements to support the user experience are planned to be introduced over two phases, Phase two and Phase three.

7.2 Planned expansion: phase two

Phase two is currently in progress and includes the rollout of CP-IS to further health settings and introducing a silent read function (explained below).

The below health settings are scheduled to be linked up to CP-IS as part of phase two:

- Primary Care: General Practice in hours.
- Mental Health: Child and Adolescent Mental Health Services.

- Sexual Health: Sexual Assault Referral Centres and termination of pregnancy services.
- 0-19 Services: School Nursing and Health Visitors.
- Community Paediatrics: for scheduled and unscheduled care.
- Dentistry: for both emergency and routine appointments.
- Integration with Shared Care Records at the Integrated Care Board Level

Critical feedback on the notifications at present, is that social workers can be overwhelmed with notifications which do not offer enough information for them to know what to do next. There was a concern that expanding CP-IS to additional health care settings could further increase the notifications sent to social workers, compounding the problem. To respond to this concern, the 'silent read' of CP-IS is being implemented to mitigate the risk of overwhelming social workers with notifications, as they will only be sent notifications when needed, as advised through consultation with LA colleagues.

A further enhancement is to include in the information shared by social care the type of CPP a child is subject to, physical abuse, sexual abuse, emotional abuse, or neglect. This will assist health professionals in their assessment and treatment of children, as they will have more understanding of the concerns of social care. This development has been prioritised, to support the government's response to the IICSA recommendations. This has also been requested as a priority to ensure the safeguarding of children remains paramount, when consulting with colleagues across government.

7.3 Planned expansion: phase three

NHS England have put forward ideas for the enhancements that phase three could include, based on the lived experience of people using the service. The main one of these is to extend the reach of CP-IS to include children in need, who fall within the scope of section 17 of the Children Act 1989. This means that information would be shared about an approximate additional 400,000 children between health and social care. This is a known gap in the service and would be a priority for inclusion if and when CP-IS is further developed.

This expansion would require LAs to update children's records with the appropriate flags and ensure that CP-IS flags are loaded on all relevant records within the NHS Spine. Expanding CP-IS to cover more cohorts of children will enable health professionals to identify and take more safeguarding decisions, ultimately improving the protection and care of vulnerable children.

Further work is required to help shape phase three and DfE are in discussions with NHS England to be part of this, to ensure the benefits are realised for both the health and social care workforce.

From the research we have conducted already we feel the below list of capabilities would be useful to social workers and health practitioners and that the enhancements to CP-IS could be substantial over time. We plan to work with practitioners to ensure we understand what enhancements will be most useful.

The below headings cover potential improvements that a phase three expansion could include. These suggestions have come from the user research so far, but further exploration with practitioners will be necessary to ensure any enhancements meet their needs.

Notifications & alerts

Expanding the CP-IS data set for LAs so notifications when a record is accessed from health (or other care setting depending on agreement where data can be viewed) are more meaningful and contain the information needed for a social worker to act upon.

- Introduction of a consistent/standardised CP-IS message structure.
- Include date, time and place of attendance of children in CP-IS notification.
- Include person accompanying the child.
- Include reason for attendance and outcome.
- Addition of a ‘child was not brought/did not attend’ alert.

Identification

- Ability to record children by registered or displayed name in CP-IS.
- Notifications to health and social care when a looked after child moves into their LA area.
- Introduction of out of area flag on CP-IS record.
- Ability to identify a child’s NHS number within CP-IS.

Context

- Contextual safeguarding flags – identifying if there are specific concerns for a child, such as county lines, or child sexual abuse and exploitation. This supports the requirement to include children in need within the scope of the service.
- Introduction of missing from home flag on CP-IS.
- Vulnerability markers to be added onto CP-IS tab, such as if a child has a disability.
- Visibility of parental supervision order on CP-IS record.

7.4 Next steps and long-term ambition

We plan to work with NHS England on phase three and the longer-term plans for CP-IS. The architecture is in place to enable further information sharing, but this will need to be considered alongside information governance guidelines and data protection legislation. There is the potential for the system to be expanded to other agencies, such as education and police. However, this would be completed over time and in consultation with the necessary partners.

Chapter 8 – Conclusions and next steps

The evidence gathered for this report has helped to shape the next steps below. They have been developed in a multi-agency way, via workshops with practitioners from the different disciplines. They are supported by our findings from primary and secondary sources and have been mapped against the problem statement set out in chapter 4.

We have found many examples of good local practices, some of which we have highlighted in this report. We encourage safeguarding partners to review their current practices and to take on board some of the opportunities to make improvements locally. Safeguarding partners should consider how information is shared locally within their multi-agency system, as a means of improving outcomes for children and their families, and to ensure that they deliver effective and supportive services.

To implement the changes that are needed, we have considered the tasks we can achieve quickly and those that require a longer timeframe. There is an overlap between the steps we consider to be technological and those that are not, as there are conditions that need to be in place for technology to develop.

To address the issues with multi-agency information sharing we need:

- functioning, joined-up systems across agencies that support the right data to be used securely by the right people at the right time
- an accurate and well maintained 'golden record' about a child/family
- confident practitioners who are clear on their roles and responsibilities for sharing and seeking information and feel they can do so in low burdensome ways

Through our research, we have found the focus on implementing a CCI has become a shorthand for improving information sharing. This is one part of a wider programme of work needed to overcome the barriers identified. We know that weak systems and processes, poor organisational culture and limited capacity all contribute to inadequate information sharing. The research has overwhelmingly shown that there are several key areas that need to be addressed to assist all practitioners in their roles.

We have learnt from talking to those managing local applications that to create 'golden records' and seek to link agencies quickly, the use of a consistent identifier for children is useful, but we are conscious that the work on errors, mismatching of data and the gaps in information on the system all needs to be looked at. We have learned that even where there is the use of a CCI, such as on CP-IS, there are other data fields that also have to match, for the link to be made. The sequencing of the work needs to be done correctly. LAs who have implemented NHS number for linking are confident in the benefits and we recommend that those yet to do so learn from the case studies in this report.

Ahead of this, DfE, with cross-government support, will lead a programme to develop further advice and support to improve information sharing by systematically tackling the barriers over the short, medium and longer term. The work will be developed in close collaboration with the sectors. It is essential that front line professionals from the different agencies play a key role in advising and helping design solutions needed for more effective cross sector working and collaboration. This work will build upon improvements already underway and undertake further targeted research and development work.

The programme of improvement will not take place in a silo and will be part of wider reforms, such as those in 'Built on Love.' The Rees Centre's main finding on policy implementation was the importance of integration with other aspects of reform and the need to further iterate policy with evidence[85]. Numerous reforms being planned and tested in children's social care, such as those that aim to strengthen multi-agency working and to improve data and digital capability, should have a positive impact on future information sharing between agencies. The dependencies and opportunities of the wider reforms will be acted on and the next steps to improve information sharing will evolve with evidence and outcomes of the broader reform programme.

The programme is expected to include the activity summarised below.

Next steps

Short term (0 to 18 months):

- **Mapping** – map national IT systems that are relevant across the partners involved in child safeguarding and welfare to gain a deeper understanding of challenges such as the variance of data maturity and what is working well. This will include more detailed mapping of social care, police, health and education systems, and also mapping of systems such as those used by probation and youth justice services. We will ensure we understand the information governance frameworks and practice models that support the systems.
    - This is building upon the mapping that has been completed as part of the work for this report. We focused on mapping the systems where there are joins between health, children's social care, education or police as agencies, but now need to understand the different systems within each agency, how they are linked with each other to share information and where there are joins across agencies.

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[85] Rees Centre (2023)

- **Initial development of the NHS number as a CCI** – further investigate the possible use and role of the NHS number for information sharing across agencies for children's health, social care, safeguarding and promotion of welfare purposes. Expected activity includes:
    - Issue guidance to LAs to support local implementation for those who want to voluntarily use NHS number in current / future local data management, in accordance with the current permissions in law.
    - Develop a fuller picture of the system development costs (to NHS and others) associated with implementing a mandated use of NHS number (& Spine data) across a well-defined scope of systems, in order to present a cost/benefit analysis.
    - Undertake formal data protection impact assessment work ensuring developments comply with data protection legislation. Collaboration with the ICO will be integral to this.
    - Plan and initiate regional pilots to trial the NHS number as a regional CCI for children's health, social care, safeguarding and promotion of welfare purposes. To provide a proof of concept and demonstrate value of the NHS number as a CCI, building on the work of local authorities such as Swindon and Liverpool.
- **Continue with phase two of the CP-IS rollout** – expansion of CP-IS to further health settings and introducing a silent read function.
- **Progress with phase three of the CP-IS rollout**, with a focus on improving the user experience for all practitioners. DfE to play a leading role in confirming and prioritising requirements for enhancing the service. Building on CP-IS seems most logical as this is an established system that is used by all LAs. Potential requirements to improve the service are well understood, through multiple years of engagement with practitioners across the safeguarding system. This report has reconfirmed areas of development that would benefit social workers and highlights other key stakeholder requirements.
    - This will include the completion of a six-week deep dive into the feasibility, scope, and costings of a phase three rollout, with the focus on which children will be included and what data will be shared to improve the user experiences of social workers and health professionals.

- **Strengthen guidance** – strengthen and clarify the guidance of the Information Sharing Advice for Practitioners (already underway) and the guidance of Working Together to Safeguard Children about information sharing. Develop additional guidance and tools that complement the current guidance (and advice of ICO and others) but provides more practical advice on information sharing in different contexts and situations.
- **Develop training** – develop a consistent national approach to cross discipline training on information sharing for practitioners working with children and families. It is expected to include:
    - an online training module on data protection and information sharing specific to working with children and families.
    - a multi-agency training framework on information sharing (including information seeking and triangulation) that supports local areas to deliver training locally; leverage opportunities for shadowing and co-located training to encourage shared learnings between different agencies.
    - training for designated safeguarding leads in schools.
- **Promote and spread good practice** – work with local areas to strengthen the practice and culture of information sharing and build on wider improvement activity. It is expected to include:
    - Partnering with local areas to develop and enhance local information governance frameworks. Aligning this work to the continued development of a national data sharing agreement template and guidance.
    - Showcasing of “good practice” in a series of events where local areas have developed practice and processes that has improved how information is shared (eg. information governance frameworks, multi-disciplinary models/forums, safeguarding feedback loops).
    - Contribute to the reform activity of ‘Built on Love’ related to multi-agency approaches and system-wide improvements. To ensure improved multi-agency information sharing practices are central to reforms and new practice/process. For example, ensuring smooth information sharing in the testing of multi-agency child protection teams in the Families First for Children pathfinder. We will also consider how other appropriate agencies, such as probation, can play a greater role in sharing information about the adults who pose a risk in children’s lives.
    - Identify and promote opportunities for locally (or regionally) driven solutions for improving practices in information sharing.

- **Plan and initiate a regional pilot on the use of NHS Spine data across children's health and social care systems** – progress better integration of LA case management systems with the NHS Spine Personal Demographics Service, using existing powers of Integrated Care Boards to provide a proof of concept. It would allow us to 'learn quickly' ahead of anything more permanent or on a national scale and may lay the foundations for developing the 'golden record' of a child/family.

Medium-term (18 months to 3 years):

- **Online 'one-stop shop'** – develop an online advice platform ("one stop shop") for practitioners bringing together useful materials and guidance into one place. Such as toolkits, training and "good practice" case studies. Ensuring the platform is linked with ICO online resource and other relevant sites.
- **National campaign** – national awareness campaign about information sharing for practitioners. Bringing together and promoting all the improvements summarised above to instil confidence and shared language about information sharing.
- **Conceptualise** – learning from the mapping phase will allow us to conceptualise a technological solution. Currently, a 'one view' central record of interactions is how practitioners visualise that solution. This will assist in the forming of a golden record of a child.
- **Continue with CP-IS expansion** to make more widely available across new settings, increase the scope of data and deliver functionality that enhances the user experience.

Longer term (years 3-5 depending on outcome of above):

- **Legislative routes to mandate the NHS number** for children's health, social care, safeguarding and promotion of welfare purposes.
- **Secure appropriate funding routes** for development of technological architecture that meets defined scope.
- **System development and implementation** based on learning from regional pilots evaluation.
- **Continue with CP-IS expansion.**

The seeking and sharing of information are an essential part of the job for any practitioner who works with children and families. There are continued missed opportunities to intervene early and prevent children’s needs escalating due to incomplete information. Good multi-agency practice needs practitioners across disciplines to be curious, to look that bit further into a child’s life, and securely share appropriate information to help build an holistic view. By systematically implementing the next steps in this report, we will move closer to eliminating the issues identified. At each stage, we will be nearer to our goals of better functioning joined-up systems, accurate and well-maintained records, and more confident practitioners.

Annex

Opportunities for change and recommendations (from 'Overcoming Behavioural & Cultural Barriers to Multi-agency Information Sharing in Children's Social Care')

The following text is a summary of the opportunities for change and recommendations from the report by Social Finance & the London Borough of Newham[86].

The study focuses on behavioural and cultural factors influencing information sharing between the London Borough of Newham and other agencies across London and outlines recommendations to improve information sharing in similar multi-agency contexts.

Our research team conducted 24 one-to-one semi-structured interviews and participatory ideation sessions with practitioners in the multi-agency context of the London Borough of Newham. We then developed a set of recommendations drawing on secondary evidence from the behavioural sciences, practitioner experiences explored through our interviews, and solutions surfaced in participatory research.

In the report, we outline three broad opportunity areas for change and a list of corresponding recommendations based on primary insights, behavioural science literature and ideas generated during participatory workshops with managers and practitioners.

The opportunities for change were developed from primary insights identified in our interviews. The Social Finance team presented opportunity areas to practitioners and professionals in participatory workshops to support the ideation of new solutions.[85] While our team found these opportunity areas helpful to organise the work thematically, we recognise that the barriers and solutions are cross-cutting; ideas developed in the participatory workshops frequently addressed thematic ties across multiple areas.

- **Ensure practitioners feel supported and empowered to share information effectively:** Our interviews with practitioners highlighted challenges with motivation, knowledge, and skills related to information sharing. These recommendations aim to build practitioner motivation to share information effectively.

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[86] Social Finance & London Borough of Newham (2023)

- **Build confidence in data sharing in non-statutory cases:** In particular, our interviews identified challenges associated with data sharing in cases that do not meet statutory thresholds. These recommendations aim to support practitioners to share information, where appropriate and feasible, in non-statutory cases.
- **Align diverse professionals around a shared responsibility and vision for child safeguarding:** Our interviews highlighted misalignment between agencies underpinned by low levels of trust, lack of shared identity, and structural differences. In this section, we outline interventions to align diverse professionals around shared responsibilities for child safeguarding.

Under each opportunity for change, we highlight specific recommendations. For each recommendation, we describe:

- **Target behaviour:** This is an optimal behaviour or action that has been identified as having a positive cumulative influence in a multi-agency environment. Put simply, this is a behaviour that practitioners want to see more often.
- **Behavioural & cultural barriers:** These are the psychological or cultural inhibitors that prevent various actors from doing the target behaviour. We explored these barriers in depth through semi-structured interviews with participants.
- **Summary of our recommendation:** We outline the details of the recommendation and potential modes for implementation. These are the potential ways that the recommendation could change the behaviour of actors involved in the system. Mechanisms refer to changes in the systemic or policy environment that work with, rather than against, cognitive and cultural processes. We also share the perceptions of practitioners involved in the ideation of solutions. All recommendations are preliminary: they require further refinement and assessment of feasibility from professionals in the sector before being taken forward.

  The table that follows sets out the opportunities for change identified in the report by Social Finance and the London Borough of Newham.

Opportunity for change	Target behaviour	Behavioural and cultural barriers	Recommendation
Ensure practitioners feel supported and empowered to share information effectively.	When there are concerns about a child, professionals who interact with children readily share information with relevant agencies.	Individuals are not motivated to share information if they do not understand the outcome of their actions. Skilled and proficient individuals do not feel confident in their ability to share information with relevant agencies.	In cases of data sharing into MASH or children's services, effectively communicate the outcome of a data or information share with front-line practitioners. Feedback could be automated or manual. Expand the telephone consultation line to help front-line professionals confirm and validate the value of the information that they hold. The line could be expanded to new geographies, or to practitioners from different agencies.
Ensure individuals feel supported to share information effectively in non-statutory cases.	When necessary and appropriate, individuals share information that does not meet statutory thresholds but is meaningful in the context of child safeguarding.	Front-line practitioners in children's services, health, police and education can be risk averse: they do not share data if they perceive the risks to outweigh the benefits. Professionals in children's services, police, health and education experience high information load: it is difficult to decide whether to share concerns when evidence is complex, nuanced or disparate.	Provide clear step-by-step guidance for front-line professionals to enable them to respond appropriately to non-statutory cases. The tool could take the form of a checklist or decision-tree - formats used to support people to make complex choices, or complete difficult processes, in high stress environments.

Opportunity for change	Target behaviour	Behavioural and cultural barriers	Recommendation
Align diverse professionals around a shared responsibility and vision for child safeguarding.	Children's services front-line practitioners, service managers and police, health and education professionals understand how different safeguarding terms, acronyms and protocols are interpreted across different agencies. When there are concerns about a child, front-line practitioners, police, health and education professionals share information with trusted partners. Professionals from children's services, health, police and education safely, appropriately, and securely share information.	Different organisations across the system use different terms and protocols, which can cause miscommunication between agencies. There is a lack of shared understanding across case management systems, which leads to divergent risk categorisations. A lack of trust between agencies and poor suboptimal intergroup dynamics can prevent collaboration. Interactions between staff from different agencies may be influenced by an us versus them mentality. The current multi-agency culture is one shaped by a fear of wrongdoing.	Generate a simple tool to aid interpretation of frequently used safeguarding and information terms. The tool could help practitioners to understand how the terms and categorisations they use are interpreted by other agencies, and how terms used by other agencies can be interpreted in their context. Implement co-located cross-organisational training in the MASH model, particularly at induction. Provide cross-agency shadowing programmes to give practitioners first-hand exposure to different systems and processes for information sharing. Share narrative case studies to highlight positive information sharing behaviours that have resulted in positive outcomes for children and families. Encourage trusted messengers to share their own experiences to promote safe, appropriate and secure information sharing.

Glossary

Key word or term	Definition
Application Programming Interface (APIs)	An API is a set of defined rules that enables different applications to communicate with each other. It acts as a transitional layer that processes data transfers between systems, allowing companies to open their application data and functionality to external third-party developers, business partners, and internal departments within their companies.
Case Management System (CMS)	Case management systems are local authority digital systems that support the children's social care workforce to manage child and family cases. They support social workers in their day-to-day work; carry the record of what has happened to and for a child; and hold information and data important to local and national decision-making and service oversight.
Child Protection	Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.
Child Protection Information Sharing service (CP-IS)	This service helps health and social care professionals share information securely to better protect children. The scheme links IT systems used across health and social care to help organisations share information securely. As it covers 100% Local Authorities in England, it's the only national register of social care status, and the only system to provide information when a child is out of area.
Child Protection Ministerial Group (CPMG)	A new cross-government Child Protection Ministerial Group (CPMG) was also established in late 2022. This was in response to another of the National Panel report's recommendations and a key shared commitment from government departments with responsibility for or an interest in the welfare of children.
Child Protection Plan (CPP)	A child becomes the subject of a Child Protection Plan if they are assessed as suffering, or are likely to suffer significant harm, at an initial child protection conference.
Child	Anyone who has not yet reached their 18th birthday.

Key word or term	Definition
Children's social care	Children's social care exists to support children, young people and families, to protect children and young people by intervening decisively when they are at risk of harm and to provide care for those who need it so that they grow up and thrive with safety, stability and love.
Common law duty of confidentiality	When someone shares personal information in confidence it must not be disclosed without some form of legal authority or justification.
Consistent Child Identifier (CCI)	A consistent identifier is a code that confirms a person's identity and enables appropriate information sharing once relevant agreements are in place.
Data Protection Act 2018 (DPA)	This sets out the data protection framework in the UK, sitting alongside and supplementing the UK General Data Protection Regulation.
Data Protection Officer (DPO)	Data Protection Officers are responsible for overseeing a company's data protection strategy and its implementation to ensure compliance with GDPR requirements.
Data Sharing Agreement (DSA)	This sets out the purpose of the data sharing, cover what happens to the data at each stage, set standards and help all the parties involved in sharing to be clear about their roles and responsibilities.
Designated Safeguarding Leads (DSLs)	The main source of support, advice and expertise for safeguarding in schools and colleges.
Education Health and Care Plan (EHC)	A single plan, which covers the education, health and social care needs of a child or young person with special educational needs and/or a disability (SEND).
European Convention of Human Rights (ECHR)	An international treaty between the States of the Council of Europe to protect Human Rights. The United Kingdom was one of the States that drafted the ECHR and was one of the first States to ratify it in 1951. The Convention came into force in 1953.

Key word or term	Definition
Family Hub	Family Hubs are local departments that facilitate the planning and delivery of family services. They bring services together to improve access and improve the connections between families, professionals, practitioners, services, and providers. Hubs are designed to put relationships at the heart of family support.
General Data Protection Regulation (GDPR)	This legislation governs data protection requirements for any entity managing personal data across the entirety of the European Union. It stipulates a variety of requirements around how and why data can be processed.
Information Commissioner's Office (ICO)	The ICO upholds information rights in the public interest, promoting openness by public bodies and data privacy for individuals.
Information Governance (IG)	This framework covers data protection and confidentiality, information security, information quality, and health or care records management.
Integrated Care Board (ICB)	A new type of NHS body that bring the NHS together with partners across their area. Integrated care boards are responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of NHS services in their area.
Integrated Care Services (ICS)	Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
Interoperability	The ability of different systems to seamlessly communicate and process data in a way that does not require any involvement from the end user.
Keeping Children Safe in Education	Statutory guidance for schools and colleges on safeguarding children and safer recruitment.
Lawful basis	There must a valid lawful basis in order to process personal data. Article 6 UK GDPR provides six lawful bases for processing. No single basis is 'better' or more important than the others – which basis is most appropriate to use will depend on the purpose for sharing, the type of organisation sharing the information, and the organisation's relationship with the individual.

Key word or term	Definition
Local Authority (LA)	As defined in the local authority legislation, a local authority is an elected body that provides a range of services for a particular geographical area in the United Kingdom. Local government is responsible for a range of vital services for people and businesses in defined areas. Among them are well known functions such as social care, schools, housing and planning and waste collection, but also lesser-known ones such as licensing, business support, registrar services and pest control.
Multi-Agency Safeguarding Arrangements (MASA)	Multi-agency safeguarding arrangements are the way in which local organisations and agencies work together. They help to ensure that information about a child and their family is shared effectively, risk of harm is correctly identified and understood, and that children and families receive targeted services that meet their needs in a co-ordinated way.
NHS-Spine	The NHS Spine supports the IT infrastructure for health and social care in England, joining together over 44,000 healthcare IT systems in 26,000 organisations.
Personal Data (or personal information)	Personal data (or personal information) is information that relates to an identified or identifiable living individual. An identifiable individual means a person who can be identified directly or indirectly in particular by reference to: a) an identifier such as a name, an identification number, location data or an online identifier; or b) one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of the individual.
Practitioner	The term is used in this report to refer to individuals who work with children and their families in any capacity and who makes decisions about sharing personal information on a case-by-case basis.
Safeguarding and promoting the welfare of children	Defined for the purposes of this report as: protecting children from maltreatment preventing impairment of children’s mental and physical health or development

Key word or term	Definition
	ensuring that children are growing up in circumstances consistent with the provision of safe and effective care. taking action to enable all children to have the best outcomes.
Safeguarding partners	A statutory safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as: (a) the local authority, (b) an integrated care board for an area any part of which falls within the local authority area, and (c) the chief officer of police for an area any part of which falls within the local authority area.
Shared Care Records (SCR)	Shared Care Records (SCR) integrate information from across multiple care providers to create a longitudinal view of the interactions between an individual and health and care services
Special Education Needs and Disabilities (SEND)	A term used to describe learning difficulties or disabilities that make it harder for a child to learn compared to children of the same age
Summary Care Record application (SCRa)	The predecessor of the National Care Records Service (NCRS). An application which allows health and care professionals to view clinical and demographic information.
Working Together to Safeguard Children	Working Together to Safeguard Children is statutory guidance on inter-agency working to safeguard and promote the welfare of children. It clarifies and builds upon the core legal requirements, making it clear what individuals, organisations and agencies must and should do to keep children safe. It seeks to emphasise that effective safeguarding is achieved by putting children at the centre of the system and by every individual and agency playing their full part.

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