Select Committee on Public Services

Corrected oral evidence: The role of public services in addressing child vulnerability

Wednesday 28 April 2021

4.05 pm

Watch the meeting

Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Baroness Pitkeathley; Baroness Tyler of Enfield; Lord Young of Cookham.

Evidence Session No. 3 Virtual Proceeding Questions 17 - 22

Witnesses

I: Simon Eccles, Chief Clinical Care Information Officer, NHSX; Paul Willmott, Chair, Central Digital and Data Office (CDDO); Joanna Davinson, Executive Director, CDDO.

Examination of Witnesses

Simon Eccles, Paul Willmott and Joanna Davinson.

The Chair: Good afternoon and welcome to the second panel in our meeting today thinking about how services can effectively work together for vulnerable children. In this second panel, we have three people who work a lot with data, so the question with which we finished the previous panel informs, in many senses, the way we are thinking about this particular panel. I wonder if our three witnesses can each introduce themselves as they come in and answer their first question.

Q17 **Lord Bourne of Aberystwyth:** Welcome to the three on the panel. In introducing yourselves, could you perhaps say a little bit about the remit of your respective organisations and the relationship between NHSX and the Central Digital and Data Office? We would find that useful.

My question is essentially about the number of invisible children, which is alarmingly high. In 2019 it was 829,000, and it is, as we know, likely to be quite a bit higher now after the Covid pandemic. These children are living with vulnerabilities, such as families where abuse, mental illness or addiction are present, and completely invisible to services. Could you tell us to what extent this is a result of poor data-sharing practices between public services and, indeed, across government? How are you addressing the data-sharing hurdles that exist?

Simon Eccles: I am the national chief clinical information officer for health and care. I am an emergency medicine consultant in London and deputy chief exec at NHSX. NHSX is a joint unit of NHS England and the Department of Health and Social Care, supporting local NHS and care organisations to digitise their services, to connect their health and adult social care systems through technology, and to transform the way patients' care is delivered at home, in the community and in hospitals.

In answer to your question about children who are not in receipt of specific access to care, that invisible children statistic, as I understand it, refers to children who may be vulnerable but not in receipt of care at present. They may well be known to general practitioners, health visitors, school nurses or other aspects of the health service, but they are not in receipt of care, on the child protection register, or classified as in need.

We are very keen to ensure that every member of NHS staff understands their responsibilities to share appropriate information about a child for whom they are concerned. All 1.6 million staff in the NHS have had level 1 safeguarding training. It is important to say that that is all staff, because children may reveal something to a hospital porter or to the receptionist in a general practice. It does not matter who it is. It is really important that that member of staff knows their responsibilities and to do something about it. For staff such as me in greater positions of responsibility in this regard, we have level 3 safeguarding training, to make sure that we really understand that.

It is a matter of individual professional judgment as to when they want to share a piece of information, and there is a secure mechanism by which they can share it with local authorities, which have the responsibility to act on it as appropriate.

Paul Willmott: I can talk about barriers to data sharing. Good afternoon. I am chair of the Central Digital and Data Office, which was recently established. The role of the CDDO is to lead the DDaT—digital, data and technology—function, in other words the groups of professionals in those roles across government, and to upgrade the skills and capabilities of that community.

We are also here to improve working across government, which includes improving data interchange and making systems more interoperable, and to accelerate delivery, for example through agile working. What we are really trying to do is to get better outcomes from better services, underpinned by better data and tech. Improving the way that data is available, shared and used across government is central to our mission and ambition.

There are some challenges, which I am sure you are already aware of, that we are starting to address. The first is the legal and policy challenge, which we believe the Digital Economy Act has made a good start on, but it may not address all the cases within your remit. That has to be looked at on a case-by-case basis.

Secondly, on standards and, more importantly, their broad adoption, the standards are in progress but not fully adopted across government, and every department has its own historical way of coding information.

Thirdly, on capability, data is very powerful, as we have seen during Covid, and there is a newfound understanding of what can be done with great data. It is fair to say that there are far too few folks across the system, not just within the DDaT profession but more broadly in government and the Civil Service, who are skilled in the use of data. Again, there is work under way, including the No. 10 master classes.

The fourth challenge relates to the underpinning technology—the plumbing, if you like—that allows us to get data from A to B reliably. Part of the challenge is reliable, ongoing funding. We sometimes see that funding is short term—in other words, you can lift and drop data—rather than permanent, allowing you to establish an ongoing pipe with a flow of data.

The final and most challenging one is to change the mindsets and incentives of departments about the sharing of data. At the moment, the perceived risk is very asymmetrical. If I share data with you, and you misuse it, I am perceived to be on the hook for having shared it in the first place. We need much more clarity on accountability and, indeed, liability for the use of data to unpick that and move forward.

Joanna Davinson: I can add my two pennies' worth on that. I am the executive director of the Central Digital and Data Office, working with Paul. As Paul said, we are quite recently established, having been up and running only for the last couple of months. Our overall remit is leadership in the community; setting the right strategies to drive the outcomes we are looking for, focusing on digital, data and technology; policy and standards, to get everybody aligned behind consistent ways of doing things; and assurance, performance management and monitoring what is going on, as well as, in some aspects, controls on how money is spent in certain areas; and capability, which to my mind is the really critical one.

As Paul said, it is about capability in terms of having enough people who can work technically with data. If I look across our current digital, data and technology community—this is a comment across central government—about 18,000 people are identified as being in the DDaT profession, of whom fewer than 5% have a data specialism, so we absolutely have to do more work on that.

More broadly, we are looking at what more we can do to help upskill, educate and provide the right tools and knowledge to practitioners out there who are trying to use data to do their work. As CDDO, we do not set policy on how data is used. We set policy on the standards for it, but it is up to individual departments and units to decide how they want to use data. We are aiming to provide the framework within which they can share it consistently.

Lord Bourne of Aberystwyth: Those were some very interesting points, thanks. I am interested in a particular category of vulnerable children who seem to slip through data collection: children who are rough sleeping or in temporary accommodation, perhaps staying with family or friends. There is a lot of evidence from ONS and elsewhere that they are not included in routine survey data collection. How are you seeking to correct this data gap, assuming that you are?

Paul Willmott: The data collection will be the accountability of the relevant department leading the service, so I imagine that that would be the DfE in this case. Our responsibility is to ensure that we understand what data registers are there, and that that data is appropriately maintained and of the right quality, and then to open that up to other departments that need to use it.

Lord Bourne of Aberystwyth: If you are aware of that problem, and I assume you are, would you address it with them and say that it is something that they should be looking at?

Paul Willmott: I would have thought so. Data is at the heart not just of policy-making but, importantly, of service provision. In this case, it strikes me that, within the policy remit and what is ethical, the more data that can be collected that will help solve this specific problem, the better.

Lord Bourne of Aberystwyth: Simon, is it something that you are aware of and addressing somebody's attention to?

Simon Eccles: Yes, indeed. There are a couple of critical aspects to this. Children who we know are in such a situation are classified as in need or have a plan and are on the child protection information system. That information is shared with all parts of the NHS. We currently have 150 out of 152 local authorities as part of this system and, in my A&E, as with all the others, those children are immediately flagged to us, should they attend an unscheduled, unexpected episode of care, which I hope helps with this.

I would address two other aspects. One is the need to ensure that we can accurately identify children. At the moment, we do not have a common identification system within the Department for Education, the Department of Health and Social Care or the NHS. Within the NHS, we use the NHS number, as we do in adult social care. This means that we have a single identity applied to those children.

The last aspect that I would raise is a tool that we have called the national event management system, which notes all the things that happen: attendance to an emergency department, immunisations or health visitor checks. Consequently, those in receipt of that information can note when a child has disappeared or things have stopped occurring. In pilot sites in north London, we identified a couple of children who, exactly as you described, had gone off grid, and they were able to be appropriately followed up. It is very hard to spot the absence of data, but that is the situation that you are describing there.

Joanna Davinson: Simon has described it well. The challenge is that we have to bring data from a number of data sources. This is not unique to the problem of vulnerable children. In any routine where you do that, as Simon said it is hard to spot the absence of data if you do not have a single unique identifier that enables you to be confident that you have captured every individual in scope.

To pick up a point that Paul mentioned earlier, we have the powers to share data under the Digital Economy Act, but at the moment it does not cover health and social care. One of the things that we need to think about is creating that consistent platform for sharing data. It does not stop health and social care sharing data, but we are not all on the same framework in the way we approach data sharing. We are not all under the same legislative framework.

Lord Bourne of Aberystwyth: It sounds like something we should be looking at. As you say, the power is there but it sounds like it is not quite there.

Joanna Davinson: There is plenty of scope under that Act to extend it, but we just have not yet done that.

Q18 **Lord Davies of Gower:** Good afternoon to the panel. I will begin my question by making reference to an article in today's *Health Service Journal*, in which Nicola Byrne, the new National Data Guardian for health and adult social care, says, "Data-sharing principles established during

the Covid-19 pandemic should be retained for the future". She goes on to say, in her first interview since accepting the role, that data-sharing information across individual organisations during the pandemic should already have been shared, and that this is hugely helpful.

Coming to my question, we have heard, as a committee, evidence from the Society of Local Authority Chief Executives that officials in central government and NHS England often fail to understand that local services work with sensitive data on vulnerable children on a daily basis. Would you not agree that this lack of understanding and trust can impede the sharing of data downwards? How will you tackle the culture of mistrust in central government and the NHS?

Paul Willmott: This fully aligns with my earlier point on culture and mindsets, which need addressing. I do agree that, in Covid, we have seen a very positive response to a number of crisis situations, for example in providing supermarket access for extremely vulnerable citizens. Those have been unique, one-off situations, so it is not a scalable approach. Rather, we need to move to a mindset that starts with the assumption that sharing is powerful but also bakes in the necessary processes to do that in the right way.

How do you change the mindset? Part of it is the incentives that I mentioned earlier. It is about making sure that we are clear on where the upside and downside risk of sharing is. At the moment, it is a little like being a supplier of chemicals. That chemical can be used for good or bad, but, once you have sold the chemical, it is up to the end user to decide how it is used. Currently, in government, when we give data to another department, the assumed liability is with us, having provided that data. That needs addressing.

We also need to show some better case studies and communicate them. There are some good case studies emerging, as I just mentioned, but we need to demonstrate the power of data more broadly across government and communicate it well.

Finally, I would point to a need for the improved capability and skills that Joanna pointed to. It is hard to relate to a topic that you do not understand. At the moment, we just do not have enough people across the system who are conversant with this topic.

Joanna Davinson: Just to amplify something that Paul said, in a lot of the debate and discussion about data up until now there has been a lot of emphasis on the need to protect data. We do need to protect data and to be very careful with how we use personal data. There are quite broad ethical and public trust issues to do with how we use data, but that in itself is becoming a bit of a barrier, because we need to change the mindset to being more open to sharing data without reducing our focus on protecting and securing it. It is quite a difficult balance to achieve. Good examples are really important in showing where we have managed to create that balance, as well as lots of communication and training.

Simon Eccles: It is a critical question and I am grateful for your bringing up Nicola Byrne's interview, because her predecessor, Fiona Caldicott, had a clear principle of a duty to share, which is widely underappreciated here.

You highlight that people's approach to information governance is hugely varied and unnecessarily complex. We in NHSX will publish a data strategy shortly with a specific improvement aim: bringing people closer to their data by giving everyone across England easy access to their own health and care data, and allowing individuals to update their own contact details et cetera; giving people confidence in how their data is used across the health and care sectors; and harnessing data to improve people's safety, including research.

I just want to cover a few specifics: a new statutory duty on organisations to share anonymous data for whole-system planning and appropriately direct care data in order to make people safe; delivering shared records, reducing the data collection burden, which is something that so many talk about, although we do need to make sure we are collecting the right data; and, lastly, to simplify information governance.

We did this for Covid. We issued clear guidance to the system on much simpler information governance, which was very widely appreciated. We need to create a single information governance portal that means that every part of the system understands the rules and follows them appropriately. We will share better as a consequence.

Lord Davies of Gower: That is all very helpful and interesting. Thank you for that. The Society of Local Authority Chief Executives also told us that resources were quite low. This is a very complex area, there is no question about it. More resources are needed to interpret the various pieces of legislation. What can we do about that?

Simon Eccles: Our proposal is to work with Dr Byrne as the National Data Guardian to develop new e-learning packages on the use of data for frontline staff, for information governance professionals and for the Caldicott guardians within every organisation, to help them better understand this. You are right that it is a complex landscape, but the rules are simpler than people believe them to be. If we can help make it really clear what they are, we will see much better information flow.

Lord Davies of Gower: There is a lot of misunderstanding. Even I fall into that category, I have to say. It is a question of what data public services can share.

Joanna Davinson: It is about simplifying guidance and making it consistent. Some of what I have seen is written in quite complicated, technical language, and we definitely need to simplify and demystify that. We need to give people confidence that, when they share data, they are protected under the regulatory framework that exists already.

The Chair: Simon, you talked about a statutory duty to share. Do you need legislation for that or is it within current legislation?

Simon Eccles: My understanding is that it is within current legislation, but I would need to check. Joanna is nodding with sufficient enthusiasm that makes me feel slightly more confident.

Joanna Davinson: There is certainly primary legislation that supports it. There might need to be secondary legislation for particular types of data, but I would need to know the specific case.

The Chair: I suspect that that is something we would want to look at. If you have any information that you can send us on that, that would be really helpful.

Q19 **Lord Hogan-Howe:** Exactly on this point, it seems to me that there is competition between different statutory requirements: a duty not to share on occasions, for privacy, and a duty to share. The burden of deciding which it is falls to quite junior managers at times, which drives me to think that there may be a need for a broad defence to an inappropriate sharing of data, when that decision is wrong, so there is a public good argument.

Nobody wants to see privacy breached. Particularly in health, everybody wants to see that people who need healthcare get it, unafraid that their data will be shared inappropriately with a statutory agency. That has to be a good outcome. At the moment, the outcome you describe is hindered by statutory duties that collide, and I just wondered whether you were aware of any statutory defence. I can see Paul laughing and I am with you, because I do not think there is one.

Paul Willmott: That is where I was going to go. This is a very pointed question. It goes to a complex dilemma about our duty of privacy and how we contrast that with doing the right thing. I would point to a couple of things that we are progressing on, which will help but need further development. The first is an overall data ethics framework, which our data standards team is working on and has published a version of. That needs evolving to be a lot more actionable, because, at the moment, it is rather principle-based and we need to get to the point where officials are quite clear on when, what and how to share.

Secondly, there is quite a big difference between services that are requested by the citizen versus those that we are imposing for good reason. They need to be treated quite separately from a data-sharing and privacy point of view. From my work in the private sector, I have seen that, on the whole, the public has quite a good understanding of the ethics of data. Where there is a good, solid and fair argument for collecting and combining data, there is generally good support for that, but we must not confuse that with a complete mandate to share all information at all times.

Simon Eccles: I would absolutely agree with that. In some of the work we have already seen, for example in Manchester with troubled families,

there was an assumption by all families that this information was already shared between agencies. Where we are sharing information directly related to the safety of a child, it is very hard to understand how that would be inappropriate. I hear you on the balance and why it is done on a case-by-case basis, but we will be legislating for that duty to share for the safety and direct care of children in the data strategy next month.

Q20 **Lord Filkin:** Many of us will find this session very encouraging, because it shows a lot of action on the issue that we identified in our last report.

I want to ask a question about the future and the potential of data systems to improve protection for potentially vulnerable children. In a sense, I am jumping over the immediate question that you have been addressing of how we can improve data sharing so that, at a point in crisis, we have information about the full width of issues and agencies involved in that child. One very much hopes that we accelerate over the next year or so, in the way that you have been talking about.

My question is slightly different and is about the potential for data systems better to deal with the identification of risk. To give you an illustration, which displays my interest in this, the NHS clinical dataset is essentially a clinical record of 60 million people's history, which is a phenomenal, if hidden, tool for understanding what is going on in the NHS system, when people become ill and when they are not, and what their trajectory is. It is quite a phenomenal system.

Applying that thinking, which is quite difficult for this question, we all say that we want more prevention, so that we do not deal with children only at a crisis point. The number of people who are potentially at risk is phenomenal. You can never intervene with all the people who show a risk factor, because there are far too many. In time, you need some better, evidence-led model as to the collection of risk factors that shows those who are at greatest risk, so that you have some potential for intervening early with those, say, 10% or 15% of children who have not yet reached crisis. Because you have a model of it, which has three or four factors, you know that they are at very high risk, and you then know, from the data, where to focus your intervention efforts.

Do you understand that slightly ambitious question that I am advancing? Does it make any sense to you? Clearly, it is an issue as much for the policy leads as for you as the technical specialists, but is that a discussion that is or should be taking place with the policy specialists?

Paul Willmott: Perhaps I can give a broad answer, and Simon can talk about the current state in the NHS. Broadly, the recent advances in data science, and machine learning in particular, afford us the ability to do very advanced modelling of causal factors for many trends in society. I am sure that that would apply to risk factors in this case as well.

Of course, there are all the normal caveats around accuracy of datasets, the need for good longitudinal data, and the fact that you get a risk score rather than a definitive answer. None the less, the potential is there with these datasets to build extremely effective predictive models and to

surface the main driving factors, which, in turn, should inform and shape policy.

In my commercial life, I use similar techniques in order to work out who is going to buy more product, but the very same technologies and techniques apply equally well for this worthy cause.

Lord Filkin: Simon, what do you think about the potential from NHSX's point of view?

Simon Eccles: The potential is huge. We have an example of a broadly similar initiative running in Bristol, with the Think Family database that is run there. It is a multiagency data warehouse and analytical hub for about 55,000 families. They have pulled together all their information from the troubled families programme, uploaded it to the datahub, and used it to try to identify the upstream determinants of problems, which gets to the point you raised. It uses predictive analytical techniques, as I understand it.

Our challenge here is that there is no standardised dataset of information that could be shared with regard to the vulnerable child, so much of the data sharing remains verbal and professional-to-professional, on a case-by-case basis.

By contrast, we have a standardised dataset for adult social care that allows us to use these predictive tools much more clearly. It is much more challenging in children, and I want to be very clear about that. For adult social care in the NHS, we own the data controllership across the whole landscape and therefore can build that model. Can we, as you are suggesting, use data to see upstream as to where we could intervene earlier? It may have to be on an authority-by-authority basis, but the evidence appears to suggest that we could.

Lord Filkin: You could not build it on an authority-by-authority basis; you would have to do some level of national work involving localities, to build some models and systems, which could then be operated at a locality level.

Simon Eccles: In the NHS, that data can be centrally brought together, and we do that. For children's social care data, the challenge is that no such overarching data authority exists and it is local authority by local authority. That may be changeable, but it is outside our remit.

Lord Filkin: Joanna, do you want to comment on that? I will also ask this question: if there is the potential, who is going to start to look at how to make that realised?

Joanna Davinson: I do not have anything to add to what Paul and Simon said about the potential for using predictive models. Getting to your last question, in the Central Digital and Data Office we are putting emphasis on creating common data standards so that, even where information is held in different places and systems, under different governance, if we can hold it to a common data model, it will make it

easier to share and bring together into cross-agency models. The governance and resources need to be in place to create those shared datasets and analysis on top.

Lord Filkin: I sense from all three of you that you think that the potential is huge. Paul, you spoke only about its power to feed policy. Presumably such a system would also have the power to inform practice, so that you could intervene earlier, rather than just understanding what the causal factors or the risk factors were.

Paul Willmott: Yes, absolutely. Once the risk factors are fully understood, you can then build a model to operationalise that.

On your question as to who should do this, as a general thought it is up to us as the CDDO to put in place the interchange, management and capabilities for data. In general, the use and analysis of data should be as de-centralised as possible; in other words, as close as possible to the people making the policy or delivering the service. It is not that helpful to have an ivory tower coming up with insights.

Lord Filkin: Amen to that. But if we wait for 150 local authorities to do this, when the investment in doing so is quite heavy, I have to say that I believe passionately in local government but it will not happen. There has to be a mix of some development of the system between the national state and, above all, the policy departments. Maybe you could drop us a note on the potential of this, the technical shifts that are needed, and which policy leads need to get behind this. My sense is that, in far too many cases, the policy leads do not understand the potential of this at present. Paul, do you agree?

Paul Willmott: Yes.

Lord Filkin: I thought you would.

Q21 **The Chair:** My experience is that, no matter how good the knowledge and the data are, unless there is an incentive in a particular part of the system it will not happen. One of the problems with a national system of national health is that the policymakers can say what they want, but unless the local GP thinks, "This is going to make a difference to A, B and C in my practice", some of which is money, they do not bother. We have that problem with nearly all the companies that are now doing very interesting things about the integration between health and social care, whether adult or children, and it just does not happen. How do we make it happen?

Simon Eccles: This is, in part, about ensuring a minimum core dataset that just has to be shared. It will involve aspects of health, particularly attendances at emergency departments, for example, and potentially core factors such as learning disabilities and special needs. It will involve social care data, as we just discussed, such as the presence of a family social worker, their having been discussed at a multi-agency risk assessment conference, or their having had adverse childhood

experiences. We currently collect their presence on a plan and their being specifically in receipt of care.

It includes matters from education, such as an education, health and care plan, the fact that they are being home schooled, or their school attendance record. If you had that dataset, you could almost immediately start identifying those who are at particular risk. I am suggesting that that removes, for a very limited number of things, the "do I/don't I" element that you are particularly highlighting. Therefore, it draws attention to GPs and other health professionals that there is a clear path to action here that benefits them from sharing.

Lord Filkin: Chair, it would be great if we could get a note from the three, because there is great potential here.

The Chair: I agree about the potential. The potential has been there for some time though.

Lord Filkin: I do not think that it has, because we have not had these systems before.

The Chair: I am not sure about that, but you and I can have that argument later. We would be very grateful for anything that you can tell us.

Q22 **Baroness Tyler of Enfield:** My first question is primarily for Simon. Before I forget, you mentioned some family data from a Bristol pilot, which sounded very interesting. If it is possible to let us have any more information about that, I would be very interested.

It has been put to us by various witnesses that there is more that NHS England, and indeed NHSX, could do to raise the safeguarding responsibilities that health services. At the beginning of your presentation, you talked about ensuring that all staff had received level 1 safeguarding training, but I just wondered if you thought that that was sufficient and that what people had been saying was fair, and whether more needs to be done.

Simon Eccles: With regard to the pilot I mentioned, we will happily send the committee details on that.

With regard to whether we do enough for safeguarding responsibility, one could always do more, but I am really very proud of the amount that the NHS does here to ensure that every member of staff who may come into contact with a child and have something revealed to them is appropriately trained and understands their responsibilities. That is a good thing.

We collect information on every child who is known to be in need and in receipt of care, or who has a child protection plan, and that is shared via the child protection information system. We are working now on the second iteration of that, which will include all GP surgeries, health visitors and school nurses, to try to make sure that, for every child who is

particularly vulnerable, every point of care in the system can be in receipt of that information. One can never say it is sufficient, but I hope it is a very good building block.

Baroness Tyler of Enfield: Just to pursue that a little bit, we heard in our first inquiry that GPs and other health professionals were often quite reluctant to share information and concerns with local authorities about child safeguarding. I wonder if that was a data issue, a systems issue or a cultural issue. The Office of the Children's Commissioner told us that, in many areas, children's services were unable to match unique pupil-identifier numbers on the national pupil database with children's NHS numbers, which was making it harder for early intervention services to identify and help vulnerable children. Could I have your responses to both those points?

Simon Eccles: If I can take the second one first, I agree that it is tremendously important that we can uniquely identify children. In the NHS, we have had, for over a decade now, an NHS number that is applied to every child born in England and all children who immigrate to our country. We need to work with officials at the Department for Education to agree how we are going to do that. In the modern digital era, that does not have to be a single identity, but it has to be one that matches. As we have agreed previously, the NHS number is not used by other government departments, but it should be possible to correctly identify children.

On your first question on general practice and reluctance, I do not know the specifics of that in individual cases, but you raise an important point about culture and people needing to see the value of information shared. There may be a challenge where a threshold for a healthcare professional is significantly different from a threshold within a heavy-workload social work or social care environment. Therefore, people may be reluctant to share if they do not perceive the value of doing so.

As Lord Filkin raised earlier, we need that soft intelligence of the things that are under threshold but would be useful to know, and their cumulative effects are important. We want to make sharing information more easily understood and easier to do, and we are trying to put in place elements of that with the data strategy, simplifying the information governance, and with the tools that we bring in to make the act of sharing information much easier for professionals to undertake. I hope that that will help.

Baroness Tyler of Enfield: Broadly, from what you said earlier, you would also say that training would be an important part of that, in order to address the cultural issues.

Simon Eccles: Yes, and we are proposing e-learning in conjunction with the National Data Guardian.

Baroness Tyler of Enfield: Paul, do you have any responses to those specific points?

Paul Willmott: As I said earlier, there are a number of cultural and learned behaviours that we need to tackle, as stated in response to the earlier question.

In terms of identifiers, it is quite a loaded issue, because naturally there is some privacy sensitivity around identifiers. I agree with Simon that we need a way of matching records from multiple systems, to make sure that no child slips through the net. It would make it much easier to have a single identifier, but having one would not mean that it would always be used. We could agree to share data, for example, only when there are clear risk indicators to mitigate privacy concerns.

Joanna Davinson: I agree with Simon and Paul's points on that.

The Chair: The committee has completed its questioning of you. It is a fascinating area. I have to say that I am cynical, because I had an inquiry into data sharing for vulnerable people when I was at the Cabinet Office in 2006-07. We were told then exactly what you said, Simon: that families believed that the data would be shared. It is still hugely problematic.

Thank you very much for your work. You have both have really important agendas. Neither of your organisations was around when I was doing that in 2006-07, but we have all, in different ways, been plugging away at this for a very long time. You have really important agendas that we hope you will address. I hope that you will send us any additional information that has come out from the session this afternoon. Thank you very much indeed.