Cymru Wales

Supporting Achievement and Safeguarding
Equity in Education Division
Public Services and Welsh Language Group
Welsh Government
By email only

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Consultation on Children missing education database

BMA Cymru Wales response

Introduction

BMA Cymru Wales is pleased to provide a response to the Welsh Government consultation on Children missing education database.

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

Response

The regulations under consultation require Local Authorities (LAs) to establish databases of children missing education (CME). Health Boards and GMS contractors will be required to disclose certain confidential demographic information on children (and their parents) to enable the LA to cross match with education data they hold. The disclosures would occur on an annual basis. The LAs will then identify which children were missing education and create a database for these individuals. The data on the children who are deemed to be in education i.e. not '*missing*' will be deleted.

We have significant overarching concerns about the proposals from legal, practical and information governance perspectives, and ultimately about what local authorities will be able to achieve with the data.

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Y Gymdeithas Feddygol Brydeinig
British Medical Association

Legal basis, and clarity of purpose(s) of the Regulations

The Regulations are made under Section 29 of the Children Act 2004. Section 29 provides a power to require an LA to operate a database for the purpose of arrangements under section 25 or 28 of the 2004 Act or under section 175 of the Education Act 2002. Clause 11 of Section 29 of the 2004 Act sets aside the common law duty of confidentiality for the purpose of establishing the database relating to these arrangements.

It is vital that the Regulations provide clarity and assurance to the disclosing bodies about the purpose(s) of the database and that the information will be used only for the specified purpose(s).

We are, however, concerned that the draft Regulations do not provide the legal basis, or clarity of purpose(s). Specifically, the Regulations do not specify whether they relate to establishing the database for the purpose of arrangements under sections 25 or 28 of the 2004 Act or section 175 of Education Act 2002. Furthermore, Regulation 12(2) refers to functions under the 1996 Education Act and the Additional Learning Needs and Education Tribunal (Wales) Act 2018. Neither of these pieces of legislation are referenced in Section 29 of the 2004 Act as providing a legal basis for the establishment of a database therefore their inclusion in the Regulations is inappropriate and does not provide confidence that the Regulations are legally robust.

Please can the Welsh government therefore clarify in the Regulations (or where appropriate):

- exactly what legal basis is being used to establish the database and for what purpose(s) related to the stated aim of identifying children not registered in education;
- how the legislation cited in Regulation 12(2) (as above) – but which is not referenced in Section 29 of the 2004 Act - establishes a legal basis for the database and for disapplying common law requirements; and
- that those who can access the database must only use it for the specified purposes(s).

Additional concerns and requirements

- The disclosing bodies, Health Boards and GPs, must be confident that any disclosures are compliant with their legal obligations under the common law duty of confidentiality, the UK GDPR and Data Protection Act 2018.
- To ensure compliance with data protection legislation, in particular the principle of 'purpose limitation', there must be clarity about the purpose(s) of processing within the Regulations.

- Consideration must be given to the principles of necessity and proportionality to ensure data processing required by the Regulations is limited to the specified purpose(s). This process must include consideration as to whether they are any alternative options which are less intrusive. This is important because most of the data to be processed will include children who are not deemed to be missing in education. This would be a potential breach of their rights.
- The disclosing bodies (Health Boards and GPs) need to be content that LAs can demonstrate they hold the data safely and securely with the appropriate organisational and technical measures in place to protect the data and prevent unauthorised access.
- The data to be disclosed must be kept accurate and up to date so that deceased children are excluded from disclosure to the LA. This is to avoid an LA making contact with a family when a child is deceased which would obviously cause significant distress.
- The timeframe for deletion of data must be specified. Regulation 8 requires an LA to delete a child's CME record from the database when it becomes aware that the child has become a registered pupil. The deletion must occur '*as soon as is reasonably practicable*'. To ensure timely deletion of extraneous data, we suggest specifying that the deletion must occur '*within 30 days of becoming aware that a child has become a registered pupil*'.
- The value of the data and disclosure process appears limited as an annual report will only provide a point in time snapshot and will almost instantaneously become outdated. Consideration should be given in the long term within these regulations as to usage of the National Data Resource (NDR) which may eventually encompass the required information.
- LAs must conduct a Data Protection Impact assessment in line with ICO advice which would present a good opportunity to consider all of the above points. Additionally, a suite of consistent and nationally agreed Privacy Notices, processing agreements and Data Protection Impact Assessments (DPIA) will be required. It is not clear within these proposals who would be responsible for developing and maintaining these critical requirements, but we would expect these to be drafted and disseminated by LAs and only signed by GP contractors if they are sufficiently happy with the content on discussion with their own DPO.
- As GMS contractors will be required to make the disclosure on an annual basis there are clear resource and workload implications which might arise from the additional duties.

We will now seek to answer each consultation question as appropriate to our remit as an association.

1. **Currently local authorities do not know about all children in their area but are still responsible for them. Do you think the requirements in the regulations**

will help local authorities to identify children not currently known to them and/or children missing education?

This approach could provide a better list of children registered or interacting with health services across the council area than is currently in place. However, it is important to note that a large number of GP practices in Wales are located in border areas where data would not be shared with the LA as the patients will reside outside the area.

Additionally, it may still not capture all children where they are resident in Wales but registered with GPs in England unless there is a process for those registered in England but resident in Wales to be included.

2. **Does this proposal assist local authorities with their arrangements made under section 175 of the Education Act 2002, which is to undertake their education functions with a view to safeguarding and promoting the welfare of children?**

Potentially, this proposal could minimally assist in fulfilling their duties under this act. However, the approach of a one-off exercise per annum means that data will become out of date almost as soon as it is created. Movement of children in between the data extraction points, especially in border areas, may still see children missed and additionally cause upset to families affected. Likewise coded data capture to reflect mode of education is unlikely to be included withing the GP records, meaning widening the scope of data capture in future is unlikely to be of any value.

3. **Under the regulations, local health boards will disclose the information as required in the Schedule (name, address, gender and date of birth of child) to the local authority so that they can develop a children missing education database.**

   - *Do you agree that the information requested in the Schedule is reasonable and proportionate to enable the local authority to identify children not currently known to them and who may be missing education?*

The approach specified in the proposal requests a that HBs/GPs report to LAs a significant volume of information on children registered with GPs with the intent of developing the ‘missing education’ database. The vast majority of the information disclosed will be irrelevant for this purpose. Two key GDPR principles are purpose limitation and data minimisation, and the disclosure route specified could be seen as to contravene these principles.

In terms of specific fields, for health the data item ‘gender’ as it is likely that this is recorded as ‘sex’ in the clinical record. The relevancy of this field is also questionable given the purpose of the disclosure is to identify the location of the child rather than their sex/gender. The rationale behind which fields have been specified in the regulations does not seem to have been provided in the consultation.

- *Do you agree that the information requested in the Schedule is sufficient to enable the local authority to identify children not currently known to them and who may be missing education?*

We are unable to comment on LA processes and whether the information will assist. However, as outlined it is only demographic data being requested here. Coded structured data pertinent to education is highly unlikely to be recorded in the GP records and though out of scope at present, extension of any data capture is unlikely to be proportionate or of any tangible benefit to LAs.

4. Are there alternative systems and processes that would enable the local authority to identify a child they have no prior knowledge of?

We are not aware of any sources within GP records. Consideration should be given to a statutory self-notification process whereby parents of children outside of Education processes are required to legally report their children's educational arrangements to the LA for safeguarding and assurance purposes.

5. What, if any, advantages and disadvantages do you think there would be in the disclosing of the required data to populate the database? Complete the section relevant to you.

- *Local health boards and general medical contractors*

There are several factors relating to LHBs and GP practices which merit consideration:

- Data fields: A thorough consideration will need to be made on the range of data sets and information available in both settings that will be accessed. This will need developing into a Data Standards Change Notice (DSCN) for consistency and robustness of approach.
- Workload implications: The process for GP contractors to gather and prepare the required information from their clinical record is unclear. It is presumed that GP Contractors would need to run local data reports and submit to the health board removing non relevant children. This has clear workload implications on a semi regular basis for limited apparent benefit to the population.
- Potential of misaligned areas of boundaries: Local Health Board areas and GP practice area boundaries may not directly align with Local Authority areas; this may add complexity and result in inaccuracies and the requirement for further processing. This is particularly likely to be an issue along the border areas.
- Deceased patients and HB processes: Health Boards may not have appropriate access to the extensive data sets required to complete a deceased patient check. This would be extremely important, to ensure parents of children who are deceased are not contacted during a time of grief. This risk is exacerbated by the once-a-year data extraction.

- Data processing route: The data processing route requires further clarification, in particular why the data needs to be sent from GP practices to HBs and on then to LAs. It is surely more appropriate and potentially less of an information governance risk for the data to be sent directly to the LAs from GPs.
- Controller versus Processor status: The consultation document suggests that GPs will be the data controller and the Health Board act as the data processor for that data obtained from GP systems. This may not entirely be correct if the Health Board is undertaking a data matching exercise and rationalising the list provided with other extant data sources. If this exercise results in a separate list then the Health Board is in fact a data controller as they have made decisions regarding data processing beyond the control of the original data controller (i.e. the GP).

6. The draft regulations propose that local health boards disclose information to local authorities annually. Do you agree with an annual return?

Please refer to question 3 above where we state that an annual return will be out of date almost at the moment the data is provided.

If this data is not utilised and followed up by LAs within a very small timeframe then the data may be irrelevant, this is specifically important where it may relate to children who have subsequently passed away. Completing an annual return will only also provide a snapshot in time and not where situations change or individuals move in or out of Wales, this will be especially important in border areas.

Future use of a system such as the National Data Resource (NDR), when fully functioning and underpinned by appropriate legislation, should be provided for within these regulations.

More frequent disclosure is a significant workload implication for submitting practices and therefore needs to be fairly and correctly resourced by collaborative fee processes.

A statutory self-declaration by parents to the LA should also be scoped.

7. What would be the implications of a more frequent data return in terms of technical, administrative and resource implications on:

3. Other

The process for GP annual returns as described would require manual input by GPs and practice teams. A clear standardised and agreed process with associated information governance documentation (privacy notices etc) is required and must be developed nationally. This annual exercise, required in regulations within a defined time period, will have implications upon capacity and workload. A more regular return would require some further support to extract and provide data in a more centralised location.

This is a potentially significant workload implication for workload saturated practices and should be commensurately resourced by LAs directly or via collaborative fee processes to GMS practices.

As previously noted, in the medium to long-term the NDR has the potential to bring LA and Health Data together in a more streamlined way that would allow for more regular reporting.

8. Who within the local authority would need access to the children missing education database in order to carry out their functions?

We are unable to comment upon LA processes.

Local Health Boards (9-12)

9. Can you identify any key privacy risks and the associated compliance and corporate risks?

It is not clear from the information provided what the HB will do with GMPs data when it is disclosed to them. If there is any data matching or rationalising then they will become a data controller and not merely a data processor as implied. This will need to be clearly articulated in the appropriate information governance documentation and made publicly available. However there appears to be not enough information provided in the consultation to make this assessment.

10. Do existing protocols concerning data of children who have died ensure that any processing of that data does not lead to any inappropriate communications with families?

No. It is a concern that HBs may not have the most up to date data or access to all relevant data sets that would enable an effective deceased patient check. This is normally undertaken by Digital Health and Care Wales and presents a real concern for proceeding with this process. GPs are likely to bear the direct impact of those families who are upset by this process being introduced.

11. Do you have any previous experience of this type of data disclosure/processing?

Health Boards regularly report/ disclose information for statutory reporting purposes. However additional unresourced reporting requirements will add to the workload at already stretched GP practices.

12. Are there additional resource and technical implications of processing and disclosing the required data to local authorities?

This will be for each individual health board to review their existing processes and establish mechanisms are in place. A suite of nationally agreed documents and template processes will aid in this function. It is not clear who would have this responsibility from the consultation.

General medical services contractors (13 to 14)

13. Can you identify any key privacy risks and the associated compliance and corporate risks?

As noted in our response to question 9, it is unclear what Health Boards will be required to do with data from GPs once received – whether they will be rationalising the data set and matching with existing HB-held information Where a HB will undertake these processes, they would be making controllership decisions. Where they are merely obtaining and processing (i.e. sending the data on and the LA will undertake that processing) it could be argued that the data should be sent directly to the LA by GPs and not via the HB.

As data controllers, practices retain responsibilities for handling all requests for access to the data, for example, subject access requests made by patients or requests from third parties such as insurance companies and solicitors. GP data controllers may delegate these activities but remain responsible for the final output. GP partners are ultimately liable on a personal level for any sanction levied by the Information Commissioner’s Office in the event of any data breaches or release of inappropriate information.

Where the HB is considered a processor, a Data Processor Agreement will be required. It is also expected that there would be a Data Protection Impact Assessment and fair processing information provided. It is not clear who would have this responsibility from the consultation although it is vital that such documents are consistent on a national basis.

GPs and their partners within practices bear joint and several liability for data governance and would be subject individually to criminal levy if a breach of GDPR caused the ICO to levy a criminal fine. This can be significant up to €30m Euro or a percentage of annual turnover, and potentially could lead to bankruptcy and closure of practices in extreme cases. This must be clearly and absolutely mitigated by the legal process and safeguards such as DPIAs and DSAs as well as enshrining the legality of the data transfer process in primary legislation.

14. Do existing protocols concerning data of children who have died ensure that any processing of that data does not lead to any inappropriate communications with families?

GP clinical records may not be fully up to date with this information, and therefore any combined data set should be checked against relevant data sets. Information on patient death is often and routinely delayed due to the poor standard of discharged and data transfer from secondary care. Ordinarily for national programmes of work this is completed centrally using the most up to date data available, however even this is not a guarantee due to the annual nature of data extraction. We would have very low confidence that introduction of this legislation will not see events of significant emotional upset for bereaved families.