HOUSE OF LORDS

Public Services Committee

Oral evidence: Role of public services in addressing child vulnerability

Wednesday 19 May 2021

3 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; Lord Hunt of Kings Heath; Baroness Pitkeathley; Baroness Tyler of Enfield; Baroness Wyld; Lord Young of Cookham.

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Witnesses

I: Dr Joy Shacklock, Safeguarding Clinical Champion, Royal College of General Practitioners; Dr Alison Steele, Officer for Child Protection, Royal College of Paediatrics and Child Health.

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Examination of witnesses

Dr Joy Shacklock and Dr Alison Steele.

Q42 **The Chair:** Good afternoon, everyone. Welcome to this meeting of the Public Services Select Committee in the House of Lords. We are continuing our inquiry into vulnerable children. We have two very interesting and different panels this afternoon. The first panel is drawn from people who work in the National Health Service, and the second from those who work in the voluntary sector in children's organisations.

I am very pleased to welcome both Dr Alison Steele and Dr Joy Shacklock. Can I ask both of you to introduce yourselves when I first ask a question of you? Just say who you are and where you are working and so on. That will help people who may be watching to know who we have in front of us this afternoon. I really want to say, "Thank you", because you are both doing very important and significant jobs in relation to children. We are grateful to you for spending some time talking about that with us this afternoon.

The Chair always gets to ask the first question, and I want to follow up evidence we have had from the Royal College of Paediatrics and Child Health which suggests that, while some children are vulnerable because of their family circumstances, they are not necessarily known to services and that this has probably been a group that has suffered even more during the past few months.

What role do NHS clinicians play in ensuring that families where there are children whose parents suffer from mental illness, addiction and domestic abuse are referred to family support services, and how often? How might clinicians' safeguarding role be strengthened? Indeed, do you think it can be?

Dr Joy Shacklock: Good afternoon. Thank you, Baroness Armstrong. I am a GP, and I am here as the safeguarding representative from the Royal College of General Practitioners. I am a GP in Harrogate in North Yorkshire. My clinical role includes being the safeguarding lead in the practice, homeless health lead and school doctor for an independent boarding school. I am also a named GP for safeguarding in my CCG, as well as the national role I hold with the college. Thank you very much for having us. It is a subject close to our hearts.

What role can NHS staff play? We very much teach that safeguarding is everybody's business, and within primary care every team member has a role safeguarding children, from the receptionist to the nursing staff to the GP to the administrative staff to the practice manager; everyone holds a role. Primary care is often the front door for lots of health services. Often, we are the first point of contact for families in need and for children in need, through all sorts of different things. We deal with minor things, as you know. We are increasingly seeing mental health problems in young people, and, as I am sure you are aware, that has become more of an issue during the pandemic. We are certainly seeing a lot more of it now as the kids have all gone back to school, with the pressures they are facing. Even before the pandemic, lots of families were under pressure. That has increased over the past year as well.

One of the key things about primary care is relationship building. Vulnerable families often have a lack of trust in professionals and often are reluctant to say what is happening to them. That is often the case with domestic abuse in particular and perhaps in substance addiction. We know that families really fear referral to social care because often people’s perception is that social care removes children. That is often what people fear the most. We all have a responsibility to break down that myth and show that actually social care is there, as we all are, to support.

Some of what we see in safeguarding is very clear-cut. There is a minority of safeguarding things where the decision is very easy—that needs referral, that is a child protection issue, that needs referral to social care—but a lot of is grey, and a lot of it is building a picture over time. Practitioners might have a few concerns, and you might be starting to put little bits of the jigsaw together, but it never quite adds up to being a real concern without other information. Health visitors and school nurses are crucial to that early help—and preventive work as well. We do not have enough of them. Their numbers have declined significantly in recent years, which is a real issue for early help for families.

The other real challenge we come across is parental consent for referral into services. Health, and all services, can refer to family services without consent when it reaches a certain threshold, but for the early help level you require parental consent, and often parents do not give consent. Even if you refer because you think it reaches the threshold, social care might not think it reaches the threshold and will ask parents for consent, and they do not give that consent. Often, we find that we are waiting for things to get worse before intervention. That is really difficult to hold. We hold a lot of risk because we have to wait until things reach a threshold, which should not be the case, of course. We should be able to support children and young people at a very early stage no matter what their age. Whether they are two days old or whether they are 17, it does not matter; we should be able to intervene.

The Chair: Thank you. Can I ask Dr Steele to come in?

Dr Alison Steele: Thank you, Baroness Armstrong. I am a consultant general paediatrician. I am currently working at Great Ormond Street Hospital, but for most of my professional life I have been based in Tyneside, either in Gateshead or Newcastle upon Tyne. I am the officer for child protection for the Royal College of Paediatrics and Child Health, which means that I am their child protection and safeguarding clinical lead.

I think the NHS has a big role to play as a multiagency partner. We need to be clear that every professional contact we have with children and families should count, and that clinicians should have open minds about vulnerability and professional curiosity and ask the right questions, not necessarily the obvious ones, about the general welfare of children and young people and, very importantly, ask children and young people themselves sometimes.

We are improving our practice in engagement with children and young people directly, and not necessarily relying on their parents to speak for them. I think that is very important. We make lots of referrals to children's social care and other agencies on both an early-help basis and a child-in-need basis. As Dr Shacklock has already said, it requires parental consent to do that, and it can be a pity when you do not get that consent or you are not able to persuade people that it is a good thing to do, because what ends up happening is that the situation can deteriorate to the point that you have to make a child protection referral without parental content. It is always a real shame when that happens. People do not consent partly because of lack of trust, potentially, in the system.

If you have spent a lot of time as an NHS clinician persuading and discussing and making a referral to social care or other agencies, and when you make that referral you do not get the response that you have discussed with the family, it makes it very difficult to make a referral next time because families perceive that they will not get the help that they need. People are often wary of making referrals just because of the issue, as Dr Shacklock said, with child protection and the ability for social care to remove children. That is always a worry for children and families. Information sharing is very important both within health and outside health, because until we can get a bigger picture we do not know what the issues are. I absolutely think NHS clinicians are crucial in this field.

Q43 **The Chair:** Thank you. There is a fair amount of agreement between you. How do we make all of this happen? Dr Shacklock, you talked about the importance of health visitors and midwives and so on. My experience was that they were critical in helping to make sure that other agencies were alerted at a very early stage. Is that something that is not happening at the moment? It really is about how we make sure that health is part of the early intervention programme.

Dr Joy Shacklock: We have seen the numbers of health visitors and school nurses decline very significantly in recent years. In primary care, for example, one of the gold standards we aim towards is for primary care to have multidisciplinary team meetings about children and families, and that would often include health visitors, school nurses and midwives to cover the range of ages. In some areas that works well, but in some areas there are not enough health visitors and school nurses to be able to facilitate that for every GP surgery. It comes back to relationship building; it is about families knowing somebody and trusting them.

If it is a GP or health visitor—health visitors particularly—and you have had two or three children and you have had the same health visitor throughout that time, it is somebody you know and trust, somebody who can pick up signs really early and say, "Do you know what? I'm really worried about your mental health because you seem to be struggling a bit at the minute. Can we get you some help and support with that?"

There is real value in clinicians knowing the families. The very vulnerable families I work with might be families who have had children removed from them before for a variety of reasons. Often, it is around domestic abuse and substance misuse issues, but they are pregnant again or might be in a new relationship. They require huge amounts of support and they require huge amounts of trust building. That is where the health visitor and the midwife can really help.

We often forget about older children. A child can be vulnerable at any age. We are seeing teenagers in particular really struggling. Quite rightly, there is a lot of emphasis on the early years because we know they are really important. I would never say that that is not important, but being a teenager is really difficult right now and they require lots of services as well. Often, there are no services for them because they are becoming a bit more independent and there are outside influences that are nothing to do with the family—peer influences, county lines and drugs and all of that sort of thing. There are mental health issues. We struggle to get services for older children, particularly as they are coming up to 18. Often, services say, "They're too old for us", and they do not quite fit adult services, so they fall off the edge of a cliff sometimes and fall through the gaps. While early years help is really important, teenagers and older children need the same level of support, albeit not from a health visitor but more like a school nurse, for example.

The Chair: Thank you. Dr Steele, what we are really talking about is the role of health in bringing people together. Health may well be the first agency, as it were, that comes across a safeguarding issue. What do you think we should be looking at to enable health to better pull together the people who are needed to properly help a family?

Dr Alison Steele: Health can be quite crucial. Certainly, if it is somebody from health who has the best ongoing relationship with the family—as Dr Shacklock said, often it may be a health visitor because that is a universal service, so they will have had contact with all families—it is often useful for them to be the lead professional to form the team around the child, which is a concept I am sure you are all aware of. I think the issue is how that lead professional interacts with other agencies, including social care and education, and what pathways and services there are locally. It is really important for people to understand what is available in any locality within which they are working. Networking with other professionals in localities is also really important because it is about trust between professionals as well as trust between professionals and families and young people.

The Chair: Thank you. I would love to go on. However, colleagues are waiting to ask questions. I will bring in Lord Bichard.

Q44 **Lord Bichard:** This is really developing your questions, Chair. Thank you both very much for coming along this afternoon. You have made some hugely important points about lack of trust, the fear of losing children, and the way in which professionals have to wait for things to get worse before they can do something. Can I ask you to think about whether there are any specific changes—maybe changes in legislation or guidance—that you think we need to make your lives easier in order to protect children better? Are there some specific things that you would like to see changed, Dr Shacklock?

Dr Joy Shacklock: Resource is always really important, as are people. People are really important in this process, and that means health staff. Technology can only do so much. It cannot replace people and human interaction. As a GP, I can do more if there are two of me rather than one, and we can interact. The same is true of health visitors. If there are two health visitors rather than one, we can do more and we can impact more, so resource for staff across community services is something we would certainly like to see.

Technology is a barrier as well as a help, particularly around information sharing. For example, in the area where I work, we use an IT system called SystmOne. The midwives, health visitors and school nurses are all on the same system. They input to our system. If I point to a child's record, I can see the health visitor's entry. That makes information sharing very easy because they do not have to pick up the phone to speak to me; they can just send me a message to say, "Can you see my consultation from today?", or vice versa. That really helps.

Information sharing is probably one of the most complex and challenging things we come across. In my various safeguarding roles, it is probably the thing I am asked about the most and that clinicians struggle with. We provide a confidential health service. The whole point is that you can go and see a doctor and your information is confidential. The other partner we do not often talk about in this scenario is the general public. Understanding among the general public about why professionals have to share information, or need to share information, particularly at an early stage, is something we all need to work on. Shared understanding, not just within our professions but across the general public about why that is important for children and their well-being, is one of the key things. There are some key public health messages around that. Breaking down barriers around what social care does and what it is there for, which is to support families who are struggling, is really important as well.

Professionals, too, need reassurance that information sharing is okay. As you probably know, we are bound by the General Medical Council guidelines. They are good robust guidelines around information sharing for child protection and child safeguarding, but there is a lot of fear sometimes with professionals that they might be sharing information in the wrong way, particularly when it does not meet the threshold. When it meets a high threshold, that is fine and everybody is fairly comfortable, but it is at the lower level. We are starting to get a lot of pushback from patients as well: "Why have you shared my information?", and, "You don't have the right to do that". We are getting it from both sides.

The other thing for us in primary care in England is that patients can access their online medical record, which obviously has lots of benefits for lots of patients, but from a safeguarding point of view it is incredibly challenging, particularly when it comes to things like documenting domestic abuse. We have to be really careful how we document domestic abuse in a child's record, for example, because if the parent who is the alleged perpetrator of the domestic abuse inadvertently sees that disclosure, it puts the victim at significantly higher risk of harm. The IT systems we have do not have security in how we document things, so that is another real challenge for us, particularly in primary care.

Dr Alison Steele: Information sharing is key. There is a strong public interest in confidentiality, but that is not about secrecy; it is about respect for people's information. Although there is guidance about information sharing, I think it could be clearer for professionals. I also think there is something about informing and having a dialogue, and having a discussion, including the general public and children and young people, about why we want to share their information and when we would share it. We would let them know that we were sharing it and for what purpose. I think there is something about advocating to the general public, including children and young people, that what we are about and what we are doing is actually for their benefit and for their welfare, and to somehow make it less stigmatising, because there is still a stigma associated with needing help and having a social worker. There is a lot of public messaging that could be done that would then make it easier for health professionals when they start discussing appropriate referrals for additional help and support.

Q45 **Lord Bichard:** Thank you. Can I roll up two questions in one? In March, the Government announced an expansion of mental health teams in schools, increasing them from 59 to 400 by 2023, and these teams are to support 3 million young people. If my maths is right, I think each team will support something like 7,500 young people, and provide support and training for schools, colleges, parents and teachers. In relation to that announcement, is it a sufficient response from government? Will it meet the needs of children who do not reach the threshold for statutory support? Is there sufficient professional resource available to achieve the target?

Coupled with that is the second part of the question. The Government also committed to expand statutory mental health services to reach 345,000 more children by 2024. These are the same questions really. Is that an adequate and sufficient response to the problems we are seeing? Are there sufficient professional resources available to deliver the target? Are you optimistic that it will be delivered, Dr Steele?

Dr Alison Steele: Any additional resource is obviously very welcome. I do not know whether it will be enough, to be quite honest with you, because that additional resource for schools needs to do a number of things. It depends on what you prioritise. Are you prioritising upskilling teachers? Are you providing individual work for children and young people? In a way, it would be better to do a needs assessment and try to assess exactly how many mental health workers are needed per head of school population. That will vary, I suspect, according to levels of deprivation. I do not know how it has been arrived at, but I suspect that you actually need to look at the needs of each population of children and young people in school and ask what the additional support needs to do in order to mitigate the mental health issues that are emerging. They were emerging before Covid and are particularly prevalent now. Obviously, increasing numbers of children and young people are in difficulties for a number of reasons. I am not certain that it will meet that, but I do not have enough data to make any statements about it.

What I would say is that to increase mental health support you have to have the resource of skilled workers, and it takes some time to increase the workforce. With anything that means additional resource and additional clinicians, there will obviously have to be a time lag because you cannot just produce them. They have to be skilled and trained. You need a plan that goes over a number of years. It is very difficult to put in increased resource immediately. You would have to take it from somewhere else and it will take several years to train staff sufficiently to provide that resource. Those would be my only comments.

Lord Bichard: Dr Steele, in your world is there a shortage of those staff at the moment? Are they difficult to recruit? Are they difficult to recruit in certain parts of the country? What is the situation?

Dr Alison Steele: I am in the Royal College of Paediatrics and Child Health. I am not a child psychiatrist or psychologist. What I know from a paediatric perspective is that there are often quite long waiting lists for CAMHS, and there are sometimes really difficult resource and threshold criteria. There are a lot of children and young people who might not have a formal mental illness but have issues with emotional well-being. That is softer and more nuanced, and we need a multidisciplinary approach. It is not always a purely mental health approach that is required. I am worried about the large numbers of children who are in difficulty emotionally but may not have a formally diagnosed or treatable mental health disorder. It is how you approach that. A joined-up approach for that is also very important—not just CAMHS going in, but thinking about a joined-up approach for social care with education.

Dr Joy Shacklock: From our perspective in primary care, there are massive mental health needs in young people that are far greater than anybody might necessarily know, and we are seeing that increasingly. We see it increasingly in younger children, as young as six or seven. We have parents ringing us saying that their children are talking about killing themselves at the age of six and seven. I agree with Dr Steele that any increased resource is absolutely welcome; there is no doubt about that at all. I equally echo what she said about it taking time to build up expertise. It does not happen overnight. There is no way of knowing whether that will meet the need, because there is huge need.

One of the things that we struggle with in primary care, and that we see a lot, is services putting boxes around themselves; you have to fit into a certain box to access that service. Eating disorder, for example, is often a good one. Your BMI has to be below a certain level before you are accepted. We see that with CAMHS. CAMHS works really hard and is overwhelmed. It works all the time, but there are not enough of them, so it has to put thresholds for which children it sees. From our perspective, children we refer do not meet the CAMHS threshold. Historically, school nurses would often have picked up some of the work around emotional well-being. They still do a lot of that, but there are not enough of them either.

Mental health input to schools is very welcome, but I find that some of the young people I work with do not want it in school. They do not want to be seen to be accessing help in school. If it was a more universal service in school, perhaps it would be different, but a lot of young people do not want to be seen accessing mental health support in school. That is another stigma and barrier that we need to get across. It is not just help for the young people; it is help for the parents as well because they come as a unit.

If you have a six year-old, for example, who is telling their mum that they want to kill themselves, that parent needs a huge amount of support to manage that day to day. If that young child is saying the same thing to teachers at school, those teachers need appropriate support and resource to support them to look after that child as well. It is not just about support for the child. As Dr Steele said, it is often a multidisciplinary approach. Parents are often the ones who need the support as well, to be able to support their child or young person.

Lord Bichard: Thank you. Chair, I was going to ask a question about information, but our witnesses helpfully covered that in the last question. To help you with time, I will not. Thank you very much.

The Chair: Thanks very much indeed, Mike. Lord Davies of Gower has his hand up.

Q46 **Lord Davies of Gower:** Thank you very much indeed, Chair. I cannot let the moment pass without asking Dr Shacklock why she thinks that six year-olds suddenly believe that they want to kill themselves. What brought that about? It is news to me. Why has it come about?

Dr Joy Shacklock: I think it is a variety of things; there is no one thing. With the children we are seeing, it is not that we are aware that there is domestic abuse or abuse going on in the family, for example, but it is always something that we have to think about, or whether it is what they are experiencing in school in friendships, or whether it is just that young people are much more aware of their emotional well-being. Thankfully, we talk about mental health a lot more, and schools talk about mental health a lot more, but it is desperately sad to hear anybody, particularly children and young children, use those words. I could not say that they all have this problem or that problem. It is just something that we hear. Whether it is peer pressure or whether it is what they are watching, who knows? It could be a number of different factors. It is desperately sad.

Lord Davies of Gower: I do not want to dwell on this, but do social media play a big part?

Dr Joy Shacklock: I am sure social media play a part in it. Perhaps younger children are unable to verbalise that as well as teenagers are able to verbalise it. We know that social media puts a lot of pressure on young people. You do not even have to know a lot about social media to know that it is there 24/7 for young people. Particularly when there is cyberbullying or name-calling or children being unkind, however you want to frame that, it can go on 24/7 once you are out of school as well, and that can have an impact on young people and children's well-being.

The Chair: Can I bring in Lord Filkin to ask his question?

Q47 **Lord Filkin:** Thank you, Chair. Good afternoon—and thank you for your time—to both our witnesses.

We recently were told by the Department for Education that the Government did not have an overall strategy for vulnerable children. Does that matter, and, if so, why? Dr Shacklock, would you like to start?

Dr Joy Shacklock: I think children and young people have to be central to everything we do. Whatever policy it is, be it mental health or physical health, children and young people have to be the focus, because if we get it right with children and young people, we are much more likely to have better outcomes. You may have heard the term ACEs—adverse childhood experiences. We know that if children experience multiple ACEs, such as abuse, death of a parent or a parent in prison, it has a massive impact on their physical and mental health longer term. They are more likely to have cancer. They are more likely to die young. They are more likely to have heart disease.

The impact of childhood adversity is huge. The problem comes when you talk about who is vulnerable. Children and families are vulnerable in different ways. There are those who might seem obviously vulnerable; for example, a refugee family, new to the UK, will have a number of vulnerabilities that might be picked up straightaway, but other families will not seem so vulnerable. I work in a quite affluent area. One of the groups of children who are often not seen are children of affluent parents, and where there is domestic abuse or substance abuse—

Lord Filkin: The question is about an overall strategy. Does it matter that there is no overall strategy?

Dr Joy Shacklock: I think it does matter that there is no overall strategy. There should be an overall strategy, but it has to take into account the different types of vulnerability, because no one size fits all. There are general things such as childhood poverty. That is a key thing that has to be addressed. There are some larger social things and then it comes down to services.

Lord Filkin: Thank you very much indeed. Could I ask Dr Steele the same question?

Dr Alison Steele: Yes, I think it matters. The RCPCH is clear that we need an overall, overarching cross-departmental child health and well-being strategy, and that part of that child health and well-being strategy would be looking at vulnerable children. We think that vulnerable children should be part of an overarching strategy for children. That is partly because, if you have an overarching strategy that looks at how all your policies impact on children and young people, you can look at prevention issues—we want to prevent children becoming vulnerable—and it will also target those who are not known to be vulnerable. They are a key group, and we worry about them because we have not recognised them yet as vulnerable.

We should have, and the RCPCH advocates, an overarching child health and well-being strategy that would include vulnerable children. We also advocate a lead for child health in the new ICSs. We want a champion, an advocate, for children and young people's health and well-being in the proposed new integrated care systems.

Lord Filkin: Thank you; that is very helpful. Staying with the same question about a strategy for vulnerable children, is there shared understanding and consensus about what the key element for a strategy would be? For example, there could be a shared view of what the priorities are, a shared view about the role of early intervention, and a shared view about the priority outcomes. Dr Steele, would you like to kick off?

Dr Alison Steele: There probably is agreement about what is classed as vulnerable and about priorities. A lot of work has been done by various bodies, including the Children's Commissioner for England, on which groups of children and young people are vulnerable, and I do not think there is any dissent from that.

It is quite important that we look at the social determinants of vulnerability, as well as how we respond once vulnerability is determined. There is a huge overlap between child poverty and vulnerability; it is not absolutely equal because there is an overlap, and it causes huge stress for families. We need to look at issues around children in need, children looked after, children with plans, children in families with domestic violence or mental health or drug misuse problems, and young carers.

There are large groups of children and young people who I think we would all agree are vulnerable. There is shared understanding of what we mean by vulnerability, but we need to concentrate on prevention and mitigation as well. We can address the vulnerability, but we need to think about how we prevent them becoming vulnerable and how we mitigate that, because, whatever we put in, it will probably very rarely completely take away all vulnerabilities. There may be some vulnerability left; therefore we need to mitigate and build resilience. That is really important as well.

Q48 **Lord Filkin:** Thank you very much indeed. Could I turn to a more specific couple of questions? First, how effectively has the Supporting Families programme worked with the NHS? Secondly, Andrea Leadsom's committee recently suggested that family hubs were perhaps the best model to address the root causes of child vulnerability. I am putting two questions together because of time. Dr Shacklock, would you like to have a go at either of those or both of them?

Dr Joy Shacklock: On the Supporting Families programme, we often do not know in health that a family may be having that sort of intervention. We often do not know when social care is involved with a family, for example. GPs across the country tell me that they do not always know that a child protection process is going on for a family, never mind any of the lower strategies. I do not think that I can say whether it worked or not because often, as health, we were not necessarily involved.

I think family hubs are one solution. No one thing will suit everybody; that is very clear. Having a universal service is really important, so that there is no stigma attached to visiting your GP or your health visitor, for example. With family hubs, you have health visitors and social workers. Domestic abuse advisers would be amazing professionals to have in those family hubs, along with benefits advisers and housing officers, because there is a huge amount of stress on families who are homeless or in temporary accommodation.

I can certainly see merit in a family hub that is like a one-stop shop. If you need help from a health visitor that day, that is what you can get. If you need help from a benefit adviser, that is what you can get that day. They will not meet everyone’s needs. There are questions, particularly around older children, as to whether parents of teenagers would be able to get the same resource to help them as a family with a one year-old.

Dr Alison Steele: It is very interesting because I do not think health always realises that what is happening is a Supporting Families programme. We might refer people to social care for early intervention or help, but we would not know that they tick the criteria for the Supporting Families programme. I think there are six criteria, of which you have to meet two. I do not think, from a health point of view, that we would understand that that is what was happening. We would understand what services were available, but most people in health would not know that they were necessarily under that umbrella. Strategic leaders in a locality might be aware that that was how such services were being delivered. What most health professionals need is access and pathways to support families, whichever programme is being put in to do that.

Like Dr Shacklock, I think family hubs are a really good idea, but they are only one of a range of measures that need to be put in place. I am aware that some of the original Sure Start centres have become family hubs, and that a pilot model for family hubs will be put in place shortly. I think they are a very good idea. The family hubs will be important in concentrating on the early years, from conception to two, but we also have to think about older children, because children and young people can become vulnerable at any age. They need to be one part of an overarching programme of early intervention, help and support for families of children and young people.

Lord Filkin: Can I ask for a bit more detail on the family hubs? We all tend to seize on a new idea, particularly when somebody says it is going to crack it. What else do you think, being specific, ought to be done as well as family hubs on delivery systems?

Dr Alison Steele: We need adequate resources. There is something about organisation and actually getting the best value for the resource that you have. There is a lot that is important around communication and information sharing, but you need a workforce on the ground to support and help as well. You need enough health visitors, enough youth workers and emotional support for teenagers. It is a combination of organisation and resource.

Lord Filkin: Thank you very much indeed. That is very helpful. Chair, back to you. Thank you.

The Chair: Thank you very much and thank you to our two witnesses for that. Can I now turn to Lord Davies?

Q49 **Lord Davies of Gower:** Thanks very much, Chair. We understand from the Government that their new NHS Bill will improve health and social care through better integration of services and prevention. From what you know of the new NHS Bill, do you agree that it will facilitate greater integration of services around the needs of vulnerable children and encourage the commissioning of early intervention services? From what you know of the Bill, is there anything more that can be done to strengthen it?

Dr Alison Steele: Should I go first?

Lord Davies of Gower: Please do, Dr Steele.

Dr Alison Steele: I am not hugely knowledgeable about the Bill, but I think that integrated care systems are definitely the way forward. They need appropriate resource. They need appropriate information sharing within them. I am very keen, and the RCPCH feels that it is crucial, that within the integrated care systems there is a lead for children and young people so that they do not get lost. My experience is often that when children and young people’s services compete with adult services, because of the greater numbers of adults and because of issues around older adults maybe with disability, children and young people can get left out. It is crucial that there is someone co-ordinating the children and young people part of that workstream.

Lord Davies of Gower: That is a very interesting point. Dr Shacklock, would you like to come in?

Dr Joy Shacklock: Thank you, Lord Davies. Like Dr Steele, I am not hugely knowledgeable on the NHS Bill either, I am afraid. Integration of services sounds like a good idea in theory. However, I wonder how that would happen when lots of health services are not integrated, never mind integrating them with social care, which is a whole other profession. Given that we do not have the IT systems, for example, to support good information sharing and linked up systems within health at present, I see quite a lot of challenges that would come from that.

What we know about both vulnerable children and families and adults is that when services work together you get the best outcomes. We know that. It works when everybody works together, and families are confident that health professionals are working together for the best outcome. Integrating services and sharing information will help with that. However, I think there are huge challenges about how it will happen.

Lord Davies of Gower: The Royal College of Paediatrics, in its written evidence, stated that, if early intervention services were able to access vulnerable children's NHS numbers as unique identifiers, they would be able to better target their support. What are the barriers preventing the NHS showing this data and what can be done to overcome them? Perhaps Dr Steele would like to answer that.

Dr Alison Steele: I am not sure what the barriers are. We will have to get back to you on that if you do not mind. There should not be a barrier to being able to share an NHS unique identifier, but I am not sure why we are not doing it already. It would be a unique identifier for education, for social care, and for other services. I do not know what the barrier is. I do not know why we are not doing it already. Sorry.

Lord Davies of Gower: No, do not apologise. It is an interesting question, and we really need to know the answer in the long term. Dr Shacklock, do you have a view on this at all?

Dr Joy Shacklock: I think the services have just been really separate. Historically, education is separate from health, separate from police, separate from social care, and everybody has their separate numbers. Even within health, each hospital has its own hospital number for patients. The NHS number should run throughout, but my two local hospitals have a different number for the same patient, if that makes sense. There is something about streamlining in health, first of all, and making sure that the NHS number is used across health. I suspect it is just a historical thing that sharing the same number across services has never been considered before.

Lord Davies of Gower: That is interesting because of all the evidence we have been getting. We have heard from a few NHS professionals, and they have come to realise that there is limited awareness of their responsibility to share data when they can on vulnerable children.

Dr Joy Shacklock: I suppose it depends on what you are talking about. If you are talking about sharing NHS numbers, that is one issue that potentially could be used. On sharing data, I know that—

Lord Davies of Gower: Yes, data really.

Dr Joy Shacklock: There is one thing about sharing anonymised data, so that local services can have an understanding about how much knife crime there is in their area among young people, for example. The sharing of anonymised data can be much more straightforward. When you are sharing personal data, it becomes much trickier. If we go by our GMC guidelines, for example, we talk about implicit and explicit consent about information sharing.

Implicit consent would be that if I was referring a child to my local paediatrician, for example, I would not ask for consent to share that information because it would be implied that I would share information about that child with the paediatrician. However, I would have to seek explicit consent from the family to share information with social care, for example, unless it met the threshold for child protection. I would have to seek explicit consent to speak to the school, or to share information with the police, unless we were talking about those higher thresholds.

GDPR has caused all sorts of confusion among front-line professionals across all services. People are afraid of it. Although there is a lot in the guidance about how you can share information, and that it is not a barrier to information sharing, and we teach that—that is what we try to get across—professionals are still afraid of doing the wrong thing, and feeling that they might be sharing information illegally, with the repercussions from that. There is something around increasing confidence that the law is not a barrier to information sharing and sharing of that data.

Lord Davies of Gower: That is very helpful. Dr Steele, do you have anything to add?

Dr Alison Steele: I wonder whether there should be something more explicit about information sharing when you first see a young person or child. Certainly, when you go to CAMHS, there is almost a consent to say, "We cannot deal with this situation. We cannot assess or treat your child or young person without some sharing of information. So we will need to talk to your school. We will need to talk your GP. We might need to talk to your paediatrician. We might need to talk to your youth worker".

I wonder if there could be something up front about why we need to share information and what we are doing with it. No one likes to feel that they are being talked about behind their back. That is a natural human response. We need to think how we would feel if information about our children or our grandchildren was being shared. If we can understand why it is being shared, there will not be so many issues, I hope.

Lord Davies of Gower: Thank you very much indeed. Chair, over to you.

The Chair: Thank you. A host of my colleagues want to come in. First is Lord Hunt.

Q50 **Lord Hunt of Kings Heath:** Thank you, Chair. It has been a fascinating session. As the GMC has been mentioned a number of times, I should declare my interest as a board member of the GMC, although clearly not speaking on its behalf.

Integration is the buzzword. It has been around for years and years, but in all the evidence we have had in this inquiry, although lots of people mention integration, they never say what they mean by it. Could you give me a flavour of what we should be seeking to do? What lies behind this magic word? Dr Steele, would you have a go at that?

Dr Alison Steele: I think it is really important. It is much more difficult to operationalise than to strategise about. There are a number of things. I think collocation helps. Without a doubt, if you have services that are collocated in the same place geographically, your threshold for discussing things with a person absolutely goes down. I am not saying that it would be in the corridor, but in a coffee room or just going to see them because their office is around the corner. There is more we can do by actually meeting—multidisciplinary meetings—so that everybody sits down together, and that might include the child or young person and the family as well, and we can look at more joined-up services.

I chair a lot of clinical meetings with Great Ormond Street Hospital staff and local staff, and maybe general practice as well. To me, that is integration, because sending copy letters to each other or seeing something on a system is just not the same. Professionals have to talk to each other to exchange ideas and ask questions so that they can get a really good understanding of what the issues are for the child or young person and family, and do that with the child or young person and family. We need to include them.

An integrated service is one where you facilitate professionals talking to each other, discussing, planning, thinking about what actions we need to take—six points to an action plan. What can we do in this locality to help this child or young person to become less vulnerable and more resilient? It is about practical solutions and knowing the locality you are in, because different localities have different services. They should have the same principles, but localities will differ and there will be different services wherever you go.

Lord Hunt of Kings Heath: Dr Shacklock, do you agree? If you do, what is stopping it happening? Why do local professionals across the different agencies not just get on and do it? What are the obstacles?

Dr Joy Shacklock: Time is our biggest obstacle. I completely agree with everything that Dr Steele said about collocation of services. When health visitors used to hold their clinics in our surgery, for example, you could just pop across the corridor when they were holding a clinic: "This family is coming in. Can we have a chat and catch up? How can we support this family?" Collocation is really important, but the pressures on front-line staff have become so immense that for me as a front-line GP to take an hour out frequently to attend meetings is just not possible because of the limitations of time and the demands. It comes back to the question about resource.

It is the same for health visitors and school nurses. When we used to have MDT meetings, where the health visitors knew the families, it was incredibly helpful, but their service has become so small now that there are not enough of them. They do not have time to go to every GP surgery once a month for a meeting of an hour or an hour and a half. All of these things are great in theory, but the reality is that we do not have the resource to be able to give the time to them.

The Chair: Thank you both. I will try to bring in several colleagues quickly. Lord Hogan-Howe first, then Baroness Pitkeathley and Lord Young.

Q51 **Lord Hogan-Howe:** Thank you, Chair. This is a question for Dr Shacklock. You said that people are frightened about making the wrong decision about data sharing. You have articulated best what we have heard intimated before. As a practitioner yourself, what do you think at the moment is the defence that is best available to professionals such as you for making the wrong decision about data sharing? What would you be able to rely on in law as a good defence? Do you know?

Dr Joy Shacklock: The GMC guidance is very clear. If you share in good faith that you are concerned about a family and share a proportionate amount of information with the right person, even if it turns out not to be abuse, for example, you will still be justified in sharing that information. The GMC has good guidance around that.

One of the difficulties we have, particularly in primary care, is not just about sharing information about the child; we hold information about the parents, which is where it gets particularly tricky. Sharing information about a child is one thing, but often it is the information about the parents that is the most relevant—for example, the information we hold about mental health, or a history of violence or domestic abuse. That can be more difficult. The GMC has some clear guidance around that, which would justify you sharing that information.

Lord Hogan-Howe: Thank you. Chair, it might be worth our finding out a bit more about that advice and whether it is based on the Information Commissioner’s advice or not. Thank you.

The Chair: Okay. I will bring in Baroness Pitkeathley.

Q52 **Baroness Pitkeathley:** I want to take Dr Steele back to something that she said about people not wanting information to be shared. In all my dealings with families and patients over the years, I found quite the opposite to be true. The patients are always mystified that social care does not know what health knows, what education knows and so on, and always assume that professionals, in fact, do talk to each other and share that information. Is that experience very different from the one that you have had, Dr Steele?

Dr Alison Steele: I do not think so, Baroness. The issue is that in that situation professionals were already involved. If families know that professionals are already involved and engaged, they expect them to be sharing information, although sometimes they do not allow that. I have had social workers say that they cannot share information with health because it is a child-in-need plan and the parent does not want them sharing information. Generally speaking, families want information shared, because they want a good joined-up service.

The problem probably comes before other professionals are involved. It is about the level before you get to the threshold where multiple professionals are involved. People are worried about what will happen with their information, what others will think about them and what they will do with that information. Obviously, some of it is very sensitive. Do you want your child's schoolteacher to know that you have a depressive illness? You need to be reassured that they will deal with that confidentially and in a supportive fashion. Those sorts of things are worries for parents. I do not know whether Dr Shacklock would agree, but I think there are some situations in which families are concerned about their information and reticent to share it.

Baroness Pitkeathley: Thank you.

The Chair: Can I bring in Lord Young?

Q53 **Lord Young of Cookham:** Thank you very much, Hilary. I want to go back to a question that Lord Bichard asked right at the beginning about whether we have the legal framework or the guidance right. He asked that question in connection with parental consent, but it has just arisen again when Dr Shacklock said that she could not share information. Do we have the legal framework right? Going back to what Lord Bichard said, is it inhibiting the sharing of information in the interests of your patients?

Dr Joy Shacklock: I think the law and the guidance are very clear when there are very clear safeguarding concerns, but what we struggle with is when we do not know. We might have a pattern that we often see in health. One of the things that we have been looking at over the past few years is children not being brought to appointments, for example, so we have changed the language. We do not say children DNA'd—did not attend—an appointment. Children have to be brought to appointments, and sometimes we pick up a pattern of children not being brought to appointments. There might be a mild mental health issue with one of the parents and you start to have some worries, but you do not know. It does not reach a threshold for safeguarding, but you would like to know whether, for example, education or social care or police hold any information. Police hold sometimes fascinating information, particularly around domestic abuse, that primary care and health do not know.

The process is almost the wrong way round. Professionals should be allowed to share minor concerns to get information from other agencies, so that we can decide whether there is an actual concern or not, rather than having to wait until there is a certain threshold, and only then will social care ask other agencies. We do not have that enablement. I do not think agencies have that enablement at the lower level when you just have a few concerns and you do not know whether there is anything worse than that or not.

The Chair: Thank you enormously. As you can tell, all the committee would like to have continued to question you, but unfortunately we are out of time, and you have already been exceptionally generous with your time. If there is anything you think we have missed and if there is anything you have supplementary information on, please write to us. We are always interested in making sure that we establish a good relationship with you and that you feel you can add to any information that you have given us today. Thank you very much indeed. I now formally suspend this meeting.