HOUSE OF LORDS

Public Services Committee

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

Wednesday 21 July 2021

3.55 pm

Watch the meeting

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

Evidence Session No. 28 Virtual Proceeding Questions 223 - 230

Witnesses

I: Professor Simon Kenny, National Clinical Director for Children and Young People, NHS England; Ade Adetosoye OBE, Solace spokesperson for children and families, and Chief Executive, London Borough of Bromley; Jon Rouse, City Director, Stoke-on-Trent City Council.

Examination of witnesses

Professor Simon Kenny, Ade Adetosoye OBE and Jon Rouse.

The Chair: Good afternoon and welcome to this second public session of today's Public Services Committee in the House of Lords. We have three witnesses. We have asked them to come to think with us about the integration of different services, particularly at local level.

From NHS England, we have Professor Simon Kenny, who is national clinical director for children and young people. Ade Adetosoye OBE is here as the Solace spokesperson for children and families. He is also chief executive of the London Borough of Bromley. Jon Rouse is city director at Stoke-on-Trent City Council. Jon, I suspect we will talk to you a fair deal about your time at Greater Manchester.

Welcome to all of you. I have certainly worked with Solace and NHS England before. I used to know Stoke very well when I was Local Government Minister, so I think I have a little bit of knowledge of the context you are coming from. We are very pleased to welcome you this afternoon. The first of the questioners from the committee is Lord Davies.

Q223 **Lord Davies of Gower:** Thank you very much indeed, Hilary. Good afternoon, and a warm welcome to the panel. We have heard an awful lot about barriers to collaboration between organisations. What do you think are the main barriers to collaboration between the National Health Service and local authority services in supporting children in families where domestic violence, mental ill-health and addictions are present?

Professor Simon Kenny: Thank you for inviting me to give evidence this afternoon. I could go on for a long time about this, but I will try to keep it brief. There are barriers from a legislative angle and a data-sharing angle, and there are cultural barriers as well. To a certain extent, it is getting an interface between a national organisation, albeit one that is regionally delivered, and local authorities. Wherever you have organisations that are separate and coming together, that is usually where the gaps can occur. That is where the main risks are. Is there any particular area you want me to drill into under that?

Lord Davies of Gower: Perhaps you could give us some examples of local areas that have been able to overcome the barriers that you may have knowledge of.

Professor Simon Kenny: Culturally, there are huge numbers of areas that are overcoming the barriers. If I think back over my career, there has been a huge improvement in how agencies work together over the last 20 years. In most areas now there is a multiagency safeguarding hub in place, which allows children who are on protection registers to be identified when there are safeguarding concerns.

I cannot point to a particular area because I think all areas are really close to getting that. Obviously, there is variation in how those are delivered and how effective they are. The areas where we struggle are in

the legal framework and the data. I am sure we will come on to this. It is how we identify children before they get on to those registers and how we identify families where we know there is risk. At the moment, it is largely dependent on human relationships and interactions. It is staff from different agencies sharing information about families. That definitely happens. Could I provide you with assurance that that happens right across the country? No, I cannot, but we are certainly a lot better than we were 20 years ago.

Lord Davies of Gower: Thank you. That is helpful. Would you like to go next, Mr Rouse?

Jon Rouse: Good afternoon, everybody. Thank you again for the opportunity to provide evidence to you as a committee. I want to make one slightly tangential observation very quickly, and then answer your question directly.

The observation is that just limiting this to the NHS and local authorities is problematic in itself. The best partnerships in the country actually do it on a wider, multiagency basis. On the commissioning side, that would definitely need to include the role of the office of the police and crime commissioner. On the provider side, it would certainly need to include the voluntary and community sector, and schools. I am sure we will come to some of those things later.

Setting that aside and answering your question directly, I think there are five main barriers. Simon Kenny identified at least two, so we have a bit of duplication, which is probably a good thing, in that we recognise the same things.

The first barrier is that differences in operational geographies still get in the way. There is lack of contiguity. It is no coincidence that some of the areas I admire the most have contiguous boundaries for the organisations, the NHS and local government. The second is how funding flows down from national government. There are different rules and different criteria. Trying to make those fit together at local level can be problematic and wearing at times.

Thirdly, and this really goes with the second one, there are different accountability frameworks. Often when local authorities, voluntary and community organisations and schools look horizontally, NHS colleagues are constantly looking vertically. They are looking up at what their regional office is telling them and what responsibilities they have under the national NHS plan. When push comes to shove, that tends to trump local objectives in my experience.

The fourth barrier is information sharing. I will not say any more about that because I think we will get on to it in more detail.

The fifth, which Simon also recognised, is professional cultures. They can be overcome but it needs a lot of hard work. It is about learning a new shared language and a strengths-based approach to the delivery of

services, breaking down professional silos. It goes right back to how staff are trained, with different pathways for nurses, therapists, social workers, et cetera.

The good news is that, while those barriers cannot be entirely removed, they can be largely overcome. There are some good practice examples. Since I got involved in this world back in 2008, I have seen many over the years. Leeds and its child-friendly city, Wigan, Salford, Oldham, and Highlands and Islands in Scotland have done some really interesting work.

What are the key ingredients? There are four. One is that organisations in those geographies have somehow collectively managed to protect or rebuild dedicated resources for family support. They do the early help and intervention part well. They have prioritised and protected it as best they can. The second is that they have an integrated model of support at the most local level, by which I mean the neighbourhood level, of 30,000 to 70,000 population, with integrated teams working directly with families across agencies. The third is that they have joined up their commissioning and have at least aligned the relevant budgets even if they have not pooled them. They are thinking of £1 for their geography: "It is a single pound and how do we now best spend it, regardless of which organisation holds it?"

The final thing is that they have tended to move away from a strict tiered provision of specialist services, where you have to prove how needy you are before you get through the door, to a model that is much more adaptive and flexible to the help families and children need at any given time, whether that is through the Thrive model or another variation. North Yorkshire's No Wrong Door would be an example. Those geographies have managed to break down the tiered gatekeeper system.

I am sorry that was quite a long answer, but I hope it covered your question.

Lord Davies of Gower: That was quite comprehensive. Thank you. Can I go to you please, Mr Adetosoye?

Ade Adetosoye: Thank you, Lord Davies, Baroness Armstrong and the committee, for inviting me to give evidence to you today. The real joy of coming third after Professor Kenny and Mr Rouse is that I can add key things that they have not mentioned.

The key barriers from my point of view are three key fundamental challenges. One is that the NHS and health partners are broadly focused on a medicalised model of care, based around symptoms as opposed to causes. One of the key consequences of that is that investment, in my view, is stuck at the acute end of the system, with little flow into prevention and help.

The second key point is what I see as the lack of joint commissioning between the NHS and local authorities. I see this as another barrier to effective support to families with DV, mental health and addiction.

The third, going back to what Professor Kenny and Mr Rouse said, relates to the cultural values of different organisations with different priorities, meaning that we all have different drivers pulling the two organisations in two different directions, with two sets of accountabilities and two different funding streams, overseen by two different central government departments working on different pieces of legislation.

Chair, I am sure you would believe that that is a recipe for confusion. What are the key things we can do to overcome those barriers? It is fair to say that nationally there are four key points. Years ago, the challenge between local government and the police in managing safeguarding led to the establishment of the multiagency safeguarding hubs—MASH. This was an opportunity for the police, the local authority and partners to collocate work on tackling the key fundamental issues affecting our families and children. For me, that is definitely a solution. We can even integrate further between local government and NHS colleagues.

The second thing, going back to what Mr Rouse said, is integrated delivery. In my own local authority, for example, as for three or four other chief executives I have spoken to, we are beginning to see the joint appointment of directors working across local government and with NHS colleagues. In my own local authority of Bromley, we have a joint director who is able to help us jointly in commissioning services for children across the three key themes that we are discussing today. I think that is one of the key solutions going forward.

The third thing is thinking about mental health. My take is that the pilot, which was way back in 2019 and allowed mental health support to be provided to children in schools and was funded by the NHS, is another way of breaking down the barriers that I have discussed.

The final point is on domestic violence, which you raised, Chair. One of the key issues is the IRIS model—identification and referral to improve safety—which we are beginning to see across London and in other local authorities, whereby GPs can talk about suspected abuse with their patients and can refer to the voluntary sector through Operation Encompass, which supports children in schools.

To conclude, I sincerely believe that there is a need for a comprehensive, all-age, multiagency prevention strategy that is fully funded, to enable our local authorities to really implement the evidence-based practice that we see across NHS practices and in local government in a disjointed manner. Thank you, Lord Davies, for asking the question.

Q224 **Lord Davies of Gower:** Thank you very much indeed for your comprehensive answer.

Professor Kenny, under the Government's current plans only 20% to 25% of schools will have access to mental health support teams by 2023.

What do you think the consequences of that will be?

Professor Simon Kenny: One thing about the long-term plan is that Covid has shown the wisdom of what was in the long-term plan. It has accelerated the need.

We have allocated £785 million to mental health programmes in schools, with plans to roll it out until 2023-24. We have accelerated that in response to Covid and the pressures that have emerged. We will have delivered the 22% to 23% figure that you referred to by 2022 and not 2023, so we are ahead of the programme that was set out before Covid hit. We completely recognise the need to do that.

It is a substantial investment and a cultural change right across NHS mental health services with schools. To put it into context, by the time it is completely delivered, there will be a workforce of about 8,000. The current existing workforce is 11,000, so it is increasing the workforce considerably. We are accelerating that. By the time we complete the existing part of the plan, in 2023, we will have coverage for 35%. I am sure you will agree that that is clearly not enough. Any further investment will require approvals in spending plans in the future.

The impact on that is that we are concerned about it, but there are other measures we have in place to try to mitigate the rollout of that plan. There is the Wellbeing for Education Return programme that we have put in place to help schools support children returning to the school environment. There is the Link programme between specialist mental health teams and local services, including schools. With local authorities, we are working to appoint school mental health leads and to support them. We are taking a number of different actions. There will probably still be a gap, but we are doing everything we can to roll out those programmes at speed.

Lord Davies of Gower: Thank you. Do the others have a view on that?

Ade Adetosoye: I echo what has been said. I have seen the real evidence and the real benefit of mental health support in schools. My own local authority was selected a couple of years ago as one of the pilots. I can see the real relevance of early intervention on needs in our schools. I sincerely welcome these as one of the long-lasting solutions to helping to break the barrier.

Lord Davies of Gower: Mr Rouse, do you have anything to add?

Jon Rouse: No. I echo exactly the comments that Mr Adetosoye has made. That is exactly my experience as well. All we can say is that the sooner this programme is universal across all schools, the better, while recognising the constraints that Mr Kenny set out with respect to the scale of the rollout. Where the programme is in place as an integral part of the early help offer in schools, it makes a major difference. This is a good programme.

Professor Simon Kenny: Could I add slightly to that? I think it echoes the need for the NHS to reorient from reaction to established conditions. Currently, we are seeing significant numbers of children with mental health problems in acute care settings. The investment will prevent that. It will mean that we have a population in future that has the resilience to cope with life.

Lord Davies of Gower: Thank you.

Q225 **Lord Filkin:** Welcome to the panel, and thank you for your time. That was a very positive start. It will be good to see if we can be as specific and clear about prescriptions for change in the next topic. It is one you know well. It has been a repeated theme of almost every inquiry we have held. People have said that information and data sharing is problematical and impedes good service outcomes. That seems to be particularly true for vulnerable children.

First of all, I would like to ask Simon Kenny if he would respond to the charge sheet that the NHS is particularly problematical on this, as we have seen in the note, and then ask Ade and Jon Rouse, and then perhaps Simon Kenny again, about your analysis of the nature of the problem of data sharing. What are your prescriptions? Do you think it will be relatively easy and inexpensive to fix?

That is the overall picture. Simon, you have seen the charge sheet. Could you give a non-defensive view of the extent to which there is something in NHS cultures and practices that impedes data sharing for vulnerable children?

Professor Simon Kenny: Certainly. Some of this is dependent on my clinical background as well. I am a paediatric surgeon by training. In the course of that I come into frequent need to work with safeguarding agencies and with children who have undergone non-accidental injury and abuse.

I have cross-checked with colleagues and with NHSX, which has done discovery work on this, and it is not something that we particularly recognise as the NHS by itself. Some of my defence—I am not being particularly defensive—is that we, as the NHS, have a legal requirement to share data, whereas in the local authority it is somewhat more conditional than that. I could be prosecuted if I did not share data.

Within the NHS, to try to encourage that, we have significant training programmes in place that are delivered through electronic health; 1.6 million staff have had level 1 training, and all volunteers, vaccinators, et cetera, have had that. Anybody involved with children where there is likely to be ongoing clinical contact has to undergo level 3 training. It is unequivocal in the training what the legal obligation is, and you are tested on it—the implication of the rulings in the Children Act and things like that.

From an NHS England organisational perspective, we strongly support and encourage information sharing. The personal perspective is that

sometimes that comes at a personal cost, because the training and recognition on how information can be shared and confidentiality is not always respected by other parties. I have had personal experience where I have shared information and concerns in good faith within part of a safeguarding process, and then that information has been shared with families. That has broken the therapeutic relationship. There are concerns about it both ways. That is my defence, without being too defensive.

Lord Filkin: I take the caution. You mention a very important one on inappropriate leakage and how you put your trust in another agency's wisdom in that respect. We had quite a bit of evidence that people found that many NHS trusts did not recognise their responsibilities clearly enough on this. You have clearly said that there is a legal duty and that you have a good training scheme, but it does not sound as if it is actually working in practice. Do we have any systematic evidence on that?

Professor Simon Kenny: It is one of the things the Care Quality Commission looks at when it inspects children's services. I get a lot of my assurance from that playing through.

From a national perspective, we are looking at how we can strengthen assurance on safeguarding. I would be very interested in hearing particular examples so that we can look at what we can do to improve training and awareness on that. I am probably lucky, in that personally I work in a specialist children's trust that clearly has an understanding of it. I suspect that some of the issues are in district general hospitals, where they do not necessarily have the cohort of staff to support them.

Q226 **Lord Filkin:** I am sure the office can share with you some of the evidence we have received. It is episodic, which is not a very good basis for making very deep judgments, but nevertheless let us do that.

Could I turn to Ade and then to Jon Rouse with a slightly wider question? It is again a question about data sharing and information sharing to improve the protection of vulnerable children. Do you think there is a data-sharing and information-sharing problem? If so, what is it? What would be your prescription? Should it be relatively inexpensive to fix?

Ade Adetosoye: I think local authorities and their NHS colleagues face a combination of challenges in collecting, sharing and interpreting data to identify vulnerable children. For Solace, I think it would be unfair to lay the blame at the feet of the NHS for being a weak link. However, in the same way that the transformation around data sharing, way back in 2004 by Lord Bichard, was a great milestone in providing clarity on data sharing in the police force at that critical time, there are four key things in local government that we also need to do and for central government to reflect on.

One of the key points is that the NHS has nationally funded systems in place that cover the whole of the country. However, within London alone we have 32 different systems. Would it not be great if, at strategic level,

we could agree to think about a long-lasting solution for a system that can actually work well with the NHS system? That is the first key thing.

The second, although I recognise that funding is perhaps going to be an issue, is what we can do to ensure that the key systems we have in local government talk to the NHS system. What are the key processes that we can put in place? It is fair to say that local authority leaders and their NHS colleagues have tried to address that in safeguarding. Earlier, I mentioned to the committee the work around safeguarding hubs, which again allow a protective shield for partner agencies, through the MASH, to be able to share data. That is a good step, but we need to do more.

The other third key area, with my thanks to NHS colleagues—this is a challenge back to local government, and I include my local authority—is that we need to make greater use of the NHS number as the unique identifier for vulnerability. Again, we have different systems in different local government areas and the NHS, whereby people communicate using different numbers. I think that is one of the key things that we need to address.

Going back to what Professor Kenny said, my take on this is that we need urgently to simplify data-sharing agreements between the NHS and councils. One of the key lessons for me, Chair, is that during the pandemic we made things work by sharing data in a very contained manner. We need to build on that and think about simplicity in data sharing.

Lord Filkin: That is what we picked up when we took earlier evidence on lessons from the pandemic. Certainly, people had not allowed the rulebook to get in the way of common sense or the urgency for action. What was being done was brilliant.

You have been specific about NHS numbers and the simplification of data-sharing agreements. What stops you doing that?

Ade Adetosoye: One of the key barriers, going through the example that was given, is that in the safeguarding hub, if I may use that, it is okay to have data sharing because we are working in the environment of a firewalled unit that allows the flow. The legislation itself, again without going into the actual detail, is not very clear. It is fair to say that colleagues are behind the legislation, but I think simplicity is required in setting out to different organisations what they can actually share.

During the pandemic, we were able to use council tax data to identify some of the families and residents we had to support. In the past, there would have been a draconian and very bureaucratic process to go through, but the simplicity that came from central government in allowing local authorities to step into that space is similar to what we need with regard to our children's safeguarding, whereby different organisations know that some of the information, going back to what Professor Kenny said, might still be shared in a spirit of partnership. Where you have issues of vulnerability and safeguarding, my take on this

to the committee is that we need a simple way for all the different agencies, be they NHS or local authority, easily to understand what is allowed.

There is always a danger with regard to the statutory powers, and rightly so, of the Information Commissioner. Quite a lot of emails and letters have been sent to me whereby people have actually refused because their own interpretation of that piece of legislation is wrong.

Lord Filkin: Clearly, the Information Commissioner—[*Inaudible.*]—effectively strong. We have had dialogue with the office. I am still struggling as to why Solace, the LGA and the NHS could not jointly sit down in a working group on this, or are you waiting for MHCLG and DHSC to do it for you?

Ade Adetosoye: It is a good challenge. It would be wrong for me to say that we have not been working together. One of the key examples, going back to the multiagency safeguarding hub, was Solace, the LGA and the police as partners finding a solution locally to address things. It goes beyond that as regards clarity around the legislation, which is not for local government to draft. It will be for central government to go through the relevant committees to simplify that. I just want to reassure you that on the ground colleagues are absolutely doing their best to work together. It goes back to what Mr Rouse said earlier; it is about individuals. Where we have seen real flagships in delivery, it is based on local partnership working between individuals.

Lord Filkin: Thank you very much. Jon Rouse, would you like to have a go at your analysis of the nature of the problem and what your prescription to sort it out would be?

Jon Rouse: I am going third this time, and I want to be clear that I agree with everything Mr Adetosoye said. I am building on what he said; I am not competing with it. I want to make some additional points that, hopefully, will be helpful.

The first is that I think you have to distinguish two different cohorts. There are those that fall within the legal definition of safeguarding in triggering the expectation of information sharing, and then the much broader cohort of vulnerable children. We still need to share information about those children if we are to have effective early intervention and support. I wanted to make that point first.

On the first cohort, certainly in my own geography, I would say that the provision of information, particularly through the work of the MASH is, for the most part, working well. I think what we probably crave is now a step up from information to knowledge. What we are trying to do through our front door programme is to generate higher-quality professional conversations, which are about getting to a much deeper understanding of the child much more quickly so that the right action and intervention can be taken.

One of the problems in the whole debate about information sharing is that throwing data and facts at each other is not sufficient. The real benefit comes in the depth of the conversation and achieving a depth of understanding around the needs of the child and interpreting that. That higher level of partnership is one that Professor Thorpe has written extensively about. He has helped many local authorities and partners implement that type of arrangement, including here in Stoke-on-Trent, for which we are very grateful.

Turning to the broader cohort that I was talking about, it can be done. I know it can be done because we did it in Greater Manchester. We did it for early years, working through Health Innovation Manchester, with its support, and the combined authority. We were able to bring different datasets together and enable professionals to have a single view. Certainly in my time there, we did not get the whole way. There were certain datasets that we would have liked to incorporate but we did not get to that point. The whole relationship with welfare and DWP is particularly problematic in data sharing, but we certainly made a lot of progress between local government, the NHS and the police with respect to building a more integrated model.

There are some key enablers. Getting the e-book online and available to all professionals is very important because that enables us to get the parental expression of what is going on into the mix, where that is relevant, appropriate and possible. Those are some additional observations on top of what Mr Adetosoye said. I particularly agree with him about the use of the NHS unique identifier as the common starting point.

Lord Filkin: Thank you. That was very helpful. You have answered the other question I was going to ask, which was about what we could learn from your GM experience.

Simon, could I come finally to you, having initially pinned you to the floor? Would you give your high-level reflections on how we can move towards some clear action to improve data and information sharing that will be a basis for knowledge development, as Jon signalled? What more do you think can be done from the NHS to help in that?

Professor Simon Kenny: I completely agree about the NHS number. In the last year, we have been able to join huge datasets. That has benefited children enormously by identifying who is clinically vulnerable.

I have a couple of points. One is recognising the vulnerable child and defining them so that everybody knows exactly what we are talking about with regard to that. It is up to 2 million children. It encompasses children who are clinically vulnerable as well as physically vulnerable. There is some sense of getting a definition of that.

The NHS number is a key, but it does not necessarily need to be the NHS number. Personally, I think it probably should be, but it is mandated just for use in health. If we look in areas such as education and start to link it

to education, there are some legal obstacles that need to be overcome. There needs to be a legal framework to enable it. At the moment, the way these interactions are being rolled out is at local level. There is a lot to be said for commending that, but I have concerns about consistency across the country and variation because of that—in particular, looking at vulnerable families such as travelling families who move between regions and how those children could be identified. If we think about what happens to those children as a use case—they have a lot of issues and impaired life opportunities—and how we could work across local authorities nationally on unique identifiers, I think it would be really helpful. They are in danger of getting left behind at times.

Those are my reflections. We need a clear definition of vulnerability and definitely a unique identifier.

Lord Filkin: Should that action be led by the NHS, local government and police working together, or are you waiting for central government to sort it out?

Professor Simon Kenny: The Department for Education is involved as well. It is not just local authorities. There are a number of stakeholders and, as Jon mentioned, they are quite large. I feel it is a combination of both.

One thing we have not touched in great detail is integrated care systems. As part of the long-term plan, we have just invested in the start of a leadership structure for local integrated care systems for children. One of the challenges we have is embedding the statutory responsibilities of clinical commissioning groups into integrated care systems. That is one of the things that they will be tasked with dealing with.

Is it the NHS's complete responsibility? No. Are we a major stakeholder? Yes. If we have to hold the ring, we will. At the moment, my understanding is that the Department for Education is holding the ring nationally.

Lord Filkin: Thank you. All three of you have been very helpful. It would be good, if you have the time, to send us a note about what you think would be the most helpful recommendation we could make in this respect, so that we know it is informed by your reflections and your experience. Thank you all very much.

Q227 **Lord Hunt of Kings Heath:** The Department for Education told us earlier in our inquiry that there was actually no integrated government strategy on vulnerable children. That has been confirmed by many witnesses since then. If we had one in place, what would be the key priorities? Do you agree with Andrea Leadsom's recent review? She gave evidence to us last week and was of the very strong view that family hubs should be at the centre of such a strategy. Mr Adetosoye, would you like to go first, please?

Ade Adetosoye: Thank you for your question, Lord Hunt. I agree with Ms Leadsom's recent review that there is a need to have a strategy in

place. Ms Leadsom articulated family hubs as a way forward, and I sincerely believe that an integrated family hub that is well resourced will help us to tackle some of the root causes that create vulnerabilities, including poverty in our own families. Secondly, I believe that a long-term strategy for children, clearly understood by different agencies, is a good way forward.

Thirdly, of course, any strategy should be able to build on the work that the Children's Commissioner is doing, and pick up on the key vulnerabilities of our children. I think that a strategy that is fully funded, well integrated and cuts across the different statutory partners is a good way forward. On the back of the pandemic, there is an opportunity for us as a society to be very ambitious for our families as we recover from the ongoing pandemic and begin to address the disparities that we see. I think it is a good idea, Lord Hunt.

Lord Hunt of Kings Heath: Thank you very much. Mr Rouse?

Jon Rouse: First of all, yes, there should be an integrated strategy for vulnerable children. I am sure about that. I think it would have a number of priorities. The obvious one would be continued improvement in keeping children safe. The second would be about ensuring that children get the best start in life. The third would be about the support that schools need. The fourth would be a focus on effective parenting, and the fifth would be around transition to adulthood and the needs of older young people. A strategy that covered those bases and pulled all the threads together across government would be a very worthwhile planning mechanism at national level.

With respect to Dame Andrea's review, I have to declare an interest. Stoke-on-Trent was a test bed for much of Andrea's thinking on the review. She spent time here talking to some of our families and community providers and to us as the local authority. That included testing her recommendations as well. You will not be surprised to hear that we are very supportive of the outcomes of the review and the recommendations, not just about family hubs but what she says more generally about universal-plus services and workforce development. We were very pleased to see the announcement a couple of weeks ago that there will be significant investment in the early years workforce over the next few years.

Within that, yes to family hubs and, yes, as Andrea conceives them. What we really like about Andrea's concept of family hubs is that they are not one size fits all. She is not predominantly interested in the building and what happens in the building. She sees them as being quite flexible and quite fluid. They can be adapted to the needs of the local geography. The focus is more on the team around the child and how they draw down peripatetic specialist services within a geography.

That all makes sense to me; but—it is a big but—there is not a snowball's chance in hell of Andrea's vision of that network being established without major investment by the Government. That means that there is a

spending review question with respect to the restoration of early help and intervention funding, not just with respect to babies, which is where Andrea's review is focused, but more generally around early help and support. We have to have a reset.

Lord Hunt of Kings Heath: Thank you. That is very much on a par with Mr Adetosoye's comments about funding. What do you think, Professor Kenny?

Professor Simon Kenny: I completely agree. It is slightly disappointing, because you would like to think that high-tech interventions in hospitals would improve children's life chances, but they do not. I think that is recognised in the long-term plan.

When we started on the programme, we commissioned an evidence review about which interventions would improve outcomes for children and whether there was an evidence base for that. Family hubs, or whatever you like to call them, were the only piece of evidence-based intervention that was shown to be effective. It is very clear that, if we get the early years opportunities right for children, we will end up with a healthier, wealthier population in 40 years' time and I will be out of a job. I will not have to do my job any more.

Q228 **Lord Hunt of Kings Heath:** I think that might take a little time. Professor Kenny, I want to pick you up on an issue that has come from witnesses. It is that the healthy life expectancy of vulnerable children has been reduced as a result of the pandemic. Do you think that the national plan for the NHS sufficiently recognises those challenges, or is it something that you would expect to see in a vulnerable children's strategy in the future?

Professor Simon Kenny: You absolutely have to take that into consideration in a vulnerable children's strategy. I think I have already said that this answer is not going to come from more hospitals, although there are things that can come from more hospitals.

Child mortality overall has been improving in the last 30 years, but when you look at us compared with the rest of Europe we have been falling behind, relatively. In fact, for the first time, in 2018-19, we started to see child mortality increase, which is of great concern. There is a slight ray of hope, but I think it is just temporary. In the last 12 months, child mortality overall has improved, mainly due to the complete absence of infectious diseases, but that might come back to bite us shortly. It has given us a breather.

I challenge your statement that these outcomes will definitely worsen. I think we have to watch that very carefully. We are monitoring it extremely carefully. Our role, to a certain extent, is to be the canary and to warn other agencies where we see trends. I think we have seen some of that in our response on mental health in schools. We had the signals very early on, and we were working with agencies right from the start to strengthen that.

Overall, the strategy for long-term planning in integrated care systems is strong. The area I am concerned about is health visiting and the ability to reach out into the community. The provision of health visiting has waxed and waned. One of the things I observe is that the number of health visitors has reduced over time. They are funded by the local authority. It is not an NHS responsibility, but a lot of their day-to-day work is supported by the NHS. In any strategy, I would like to see health visiting strengthened because it is such a valuable link and will work well with family hubs.

Lord Hunt of Kings Heath: Thanks. We will certainly pick that up. Mr Adetosoye, we have talked about a national government strategy. In its absence, is it possible for local agencies to develop their own integrated strategy?

Ade Adetosoye: It is indeed, and it is exactly what a number of key partners are doing. The example I keep going back to is the way that different organisations work together in creating multiagency safeguarding hubs. I think there is capacity, but one of the key things is that a strategy that is not funded is as bad as not having a strategy. I think that is where the key relevance of central government oversight comes in.

Of course, local partners will do whatever we need to do, but in the context of a reduction in public funding it will be very challenging. Anyone can put together a strategy and we can all agree as local partners, but the fundamental gap is the lack of resources to implement the key recommendations in any strategy.

Lord Hunt of Kings Heath: Thank you.

Lord Hogan-Howe: Perhaps I could follow on from what Lord Hunt has just been talking about and challenge Jon Rouse and Ade. I will stick with Jon to keep it quick.

As a chief executive, I was responsible for a large organisation and saying to the Government, "Well, unless you give me money, we are not doing it". Is that the only way that this type of preventive and collaborative work could be achieved? Is it about more money, or is it about prioritising within the organisations?

Jon Rouse: At the margins, yes, and we are doing that, certainly in Stoke-on-Trent where we have made a degree of reinvestment in those services. The reason why it is so difficult for geographies like Stoke-on-Trent and other areas, and why so much money is being lost from early intervention over the last decade, is because we have seen such an increase in the requirements in crisis care. There has been a substitution effect, which has been well documented.

Once you are in that spiral, it is very difficult to climb out. It is painstaking work when you still have to meet the statutory requirements with respect to your large cohort of children in care, your care leavers,

your children with statutory special needs and the wider cohort of children under child protection plans. That increasingly takes the vast majority of most local authorities' resources with respect to children's services. It then becomes very difficult to carve out dedicated resource for early help and to ensure that you are using it effectively. So I would say that at the margins, yes, but if we want a real national restatement of early help and intervention as a priority, it will require new investment.

Q229 **Lord Hogan-Howe:** Thank you for that. It was not intended, but it is a perfect link to my question.

Josh McAlister told us that spending on non-statutory family support services, particularly on substance misuse support, had decreased by 35% since 2012-13, while spending on statutory, high-need crisis intervention had increased by 26% over the same period. That is very strong evidence for what Jon has just said. Therefore, I think you would say it is a fair assessment. The important question is: what can be done to prioritise early intervention support for vulnerable children and their parents in NHS and local authority services? Jon has just given part of an answer on that. Professor Kenny, could I ask you for your answer?

Professor Simon Kenny: With integrated care systems we are trying to join up healthcare with everything else in order to identify the children and prioritise access. That is in our plan, so I hope that in the next five years we will have a very different conversation about that, because we will see that we have done it.

Lord Hogan-Howe: A fundamental problem, if it is true that it takes 10 years of investment to get a reduction in the problem, is how the organisation deals with the immediate need to fund it. That is the big question. How does the NHS approach that? It is fundamental to NHS work generally.

Professor Simon Kenny: Yes. That is why we have long-term plans. They allow you to stop being reactive and to start to be proactive. We see Jon's example all the time in various services. I talked rather flippantly about being out of a job in 40 years. That is fundamentally what we are talking about. If we get the investment right in these children, we will not have the need for so many alcohol-dependency, et cetera, units. It is putting investment into the right place. I am not sure that on a local authority basis they necessarily have the resource to do that. That is why a national strategy is needed.

Lord Hogan-Howe: Mr Adetosoye, what is your account of that, please?

Ade Adetosoye: Building on what Mr Rouse and Professor Kenny said, the point has been made about the need for additional funding, and I think it is fair to say that local authorities and partners will continue to work with the limited resources that we have.

There are three key things, thinking about the data. The children looked after in England report in March 2019, which is a document published by the Department for Education, said that we had about 98,150 children in

care compared to 49,000 in 1994. Secondly, the children in need census, which is available, focuses on the referrals coming to local government. Those have risen from about 550,000 in 2015 to 665,000.

The fundamental point, citing those two datasets, is that they focus on the high end of care. Mr Rouse mentioned children in care and children in need. The key priorities for local government are where we can spend the limited amount of money that we have. I think the stats speak for themselves in terms of the increase in the number of kids in care and the vulnerabilities we are dealing with.

On the second key point, which I sincerely believe must be addressed, you might recall that way back, Chair, in 2011-12, we had the early intervention grant—the EIG. To give you a real context for that, in local government we had an allocation of about £2.79 billion. Fast forward seven years down the line, and the same grant reduced to £1.02 billion in 2019-20. That is based on a House of Commons briefing paper on early intervention in July 2019.

With the limited resources of local government, the key question is who you prioritise. I would make the case that we have been prioritising, where possible, kids in care, children with special educational needs and children in need. At the same time, we have been doing our best to support our children through early intervention. That is one of the key fundamental issues that we must address.

Chair, you raised a key question earlier about what we actually see and how we can actually work together. There is an opportunity for your committee, in that Parliament is going through some of the key changes in funding. There is an opportunity, I would say, through the Health and Social Care Bill, which is making its way through Parliament. There is an opportunity when it comes to your committee to ask the fundamental question about the safeguarding responsibilities of CCGs, which should be part of the wider ICA structures. That is one of the key areas that will help us. We need to make sure that the processes are in place.

Q230 **Lord Hogan-Howe:** Thank you. We have about four minutes left, so I may have to cut short some of the questions. Professor Kenny, what evidence is there that low-quality housing is a major determinant of poor health outcomes for children? Are there examples of effective co-operation between NHS England and Public Health England to address low-quality housing?

Professor Simon Kenny: There is a significant body of evidence that associates low-quality housing with poor health outcomes, both mentally and physically. I will not go into too much detail about that. It is a bit difficult to dissect underneath that exactly what the determinants are, but one thing is air quality—in particular, external air pollution. That has both physical and mental effects.

At NIHR, we are looking at the impact of in-house, internal pollution. The kind of thing we are doing in integrated care systems is looking at

asthma reduction strategies. We are looking at planning applications with regard to building houses close to major roads, and at IT solutions, so that where we see evidence of high air pollution levels we can start to individually ping out to families to make sure that their children take their preventive medication.

I think the advice and support role of the NHS is growing. It is about how we work effectively with local authorities to make improvements in children's health through good housing and good planning.

Lord Hogan-Howe: You gave me some good examples of things that might have an effect. I realise, obviously, that the NHS does not actually build the houses. Other people do that. Do you have any examples of where that type of influence has already achieved an improvement in housing, which obviously may take a while to see some health benefits?

Professor Simon Kenny: In Liverpool, planning policies are influenced by child health. Asthma rates are significantly high there. They have worked with the NHS in starting to have a strategy around that.

Lord Hogan-Howe: My final question is for Jon Rouse. What evidence is there that a reduction in early intervention funding for local authorities has resulted in poorer outcomes for vulnerable children? You have all made the point in different ways that there has been a reduction in funding and a lower number of outcomes, but are the two definitely linked, or could those who defend themselves say it is coincidental?

Jon Rouse: There has been a lot of work on this, both nationally and in other countries, over many years. One of the best amalgamations of the evidence is from the Early Intervention Foundation. It estimates that the cost to the country of late intervention is about £17 billion a year, which makes the fiscal case for invest to save investment pretty well.

The relationship is complex and not linear. The fact that we have seen an increase in the number of children in crisis over the last decade, which is reflected in the number of children who have come into care and the number on child protection plans, is not all down to the reduction in early help and prevention services. There are other factors such as the impact of other aspects of austerity. There are broader societal issues as well, which we probably do not have time to get into, in the breakdown of wider family support and the strength of communities in the sense of the village raising the child. It is not just about the reduction in early help services, but there must be some correlation.

Lord Hogan-Howe: That has been really helpful. Thank you for that brevity.

The Chair: We have covered a lot today. Thank you, witnesses. I warned you that some of my colleagues would be coming in with things that you had not been warned about, but that is what we need to do. You have been very helpful to us. It has been very useful to engage with you this afternoon.

I reiterate what one of my colleagues said earlier. If there is anything that you think we have missed, or anything that you can add to what you have already said, please drop us a note. We would be really grateful for any additional evidence that we have not had time to cover in this session.

Thank you all enormously. I particularly thank you because it has been a warm day, and one that I am sure you could have enjoyed a little bit more in other ways. Thanks very much indeed for being with us. I now formally end this session.