HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Role of public services in addressing child vulnerability

Thursday 9 September 2021

3 pm

Watch the meeting

Members present: Lord Bichard (In the chair); Baroness Armstrong of Hill Top; Lord Bourne of Aberystwyth; Lord Davies of Gower; Baroness Pitkeathley; Baroness Wyld.

Evidence Session No. 32 Virtual Proceeding Questions 247 - 251

Witnesses

I: James Shutkever, Social Worker and Frontline Fellow, Hertfordshire County Council; Jacky Mulveen, Project Manager, WE:ARE; Lucy Newman, Associate Assistant Principal, London; Dr Helen Jones, GP in East London, NHS North East London Clinical Commissioning Group.

Examination of witnesses

James Shutkever, Jacky Mulveen, Lucy Newman and Dr Helen Jones.

Q247 **The Chair:** Welcome everyone to the 18th meeting of the House of Lords Public Services Committee. We have this afternoon two very different panels, who both bring really invaluable insights to the work we are doing looking at vulnerable children, the first panel being drawn from volunteers, NHS professionals and other front-line workers, who have a particular perspective that we want to hear. The second panel is a group of international experts, because we think it is very important to learn from what others are doing overseas. Thank you to everyone. Apologies from the usual Chair, who is somewhere between here and Newcastle, so I am chairing this afternoon. My name is Michael Bichard, if it has not come up on your screen.

Let us get straight on with the first panel. It has four people—James Shutkever, Jacky Mulveen, Lucy Newman and Helen Jones—and I will ask them when they make their first contribution if they would introduce themselves. It is much better that way.

The custom is that the Chair asks the first question, so perhaps I could do that. We have heard from a lot of sources that the number of children in families experiencing addiction, domestic abuse or mental health issues was pretty high before the pandemic and has now grown much higher. Is that your experience? Have you been able to keep up with the pace of demand? We are particularly interested in what changes you have made to cope with the unique pressures of the last 18 months, changes that perhaps you would like to see retained in the future. I do not mind who starts, but you are at the top of my list, James, so would you like to kick off and just introduce yourself, too?

James Shutkever: Good afternoon, everyone. I am a social worker in the Hertsmere 2 family safeguarding team at Hertfordshire children's services. I began my career in social work through the Frontline programme in 2018 and I have been practising post qualification now for two years.

In answer to the question, there are multiple aspects to this, the first point being the question of increasing demand. I know from speaking to my colleagues across different services and teams that there is a shared view that there has been an increase in the number of children accessing our services. I am in the somewhat fortunate position of having been in a team that had a number of vacancies at the start of the pandemic, when we saw a dip in referrals, and those vacancies were filled towards the latter end of the pandemic that we are at now, so my day-to-day case load has not necessarily changed, but certainly, having spoken to colleagues, their case loads have done.

Beyond the sheer numbers of families we are working with, a key change for us has been in the complexity of the cases that are coming into our service. As a consequence, our case loads are increasingly comprised of children and young people who are at a high level of risk and of families

who are experiencing a wide range of different problems, so have a high level of need.

The question of whether this increase can be seen as being primarily driven by the coronavirus pandemic is a complicated one. On the one hand, there is quite strong evidence that the coronavirus pandemic has played a role in exacerbating and, at times, arguably manifesting the different problems that the families we work with experience. For example, we have seen increases in the occurrence of domestic abuse incidents and parents suffering from mental health difficulties.

However, ultimately, we need to look further back at the possible reasons for this increase in complexity and demand. In particular, we need to consider the resources available to families and professionals, particularly at the early intervention stage, which is incredibly crucial. This increase in demand, this real surge, has come to light more as a result of the coronavirus pandemic, because we have seen quite a sudden spike, but actually in the background this incremental increase has been occurring for many years.

In terms of service provision and its capacity to meet this increase in the numbers and complexity of the cases that we are working with, from my experience I have not particularly seen an increase in service provision that is able to meet the growth in demand. That being said, I have seen a really fantastic response from services to be able to adapt and evolve in many ways to new ways of working. That has meant that we have been able to provide consistency in services throughout the pandemic. If you had asked the majority of people I work with, a year or so before, how they thought the services would have coped had this occurred, we would have been much more pessimistic about the system's capacity to adapt to such a significant change.

Still, the fact remains that the provision of services has not necessarily increased. Ultimately, as a result of that, there are increased waiting lists for children, young people and families, and the services that are there to support them have to be much more selective in the cases that they feel meet their threshold, because they really need to prioritise not just families who will benefit most from their support, but families who need that support the most. That can mean that other families do not receive the same level of support that they need and deserve.

The Chair: That is really helpful. Jacky, can you put your camera on perhaps? I love your screensaver, but it is even better to see you.

Jacky Mulveen: That is our logo.

The Chair: Tell us who you are.

Jacky Mulveen: I will tell you a little bit about the logo as well, just quickly. It was designed by a woman who was on our programmes. She surprised us with it, because she said that that is how it made her feel. She was in a state of coming out of an abusive relationship, and she felt,

having come through our programme, that she just rose through, like the daisy that is on our logo, so it is very special to us.

I am a project manager at WE:ARE—Women's Empowerment and Recovery Educators. I have been there for 19 years. I set up the domestic project there. I am a survivor myself, so I am very passionate about the work I that do and what we are talking about today: that things are often missed. My children's trauma responses were missed, which was a long time ago. We know more about it now. My eldest son died from his coping strategies in 1999. I am so passionate about this work—early intervention, supporting children and supporting the whole family—so that children have better life chances. Thank you for inviting me today.

We have seen a massive increase. What we do at our project is post domestic abuse, so it is all about healing. We work with agencies that do the crisis support and then we are the next step. We run pathway programmes. The first is the Freedom programme, and then families or women go on to a programme called Own My Life, which deals more with the emotional distress and how we can heal from the trauma. We have another programme called You and Me, Mum, which is about understanding the impact on our children and how we can help them heal once we are on the road to healing.

There is another programme called Healing Together, which was actually written for children and young people by Innovating Minds. We piloted it with mothers, so that mothers could then do that work with their children. We also have a mindfulness programme, which enhances all the other kinds of programmes. We have mindfulness drop-in and things like yoga, book club and poetry groups, which are all on Zoom at the moment.

It is not short-term fixes when we are working with families. It is not just a family doing the Freedom programme. It is six months or one year. Some families are with us for two years until they are ready to move on to the other agencies that we work with.

When a mother is abused, the children are abused. We used to think that children were upstairs, or were not in the house at the time, but we now know more about the impact of just living in a home under a regime of power and control, and what that feels like for children. With the new Domestic Abuse Bill we know that children are victims in their own right. It has been accepted now and hopefully more support will be out there.

When you abuse a mother you abuse a child, but when you help a mother to heal you are also helping that child to heal. That is the kind of feedback we get from mothers. When you are living in that kind of situation, you do not realise what is happening. You think your children are upstairs or in the other room. You do not realise the impact on their nervous system, their body and their brain.

Did we see an increase? Yes. When lockdown started we were in the middle of all those programmes, so we knew very quickly that we had to adapt our work, because we did not want to just leave families half way through programmes. Within about two weeks we had adapted everything on to Zoom.

The big increase has not only been from women contacting us. We are only a small organisation, but we have a big social media presence. The other increase we saw was from agencies. In Birmingham, everything seemed to stop. We were getting calls, and we still are, night and day: "Where can we send this mother? What's available? We've got nowhere else to send people". We were inundated. I do not think we slept. I did not sleep for weeks, just being on the other end of the phone to agencies that had nowhere to send people. In a big city like Birmingham, that is pretty shocking, isn't it?

We are experienced facilitators, so we can manage big groups. We had about 120 women a week on programmes. It was new for everybody. When they first come to us, we have initial sessions where we go through all the functions on Zoom with them and do the paperwork, and then they join the groups. We do evening sessions as well, every evening of the week. They have been so popular, because women do not have to worry about childcare or bus fares. Sometimes a bus fare might be a family's dinner for the day.

Women had issues before when we were back at base, because work would not release them. Actually, if you are supporting somebody to feel better about themselves, it supports the work, but workplaces were not always up for letting people out. On evening sessions now, you come home from work, the session is 7.30 pm to 9.30 pm, the children are in bed.

We have seen a massive increase. We have not seen a massive amount of money coming along with the increase, I will say. We did have emergency Covid funding up until March. Two of our staff, who were just on a year contract, were able to have more time with us. We have just had to let three of our staff go, unfortunately. The increase is there, but not the support from the statutory organisations. I will say that we held up children's services throughout the pandemic, there is no doubt about that. We have been there for women on child protection, women going through the courts and women at risk of losing their children.

Child protection plans are made and women have to do certain kinds of programmes, but the people who provide those programmes are the voluntary sector, which is not actually funded by the statutory organisations. We were having women come to us saying, "I've got to do this, I've got to do that".

We have, sadly, in the last two months, had to stop taking referrals from agencies, which is heartbreaking for us because there are women and children behind those referrals we have had to turn down. Children services have said that they will do their own in-house programmes, but

there has been no start of it. We are still taking referrals from women who ring us themselves.

Can we meet the growth? We can meet it in delivering big group work, but not if we get no further funding. We have a five-year lottery bid in. I am on stage 2 of that, so I am really hopeful for that. I have a bid for the Lloyds Bank Foundation, which I was working on until 5.30 am this morning. That is another thing with the small voluntary sector or the big voluntary sector. We are continually bid writing, when what we want to do is support children and families.

How will we retain it? The plan is that, when we go back to base, we will have a hybrid project. We will still keep our evening sessions, because they have just been full all the time. The plan, I hope, is to be back at base maybe two days a week, so that we can still have face-to-face contact groups, but we are definitely keeping Zoom because it has just been fabulous. It has worked so well in our kind of work. That is us in a nutshell.

The Chair: I will come on to Lucy and Helen. Can I just say this? One of the problems with these committees is that we only have an hour, so if you can be fairly concise with your answers, adding to things that have already been said, that will be really helpful.

Lucy Newman: I am a teacher in London with experience in a range of schools in London that work with pupils in deprived areas. I echo what James Shutkever said from a social worker's perspective, in that we saw a big increase during lockdown in referrals that we needed to make for mental health issues with pupils and with families struggling, and we really felt that increase The number of safeguarding issues coming up was increasing strikingly, as were the challenges that the social workers and the councils were facing such as their increased numbers and thresholds sometimes being higher or struggling to get support.

We have in-house counselling in our school and there was increased demand for that. That is not something that every school has and that is a big funding issue, especially for schools in deprived areas. Their funding in real terms is being cut because of the new way funding is allocated, so funding and the demand for funding are major issues. It is very difficult to keep the allocation of counsellors that we need, and we would love to have more counselling service within the school.

Seeing this in the context of the burden that Covid placed on schools, schools were contact tracers, so when there were Covid cases the schools themselves were responsible for contacting. I know that might not seem relevant, but the whole Covid situation and the mountain of changes in policies that were coming out regularly just meant that leadership of schools was very stretched, at a time when pupils and families needed more support than ever.

It is just worth mentioning in that context that no extra funding was given for the contract tracing, but a lot of time was needed to do that.

There was no help from test and trace; schools were doing it themselves and it was a huge burden. I really echo the social workers' perspective as well. There has been a big increase, and there has not been more funding or support for schools to deal with it.

The Chair: Are the skills there? It is one thing to have more money, but it is not much good having money if the counsellors are not there. Is that a problem?

Lucy Newman: There are organisations that you hire in. Teachers are not counsellors, so we work with organisations such as Place2Be that have those counsellors. It is about funding for those organisations and CAMHS waiting lists that are very long. There are many pupils who would benefit from that, but there are not enough places for them.

Dr Helen Jones: I wear a number of hats. I am a GP in Tower Hamlets, but in particular I have helped to set up a provision for adolescents with a youth provision that has come out of a housing association called HARCA and Spotlight. I work with the local CCG to do the mental health commissioning for children and young people, and I am a named GP for child safeguarding.

Just ignore all that. Basically, trying to be brief, and speaking in particular from my involvement in working with vulnerable adolescents and youth workers, as everyone has already said, there has been a massive increase, but it actually went quite quiet initially in primary care health. Everyone literally locked down and shut down, but because I have the relationship with the youth workers, who are proactive in reaching out to the families they know are vulnerable, we were able to coax and engage with young people who had gone completely off radar. It was the power of the relationship that the youth workers have and, because they are out of a housing association, they know the area really well. We are in Tower Hamlets, which is the poorest borough in London in terms of child poverty rates. I would also like to flag that, I know that people probably encounter challenges themselves in accessing primary care in normal times, but we are encouraging particularly the use of online consultation platforms, so you basically contact virtually off the website. There are currently challenges and barriers for young people with that offer. I am liaising with NHS Digital, and I know others are too, but currently the main provider does not allow under-18s to access directly without a parent or carer. A lot of vulnerable young children and people do not have a trusted adult.

I could go on and on, but the other thing, as has already been said, is that when we see young people, they have been living a lockdown life. They have been living virtually. Often their day-night cycle has completely switched. I came across a young boy the other day. He had fallen off the radar of school. His parents struggled themselves. He is 16 and his day-night cycle completely switched. He is just living online and hasn't been outside for months. Young people we are seeing are deconditioned.

We know that a lot of these young people have already encountered a lot of adverse childhood experiences. Lockdown was another one of those. We are just seeing increased complexity. We are seeing delayed assessments, particularly for children with suspected SEN. In primary care, as GPs at the coalface we are managing a lot of parental anxiety about that, but there are examples of excellence.

As has already been said, the virtual working with other professionals has been good, with less time travelling around and quick meetings. For us, liaising with health visitors, school nurses and other professionals is a lifeline, but I know that their service has really taken a hit. For us working with youth workers in the provision, again, they have taken a massive hit with funding cuts, and, as Jacky mentioned, when you are a smaller organisation, if you do not get the bid and someone else does, that disrupts that relationship of trust that young people and families have.

Because the youth workers belong to a housing association, they have really good links with the parents and the carers. They have that local knowledge. They get involved with gang mediation. They know the contextual safeguarding issues. They also partner with a lot of other voluntary sector organisations, such as England Boxing, dance and creative. It is incredible to be able to partner with them as health professionals. It is a bit like what is called social prescribing. That is another thing that we use in primary care a lot. I could go on.

The Chair: Can I pick up the point you made about young people, 16 and 17 year-olds, accessing their GP on Zoom? You were suggesting that they cannot do that without someone, some parent probably, alongside them, yet some of the issues they want to talk to you about may be related to parents. Can you just confirm that, because it is quite an important point?

Dr Helen Jones: Just to clarify, it is the point where you need to make an appointment with a primary care service. You can phone, but the encouragement has been to use the online consultation platform, which is off the practice website, so you just Google the name of the practice and it comes up. These things go through procurement, so it may change, but you are right that currently the main provider of the platform that GP practices use will not allow an unaccompanied under-18.

In fact, the GMC is really clear: in primary care, we are to be as accessible as possible to young people of any age and we are allowed to see them at any age. We would encourage them, if they have a trusted adult, to bring them, but the young people I am seeing in Spotlight do not have that. They have told me that they have tried to contact the GP and not been able to, which is heartbreaking.

The Chair: We will follow that up. That is really helpful. Thank you.

Q248 **Baroness Wyld:** You have all touched on early intervention in your very helpful opening statements. I wanted to talk a bit more about prevention,

which would be everybody's ideal objective and something the committee will look closely at. We will go in reverse, so I will start with you, Helen.

I want to talk about how you see the role of each of your sectors in preventing escalation and children who could come to harm or be exploited. What can be done? In answering that, it would be helpful if you could give me your reflection on the support you feel you do or do not get from central government.

Dr Helen Jones: I am trying to answer it with the right hat on. From the angle of a general practitioner, we have a unique position, in that we often have a holistic view of the whole family from cradle to grave, as it were. Often we will pick up markers of neglect. The challenge that comes for us is that, first of all, those young people may already be on the radar of someone else in another sector. We probably will not know that, even when it is child protection level, although that is getting better. Then it is knowing what to do about the soft concern that you have, and, as we know with all the SCRs, the learnings are always about the bits of the jigsaw not being put together.

I work with Spotlight youth workers, who have more freedom and flexibility. They work hours that suit young people and families. They are not nine to five. They can do all that background relationship building, inquiry, getting alongside and building trust with a young person in a way that, as a primary care clinician, I do not have the time, or it is not really my role, to do.

As everyone knows really, it is about an integrated and holistic offer that is co-ordinated, and building resilience in the young people. I know Lucy will be able to talk about schools much better than I. That is a place where all young people generally are going, albeit that there are some who are struggling to go, where there is that building of resilience and relationships, and helping young people to understand their bodies.

Often I will see young people who are concerned because they have recurrent abdominal pain. I had a boy the other day, and actually you unpick it. It was because a little while ago he had seen his best friend being stabbed. Since then, he has not slept, he is not eating and he is smoking more cannabis, but, again, because I had that relationship with the youth workers and he trusted them, they were able to support him to access the public health-commissioned service for substance misuse, and to liaise with the hospital team, which made an admission. Shall I stop?

Baroness Wyld: No, that is hugely helpful. I had follow-up question specifically for you, which was about data sharing. You touched on the holistic relationships. The Royal College of General Practitioners, as you probably know, felt that the threshold was too high. Would that be reflected in your experience?

Dr Helen Jones: Could you just clarify the question? The threshold for sharing—

Baroness Wyld: —sharing data with social services.

Dr Helen Jones: Is that from a health perspective?

Baroness Wyld: Yes.

Dr Helen Jones: It is complex. I would not want to say yes or no, as its not always black and white, because what is key for us in primary care is that it is a confidential space where patients can tell us whatever they need to tell us. When I see these teenagers, I say, "This is the baseline premise ie that this is a confidential space. However, if I feel that you are unsafe or you need emergency support, I will tell you that and we will get help for you". Actually, I have learned from the youth workers about that. They make more referrals than we do, yet they maintain that relationship of trust with the young people. It is about letting the young people feel like they are in control, but also that we are there for them.

We should not lower our threshold in some ways for sharing information with social services, because I feel like I will be sharing information if I need to anyway, for instance, if there's significant risk or current harm. I do not know whether that makes sense. Also, when I am sharing information, what am I hoping to achieve? Is it about immediate harm, so they need the MASH inquiry and child protection? That is pretty clear, but at that lower level usually what needs to happen is information sharing with other partners first.

I am already covered to talk to health visitors and school nurses—if I can get hold of them, because they are really underresourced. Talking to schools would be brilliant, but, again, it is complex because of secure emails and I would only share info if the YP consented . If I have consent from the young person and family, I agree 100% that a lot of that needs to happen. I am repeating myself, but because I now have a youth worker with me and the patient consents to it, usually in my consults I am able to do that lower-level information sharing to build up that collective picture.

Baroness Wyld: I always run the clock down. There is loads more I would like to ask you, but we will move to Lucy, and then we might go over a bit more if we have time.

Lucy Newman: In terms of long-term prevention, I agree with what Helen Jones has said about education being really important, for example in understanding mental health issues. Personal, social and health education—PSHE—is now getting much more priority nationally, especially since sex education has become a mandatory thing, but schools do not actually get support on how to deliver that.

There are associations that make these schemes of work, which means that they suggest lessons that you can do, but no one says, "Here's a book of really good resources that schools can use". Each school making these lessons is reinventing the wheel. You can tailor some needs to your school, but there are lots of things that are universal and there is no government help to deliver that. Helping students to identify what is abuse and what are healthy relationships can help with them coming to

adults and saying, "I'm in an unhealthy relationship. Actually, this isn't okay", and making those kinds of referrals.

Also linked is careers education. We know that, if you are NEET, you are much more vulnerable to being exploited. If you are not coming to school and have attendance issues, you are much more vulnerable. Good careers education is crucial to helping young people feel that, when they leave school, they know what they want to do. Since the budget was cut for Connexions, which was a service that meant there was in-house careers education, schools are now delivering careers education without any more budget and often in a very haphazard way. Again, there are not resources and it is not clear.

There is something called the Gatsby benchmarks. PwC did a study and said that it would be about £50,000 per school. Especially in this funding context, it is very difficult to fund that adequately. From a curriculum perspective, there is lots that we can do, and there is a lot of each school working separately, so if we combined and had a really good national curriculum that gave really good textbooks and resources to teach from, rather than the odd lesson plan here which the Home Office makes and the odd something else there, it would be much easier. It is very haphazard.

People do not tend to become careers educators or PHSE teachers. They are non-specialist, and the training for teachers is a real challenge. We do in-house training. We have safeguarding training, but having some support and funding for training and having someone to come into the school is also really important. It depends what MAT you are in and it is very in consistent. There is not a lot of local authority support with that.

In terms of prevention, not being NEET and understanding the basics of personal, social and health education is really important. Schools do amazing jobs on that sometimes, but there is very little support.

Q249 **Baroness Wyld:** I have a quick follow-up, if the Chair will let me. You talked about all the things that schools are having to do at the moment—contact tracing, mental health support, et cetera. Without leading the witness, do you think we have the balance right there? Do you think it is reasonable to ask schools to cover all these areas and, if you do think it is reasonable—it sounds like you do not think they quite have the support to do that—what would be the game-changer for you?

Lucy Newman: I will just give you a small example. There are Gatsby benchmarks, which is what schools are expected to do. Each school should have an in-house careers counsellor or provide specialist careers counselling. If you funded that for each student to have what it says, which is a careers counselling session, either twice a year or twice throughout their five years, it would be a huge amount of money to have a specialist. You could train somebody in-house, but if they leave you have spent £7,000 training them and then they have gone. You can hire somebody in and it is thousands and thousands of pounds, so most schools simply do not have the budget.

It is all well and good cutting Connexions, but there is no replacement of training or funding for schools. We know that careers education is really important. The research shows it has a huge impact, particularly on vulnerable pupils. Meeting four different professionals a year in careers education, for example, can make it 86% less likely that you will be NEET. The statistics are really clear that this has a big impact, but without any funding for it schools are really struggling.

In terms of just teaching lessons, there is so much more. Thankfully, now the contact tracing has ended with schools, but the stretch to do all these other roles is not acceptable without adequate funding or provision. You can get external agencies to come into schools. If every local authority had a careers counsellor who they just sent for free to every school they employed full-time, that could work well, but without any local structure it is very difficult for schools to provide what would have the best impact on students and what the most vulnerable students need.

We know that, if you are from a better off background financially, you are more likely to have the connections that your parents have, so the careers counsellor is less important. For a vulnerable pupil, having careers counselling or careers education where you go into a place of work can be a life-changing experience, because you are not going to go with your dad or mum to a place of work, so you would miss that cultural capital. I oversee careers education and PSHCE, and it is nonsensical for each school to be trying to do its own thing and with very little training or financial support or support for the curriculum.

Jacky Mulveen: As Helen and Lucy have both touched on education and awareness, in our programmes it would be the parents delivering that education and awareness to their children, once they have gone through the programmes themselves. We have also been finding, especially with the Freedom programme, mums and their teenage daughters doing it together. At the moment, we have three sets of mums and daughters on the Freedom programme. The hope is for the next generation to stop that cycle, so the next generation is not having abuse in the home. That was short and sweet.

Baroness Wyld: Thanks, Jacky. I know we are short on time, but I read about your work and I really want to pay tribute to it. You have talked about funding. You might not want to go into it now, but is there anything else from central government that is quite obviously missing?

Jacky Mulveen: It is understanding the role of how a supported parent can then support her children. We can send children to organisations all day long, 24/7, but if they are going home and the home is not safe or, even if the abuser is no longer there, is not feeling safe, it is not working, is it? We need to be working with the non-abusive parent and the abusive parent to ensure that mum can be the co-regulator for her children and that she understands her children.

We see relationships damaged between mother and children because of the abuse, especially when it is stepchildren. We work to rebuild those

relationships, so that mum can be that person to educate her children so that they understand what abuse is, especially our teenage girls, who are going into relationships. We see a lot of young people's relationships being abusive.

What do we need from central government? It is funding, like everybody has said. Like you said, Lucy, about training staff up, we have trained three staff all over Covid and have paid to put them through all the training, and now we have lost them because we no longer have the funding for their salary, but I am working on it.

Baroness Wyld: I must move to James, because once again I have used all my time up. James, one of the earliest things you said was early intervention, so it would be very interesting to hear your perspective. When it comes to central government, I take all the points on funding, so I will take that as a given. If there is anything else you want to bring up, that would be great.

James Shutkever: My role as a social worker is in a family safeguarding team, so we are offering longer-term intervention and our goal is to help families make and maintain meaningful changes in their lives. Within that, it is also our job to be curious about the factors that may indicate risk and liaise with other professionals to be able to safeguard the welfare of vulnerable children and young people.

However, the unfortunate reality is that, very often, our day-to-day work consists of what we would term firefighting. By that, I mean having to focus on immediate and/or acute problems that families are facing. We are often having to do that in a very reactive and sudden way, so we are focusing on short-term outcomes and the short-term safety of children instead of being able to work towards these longer-term outcomes.

This is not the case for every family we work with, but—and this comes back to the increasing complexity—it means that, because we are having to focus so much on the families we are working with who are in that high category of risk and high category of need, ultimately families who are at the lower end of risk or the lower end of need are not getting the level of intervention that they would benefit from.

To the question about central government, you are absolutely right about funding. That is the difficulty and, particularly for us, we have a challenging role. We have a number of statutory duties that we need to do, and fulfilling those statutory duties is increasingly taking up a lot of the resources that we have. A quintessential example of that is private foster placements. These can cost very large amounts of money, and, ultimately, when this money is being taken from the same pot, it means that there is less money to be spent in longer-term interventions for other families, so it is a very difficult balance to achieve.

It creates this very vicious circle of spending on the complexity and the short-term objectives, and then not funding the earlier stages and being able to work towards the longer-term outcomes. The product is then that

we have families coming back in to our service who are more complex and who have had emerging needs that have not been met, and then we are having to spend large amounts of money on the care and support for them as their needs have grown more complex.

The Chair: We need to move on to Baroness Pitkeathley. I do not want to put words in your mouth, James, but are you saying that, in social work, and indeed in the work that others on this panel are involved in, we are building up a backlog, which is not dissimilar to the backlog we have been hearing quite a lot about in the NHS, and that that backlog—I do not want to use emotive language—could explode post pandemic?

James Shutkever: Yes, that is completely the case.

Q250 **Baroness Pitkeathley:** You have all talked in different ways about working with other agencies. I am interested in what the main barriers are to schools, local authorities, the health service and the voluntary sector working together. We are very short of time, so perhaps I could ask you to focus on one example of where any such barriers have been overcome. I will come to you first, Jacky, as the main representative of the voluntary sector on our panel.

Jacky Mulveen: It is hard. We have very successful links with others in the small voluntary sector. We know each other's work well, appreciate the work that we do and the demand on it, and share work. Yesterday, for example, I met with a youth project, whose timetable was amazing. It was very similar to our timetable, but they were doing it with young people and teenagers, and we were doing it with mothers, so we said, "Next week we're meeting up and we're going to join together". That was just such a brilliant meeting.

A barrier with the statutory organisations is that they overwhelm us and expect a lot from us. Like I said, we have been on the end of the phone to statutory agencies all through Covid.

Baroness Pitkeathley: You said that you held them up at one stage.

Jacky Mulveen: I believe so. We are still getting phone calls saying, "Where else can we send women to these kinds of programmes?", because in the city we are the only ones delivering that pathway. I offered that, for some funding, we could do a set of programmes specifically for children's services so that they would not have to go here, there and everywhere, but I suppose everybody has a lack of money.

Baroness Pitkeathley: We will move on to you, Helen, and your experience about any barriers and barriers overcome.

Dr Helen Jones: You said that I had to limit it to one. Is that right?

Baroness Pitkeathley: Only in the interests of time. I would love to hear 10 of them.

Dr Helen Jones: Essentially, in taking an NHS-commissioned service which is primary care—it is actually the extended access hub provision—into a community space, which was a youth provision, barriers were people's attitudes about that and feeling that is a bit dangerous to do. We have different IT systems. We have different governance. We operate at different hours, but we have overcome it by lots of communication and taking the voice of young people who have asked for it to all the different types of commissioners. We still have different IT systems and governance, but we meet after every session, debrief, share and clarify the risks, decide who is holding what and make a plan—so MDT working around the young people.

Baroness Pitkeathley: Clearly, you have seen benefit arising for the young people from that.

Dr Helen Jones: I get quite emotional, but, because the young people trust the youth workers, they will tell me things now that they would never have told me before about the harm they are facing, their suicidal thoughts and their lack of safety. They may well have already told the youth worker that, but some of that need also needed to have other health professionals brought in. The youth worker, therefore, can help the young person to trust other people and endorse the other services.

Baroness Pitkeathley: As I understand it, you are saying there were barriers, such as different IT systems, different governance and so on, but the attitudes of people overcame them. That took time too, did it not?

Dr Helen Jones: Yes, time, stress and energy, but it is because we keep seeing cases where it goes wrong and young people telling us about the countless barriers they have faced in trying to navigate a system. It just fuels the fire even more.

Baroness Pitkeathley: Can I come to you now, James, for your views on this?

James Shutkever: In Hertfordshire, we have created and use a model called the Family Safeguarding Model. That is now being rolled out across a number of different local authorities. It is a really good example of a service that can overcome quite a lot of the barriers to effective multiagency working. The key elements to this model are that we take in-house professionals from a range of disciplines, so we have people in-house who are our drug and alcohol recovery workers, children's practitioners, domestic abuse professionals who work with both victims and perpetrators of domestic abuse and an in-house psychology team.

That means that all these services are under one roof, and there are a number of benefits to doing this, which are also representative of these other broader difficulties in multiagency working. First and foremost, we are all recording on the same system, so we all have access to each other's notes. We are all aware of the family's strengths—the positives of what they are doing in their work with other agencies. We are also then

aware of any possible risks. We have very clear write-ups of any visits where potential concerns might have arisen. We also have much better access to then speaking to and liaising directly with the other professionals.

A key example of that is family safeguarding case supervision once a month, where we and any in-house practitioners who are working with the family sit down with the team manager and speak through the work on the case, our thoughts about the family and our thoughts about how better we can support them. It is a really good way of encouraging curiosity in practice, as well as collaboration between different professions.

Lucy Newman: The example I will talk about is preventing NEET—not in education, employment or training—which we know is extremely bad for life chances and outcomes for pupils. There are challenges and there is not a lot of funding, but there is a lot of creativity in schools. In a school that I have seen, for example, we have had a careers bank, where we just sent a form round to friends, family and everyone we have met and said, "Are you willing to come and speak to pupils about your job?"

Through informal networks we have 200 professionals who can speak to pupils and mentor them. This takes staff time to deliver to pupils and is a huge effort, but we know that it makes a difference to have those pupils come in. We can also work with other private sector organisations. A lot of the big accountancy firms will come into schools and talk; they have that capacity with their volunteering. We have had people in the Civil Service come in and volunteer. When schools set up links themselves, it is extremely time consuming for teachers to do and would be better done in a centralised way, but there is that capacity.

Especially during Covid, we really started using Teams and Teams-ing in a professional. You would do a lesson about something and then Teams in a professional to ask them for 10 minutes. That was a great way to get a guest speaker in who might not be able to come to the location of your school. That was a type of creativity, and we will keep Teams-ing in people who may not be able to travel in. Schools working informally with networks has been really valuable, even though it would be great if it was more systematised and given more support.

Q251 **The Chair:** One of the problems of having a panel of such interesting people with so much expertise is that you want to be here for the whole afternoon, and I have certainly got that feeling today. I just want to make a couple of points. First, if there are things that you have not had time to say, we would like you to write in and tell us. I suspect there are, so please do that. There may not be as many here today from the committee as usual for all sorts of reasons, but the other members will look very closely at the evidence and take seriously anything you provide us with.

I had a question that I was going to ask you, but I will encourage you to write to us instead about it. We were famously told by a senior official

from the Department for Education that there was no integrated government strategy on vulnerable children, which rather took us by surprise. I was going to ask you what, if there was going to be one, you would like to see in it, but maybe you could better answer that question just by dropping us your thoughts online.

The question I do want to ask, which is the last question, has occurred to me quite a lot today from what you have all been saying and from some of the other sessions. Do you think we could do more to give children and young people the confidence and the skills to ask for help? There are a lot of invisible kids out there, to whom the Children's Commissioner in particular has drawn attention. Do you think we are doing enough to help children to have the confidence, develop the skills and know where to go to get help when they need it? You have to be very brief, I am afraid.

Dr Helen Jones: That is no problem. I already raised the issue of accessing health for children and young people. They do not know their rights. Parents do not know the rights of young people. It is really clear in the GMC guidance. It sometimes surprises health professionals themselves how mandated we are to make children and young people feel welcome, able, safe and comfortable. We also need to be more trauma informed, so that when we see that mardy teenager who is rolling their eyes, kissing their teeth and grunting, and does not really want to even give their name, we allow them to come because they have come for a reason.

The Chair: Your example of the youth worker almost being used as an intermediary bridge was a very powerful one.

Jacky Mulveen: We see lots of posters everywhere, but we need to ensure that there are actually the services there for children to access when they do reach out. What we often see is mental health services, and the children are not always mentally ill. We are seeing too many children given medication, pathologised and labelled when it is their trauma responses and coping strategies. Once we can help children to understand that, which we do by helping the mother to understand, children can then say, "Yes, but that is because, and I am doing that because", and they can learn, like you said, Helen, to understand how their body and brain work. They are able to articulate and get the right help at the right time, from the right people.

James Shutkever: It is important that children and young people are able to feel safe and secure, know who they can speak to if they have any difficulties or need any support, and recognise when they may be in a position where they are unsafe. That is particularly crucial in early years and primary settings where children have not developed those skills, we may be more likely to see them in secondary settings.

Ultimately, we need to be really careful about not putting the onus of responsibility on children. Without a doubt, the focus needs to be on the professional services that are supporting children. Helen mentioned developing trauma-informed, attachment -informed approaches that

enable professionals to identify the more covert signs of risks to children. We need to then develop the ways in which we share information between agencies in order to join up the pieces of the jigsaw much better, instead of pieces of information being kept by certain agencies because they feel that they may not necessarily meet the threshold to be shared.

Lucy Newman: It is important. Personal, social and health education is about signposting. It is about saying to a child, "This is the definition of abuse and here is where you can go if you have that". That has an extremely big impact. We have made safeguarding referrals after PSHE lessons, and it can be lifechanging to have a good curriculum.

At the same time, a lot of the children who are the most vulnerable are not at school and attendance is a big issue for them. We have a huge problem nationally of students who are off-rolling, so patients are home schooling students and the challenge is what the criteria are for you to be able to home school a student. You do not have to have GCSEs, from my understanding.

That can be a way for parents who are not able and have mental health issues to keep their child from the state. That is a huge issue nationally. Where is the register? What is happening to students? Who is checking on them and how do we know that these students are safe? That is really is important, because a student cannot refer if they are not part of the system.

The Chair: You have all been fantastic and really helpful. I am sorry that we have had to rush it on occasions. Do write in if you have other things to say to us, but thank you so much for giving up your time, coming along and being so reflective and so thoughtful. It is much appreciated. I now, rather dramatically, have to formally suspend the meeting so that we can move on to the next meeting. Formally, I suspend this meeting, Thank you very much indeed.