

Select Committee on Public Services

Oral evidence: Public services: lessons from coronavirus

Wednesday 10 June 2020

4 pm

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

Evidence Session No. 4

Virtual Proceeding

Questions 27 - 34

Witnesses

I: Anne Longfield, The Children's Commissioner; Claire Murdoch, National Director for Mental Health Services, NHS England and Chief Executive Officer, Central and North West London NHS Foundation Trust; Amanda Spielman, Chief Inspector, Ofsted.

Examination of witnesses

Anne Longfield, Claire Murdoch and Amanda Spielman.

The Chair: In this session, we again have a star-studded cast: Anne Longfield, the Children's Commissioner; Claire Murdoch from NHS England; and Amanda Spielman from Ofsted.

We will move straight into the questioning. It would be helpful, witnesses, if when you answer your first question you could say who you are and where you are from. As ever, we have to fit this into a particular time slot, and unless I get on with it that will not happen. Our first questioner is Lord Filkin.

Q27 Lord Filkin: Witnesses, it is good to have you here. First, I have a question about vulnerable children. What are your reflections on how well or not they were served, and what lessons can we draw from that?

Amanda Spielman: Vulnerable children have had a great deal of attention, in particular for their core needs. The crisis has made everybody focus on the things that absolutely must not drop at the core. There are a great many things that are important to vulnerable children

but not necessarily absolutely essential. Many children's services, and of course their schooling in many cases, have been suspended. At one level, their interests have been prioritised and protected, but at another level there is a great deal that I am concerned about that is not happening.

I am also very concerned about the pipeline of referrals that would normally be flowing, mostly via schools, that are not happening. Schools are crucial gateways for identifying vulnerability, and to a large extent they are not fulfilling that purpose at the moment.

Anne Longfield: For the last three or four years, I have seen the whole issue of shining a light on how many vulnerable children there are, and the nature of that vulnerability, as core to what I do. I have talked about that to many parliamentarians over that period.

What the emergency has demonstrated and exposed is the scale of vulnerability. We are talking potentially about one in six children with significant vulnerabilities, many of which were hidden before the actual crisis and have remained hidden. A lot of those children will not be in regular contact with support services; others will be in and out of them.

I am pleased that there has been a level of focus, as Amanda says, on vulnerability. That has meant that places have been kept for vulnerable children in schools, although there have not been large numbers of vulnerable children using those places. There has been more focus from the Cabinet Office across different departments, co-ordinating and looking at the detail of vulnerability. The DfE has done a lot more work on that as regards data understanding.

At the core, services have held up better than I thought in many ways. Children's social care and many schools have gone beyond what they might have been expected to do in supporting vulnerable communities, but it has not been wholly consistent in every area. A lot of the local authorities that were running services very effectively before were much better able to do that. Schools that had good relationships with the community were much more able to do that.

To be able to function well, services have had to retrench back to their core business. That means RAG rating and a lot of emphasis on those who are known and those at higher risk, but less ability to anticipate where those risks are, to help children with lower needs and know when children move into vulnerability, which is why the huge drop-off in referrals and identification is such an issue. It has exposed and exacerbated what already existed, and shows what needs to change going forward.

Claire Murdoch: As the national director for mental health in England and chief executive of an NHS trust, I have both a local and a national perspective.

From the NHS point of view, we were clear throughout the last weeks that vulnerable children, and indeed children with mental health or any

disability problems and autism, would remain a key focus. We did not stand services down. We prioritised them. We obviously had to juggle some of the issues of social distancing, face-to-face contacts and, at the peak of the virus, pockets of staff sickness. It meant that we had to radically change our model, but we were clear that we needed to prioritise continuity for the children and families we knew.

Lots of our staff who had to shield could still make phone calls. We have seen a thirty-fivefold increase in our use of digital contacts with youngsters and their families. We have brought forward by three years, from 2023 to last month, our 24/7 crisis lines in all parts of the country. In April, when 50% of the country had 24/7 NHS crisis lines in place, I wrote to my colleagues across the country and asked them to establish 24/7 helplines immediately. I am delighted to say that they did. We worked with Public Health England, with schools and with others to try to make sure that we put out additional resources that youngsters could use.

Having said all of that, we have been concerned about the loss of some of our referral routes, whether through A&E, schools or local children's services. The under-18s are the group of youngsters we are keeping the closest eye on. We have made them the focus of our NHS Help Us Help You campaign. We are trying to raise awareness that we are here and want to reach out to the most vulnerable, particularly the young who we think have been so affected by the pandemic.

The Chair: That is an interesting introduction to the session. Do you have any supplementary questions, Lord Filkin?

Lord Filkin: Lots of them, but not for now, Chair. Thank you.

Q28 Lord Davies of Gower: Good afternoon, panel. I think we are all very aware of the pressures that providers are under at the moment. My particular question is regarding NHS services, special educational needs and disability services and children's social care. Do you think they have worked together effectively during the crisis? Perhaps if you have a good example, you could give it to us.

Anne Longfield: There are some fantastic examples where, on the front line, services have worked together. People have responded to the emergency and the crisis. They have had to reconfigure their ways of working, literally overnight. They have found new ways of working that, in many ways, have been very immediate and because of that quite fulfilling. There are some great examples, and, if there was more time, a lot of people would be able to talk about how that has made a difference.

The areas where there were already tensions, gaps in services or indeed particular gaps in early identification are where things have slightly fallen away. People have had to go to core business, which means that they have not been able to reach out in different ways. Some of the lack of structures between different agencies has meant that there has not always been communication about particular need if it is identified.

On the front line, there are a lot of great examples. People will want to hold on to those and build on them. It is the infrastructure that is stretched and clunky, and does not always focus on the child. That might sound odd, but often the focus has been on organisations, services and infrastructure rather than on children themselves. That needs to catch up and reform around the new spirit of co-operation, if that is what we find has happened in the majority of places.

Amanda Spielman: I echo much of what you heard in the previous witness session. The sense of common purpose has galvanised a lot of people in good partnership working. The focus is on essentials and taking down a lot of the normal operational walls. There is an emphasis on speed and being more willing than usual to take risks. Those have all been plus points.

On the downside, we have seen the extent to which many things have been constrained by the vertical silos that are always to some degree barriers to good partnership working and cross-organisational working. As an example, a lot of us have realised that our emergency planning was much more within our organisation rather than across organisations and across different areas of government. There are not many incentives for cross-government working. We do some cross-government inspection; we do joint targeted area inspections on thematic issues, and area inspections of special educational needs where the main partners are the local authority and the clinical commissioning group.

The lack of overlap in boundaries, and the fact that different services are aligned to slightly different areas also makes it harder. The crisis has shown us how hard it can be sometimes to move capacity to where it is needed, or conversely move tasks to where there are people with capacity. One of the hallmarks of the crisis has been that there are many parts of the public and private sectors where some people are working absolutely flat out and 200%, and other people are twiddling their thumbs. There has not been, as I understand it, much formal redeployment between organisations in government. The people I have been able to redeploy elsewhere while routine inspections have been suspended have been a surprisingly large proportion of the total.

Claire Murdoch: As I said in my previous answer, in health we continue to have a rigorous focus on our young, and the services that we stood up, some of which we brought forward from our long-term plan to now. In a local area, there are many examples of people and agencies working well across the silos. I can think of examples across the country where we were able to move staff across health to make sure that we focused on the most vulnerable. In that sense, I am pleased.

The use of digital has significantly changed the way we are going to think for ever about how we can quickly pull multiagency meetings together around the needs of more vulnerable youngsters, literally on the same day, to try to intervene sooner. There have been many examples of education and care reviews to think about a youngster that have gone on, regardless of our need to socially distance.

We have seen a reduction in admissions to hospital. We are worried that they might start to creep up. We have seen more focus on what 24/7 plans might need to look like to support the most vulnerable in the community. That has definitely involved education, local authorities, children's services and health working together. I can give the Committee examples of where that works very well. Manchester is a great example. Liverpool is doing some really good work, and there are many other places.

That said, our key focus still has to be on the variability across the country. In the previous panel, someone said that where joint working was good before Covid it was probably rapidly reinforced and built on during Covid, and the areas where it was less good probably struggled more. That is a view. In health, we have absolutely valued the need to work in partnership. At any one time, there will be vulnerable children who may not be known to health or on our case registers currently, but who will be receiving lots of support from other agencies. We have been very keen to be part of thinking about their support.

Anne Longfield: I know you want me to be fast on this, so perhaps I could send a note afterwards. There are two things. The reality for a lot of parents and children with special educational needs is that they have not been able to use places in schools because their complex needs were too much for the school during this period, and they were not able to get the support that they would normally get at home. The reality for a lot of those families is that they have been left to look after their children and provide complex care without much support. Because they have more complex needs, going back into school afterwards will be much more complicated and may take longer. That is clearly something for children and families.

There was an ongoing and long-standing lack of support pre-crisis, and pre-secure, for a lot of children with special educational needs. That is an area that, in a recovery slot, will benefit from the ability to reset, where agencies, the DfE and the NHS can work together positively to develop new models of practice. At the moment, there has been a bit of a dearth, and children tend to get passed from pillar to post, between the responsibilities of the local authority and the responsibilities of health. Moving beyond the crisis, that has to be one of the priorities to address.

Q29 Lord Bourne of Aberystwyth: Thanks to our witnesses for some excellent evidence and for their presentation. Building on the last question, could I probe a bit further about the collaboration that we have been hearing about and the positive aspects? Could we have some specific examples briefly, and afterwards, if there are things that could be added in writing to us, that would be useful. Could we hear something about how, outside this acute emergency, we can make sure that we continue with that collaboration and that we are able to carry on delivering it. I suspect it is a massive challenge. Some thoughts on that would be useful.

Claire Murdoch: I echo what the Children's Commissioner said. Although I thank NHS staff and other colleagues for some incredible work over the last several weeks, none of us should be under any illusion that many families across the country have suffered real hardship. We will see pent-up demand, and we need to be ready to move very fast now to bring in that support.

Nationally, to remind the Committee, we were fortunate in having a long-term plan for the NHS. We are in year two of that five-year plan. Simon Stevens and the NHS set out clearly that more money should be spent on mental health in relation to growth, on parity of esteem and the mental health investment standard, than on other areas of health; and within mental health, more still—a higher percentage of the budget—should be spent on children. We are fortunate that we had a clear and ambitious plan before we went into the crisis, around increasing access and reducing waiting times. For example, we said that we would see 70,000 more children and young people a year by 2021. We have achieved that a year early.

The plan has many more aspects. One part that we are particularly pleased with is the introduction of mental health support teams in schools, and I do not want to forget colleges and young adults, who have probably been hit very hard. It is our plan to spend £250 million a year more by 2023, introducing mental health support teams in schools. We have a trajectory each year up to then. We have been working closely with the Department for Education. We are putting mental health support practitioners into schools. We have worked with 13 universities to recruit and train those practitioners. That will cover more than 1.5 million children, and 25% of the country, by 2023.

My colleague, the Children's Commissioner, will say that it does not go far enough. Perhaps that is for the Government or others to answer, but we are recruiting, training and developing mental health support teams in schools and colleges, in partnership with the Department for Education, schools, headteachers and local areas. It presents one of the most exciting opportunities to detect issues sooner and get earlier diagnosis of things such as autism, which we have underdiagnosed and therefore treated less effectively and not soon enough. We need more preventive work.

We are picking up our long-term plan and adapting it now that we have moved very fast on some things during Covid. We have pulled funding forward for some things. Basically, we are working very hard with children's services, the Department for Education and Public Health England on making sure that we spend the additional money we have on better access, more services in schools and colleges, and more children and young people seen within one to four weeks. We want to bring down the waiting times. I mentioned the 24/7 crisis services that we have pulled forward by three years.

There was work in train before Covid. We have fast-tracked some things, in partnership particularly with the Department for Education, and now

we will redouble those efforts to meet the pent-up demand, particularly working with education. We need to work together to look at what happens over the summer to help youngsters be school and college ready in September. That is an area where we could do more joint work. I look forward to doing that with colleagues.

The Chair: Anne is keen to come in, but I am going to ask Amanda to come in first so that we get the education perspective, and then the more general one.

Amanda Spielman: The question was about kinds of collaboration, and because routine inspections are suspended and most schools have been closed there is relatively little that I can say at this stage. Much more will emerge when we start going back into schools. From the work we have been doing with the React groups, we know about schools doing home visits and some more assertive outreach work using the capacity released by not having normal teaching going on. We know about child protection work, for example, and the use of videoconferencing.

Services have been using tech to stay in touch with care leavers, and some care leavers have valued the more frequent and more informal contact that has come from that. Technology and videoconferencing have been used for contact visits. In some cases, it is reported that children find that interaction less stressful than personal contacts. A number of interesting things have emerged and some clear opportunities, in the sense of things that can potentially be carried on and developed after this crisis.

Anne Longfield: On the two examples we have just heard about, I have noticed that a lot more schools have been talking about their pastoral care. Some have recognised that it is an important part of what they do. Going forward, for the children in the years going back to school the emphasis is very much on well-being and pastoral care. I hope that will not just continue through the recovery period but will be built into what we deem to be an example of a very positive aspect of school, and recognised as such in inspections.

As Claire says, the work around schools is a really good example. It was happening beforehand, and it needs to be in all schools. It is a good example of what can be done. It probably took quite a long time to get there because you have two different sets of cultures and bureaucracies between departments that are not used to working together. We need to solve some of that.

More broadly, I do not think the scale or nature of childhood vulnerability was recognised. There has been a move to recognise that across government departments, with some co-ordination from the Cabinet Office. That work has to continue and should now become the focus. It demands that at national level there is a joint approach with a clear understanding of what the joint outcomes are and the joint responsibilities. There should be some pooling of budgets. You can look at that all the way down. Until we get that process, which identifies risk,

responds to risk and has a joint understanding of what it means when you get there, it will be difficult to maximise the potential of all the good local initiatives.

The Chair: I am going to move on to the next question, although I am tempted to come back on something. If we get time, I will come back at the end.

Q30 **Lord Bichard:** As the panel will recognise more than most, one of the root causes of nearly every child protection failure of the last 50 years has been a failure to share data and information between education, social services, health and the police. We have heard a lot about collaboration, some of it very encouraging, during the pandemic. Have we seen examples of services finding new ways of addressing the problem of sharing data? From the experience we have gained in recent weeks, are there barriers and issues that the panel think should be revisited and looked at again at the end of all this?

Anne Longfield: I would have preferred it if there had been some guidance on data sharing during the emergency period. That would have been helpful. There has not been, but people have muddled through. Sometimes there have been good examples of local practice, potentially around a family hub, where a group of people have gone above and beyond in identifying which people need help, and have worked together to provide that.

As you would imagine, there are some deep-seated problems in information sharing that need to be overcome. Some of them have become more difficult through the use of virtual working and tech. For instance, a professional working with children who is not a member of the MASH team—the identification safeguarding hub—has to ring the police through 101, the normal number. If they are doing that virtually, when people have their main phones diverted to mobiles, it can take forever. That should not be the case.

A lot of health visitors were deployed at the beginning. That disrupted information about when children were being born and knowledge about children that would have come to the local authority. Health visitors were not going in to do pre-birth checks or neonatal checks. What does that mean for children who would be identified at that point as being in need?

There are some very specific things because of the emergency situation, and there is a need to be much more robust about sharing information. People find a way to get round it, but they are still very worried about what the legislation means. In my view, the legislation enables data sharing, but people need more confidence and help in understanding that.

Amanda Spielman: I share a lot of those views. In a lot of the working groups, there has been good sharing of area-level and group-level information. The same very high degree of nervousness that comes from sharing information in a system that is fundamentally designed around

protecting privacy persists. It is still very much the case that the most cautious link in the chain, where a number of organisations are involved, will determine whether anything is shared.

When I think about how much of my time ends up in talking about data-sharing issues that have been escalated to me to try to help unblock, it is more than I would like. Where we have been able to share—for example, in the React groups—it has shown us the value, and there have been a number of cases where speed of sharing has been very helpful. There is a lot more to be done when people have some head space to think more widely about collaboration, the value of data sharing and the ways we could make the channels for doing it a little easier to unblock.

Claire Murdoch: In areas where there is a will, there is generally a way. Rapid escalation to more senior decision-makers in the most complex of situations needs to be in place. More senior folk across all the agencies will recognise a complex situation. If they are putting the child and their need first, they will generally be much more permissive in the information that can be shared. Additional legislative change might help. I worry that obviously we are balancing two huge rights. It will never be straightforward. I leave that to the legislators and people with bigger brains than mine.

One definitely sees more examples of sharing information, and I hope we will see it in the mental health support teams in schools, when we bring together primary care, school staff, parents and the NHS to think about the youngster in front of them and what they need, and share information, be it with safeguarding or others, around their care and treatment. There are some great examples in places. The NHS absolutely has to be part of universally sharing through safeguarding boards and other things. We are determined to do that.

You asked about changes. Some things that have made life somewhat more difficult recently are the vital roles of health visitors and school nurses. There are examples where those services are put out to procurement every three years through tendering processes, because of worry about legals and competition law. That can be very corrosive to building trusting relationships. Some of the best information sharing I have seen happens when groups of multi-professionals know and trust each other. I do not think perpetual change always helps. I am all for healthy competition and anything that challenges complacency, but perpetual cycles of re-tendering for health visitors and school nurses are not helpful, in my opinion.

- Q31 **Lord Young of Cookham:** Some of the encouraging things about our inquiry so far have been the many good examples of local collaboration, with strong local leadership, good working relationships and getting things done. Amanda, you referred to taking down operational walls and referred to new ways of working on the front line, but we also heard about vertical silos from Amanda and about clunky infrastructure from Anne. How can central government and local government, commissioners and regulators encourage better collaboration as we go forward?

Amanda Spielman: That is the million-dollar question. We have a structure of government whereby each department is, understandably, very strongly aligned to its Minister, and quite small things that need alignment between departments can take a surprising amount of negotiation, which certainly leads to delay and sometimes sub-optimal decision-making.

At the very least, it feels as though we need some cross-government contingency planning for situations when there simply is no time to apply normal models. How are we going to handle things and stop the channels getting clogged up? Perhaps picking up on what we have learned about this period, in which people have been able to be less risk averse, we can think about what we have gained from some of the streamlined ways of working. That would be valuable in making people recognise that, if they are not ready or comfortable to change the normal way they operate, at the very least they can have some sense of what the fallback mode they should switch into where necessary should look like.

Anne Longfield: For me, it goes back to the need to have a clear understanding that there is a central commitment to reducing risk for vulnerable children. There are many departments that need to play their role. For instance, one of the more complex issues that people were looking at last year was gangs and serious violence. Of course, the police know about that day in, day out.

Those children will often be excluded from school, so there is a straight educational aspect. They will be excluded from school and possibly known to children's services around that time. If they had had mental health support before they were excluded, they might not have been excluded. If they had had speech and language support before they went to school, they might not have fallen into whatever was happening during their primary school years.

Children do not live their lives in neat pigeonholes. The crisis has exposed the symptoms of what that means, but I hope it will also give an understanding, or at least some kind of confidence, not only that there needs to be a solution but that there can be a solution. There are lots of good examples in local areas. Some local areas that are doing well have a common outcome framework in their area. They might have joint activities across different services. They might share budgets.

Another aspect is that they identify which children are at risk and then work together to ensure that they meet those risks. There are good examples of local authorities that plan well. Leeds plans well. There is good work going on in Manchester and in other areas, but sometimes that is despite the clunky infrastructure that does not enable it to run smoothly enough or make money available where it is needed. That, for me, is what needs to change in the next phase of reset.

Claire Murdoch: I mentioned the long-term plan earlier. We have committed to see 345,000 youngsters a year more by 2023 in specialist CAMHS. In a sense it is my job, the job of my team and the NHS across

the country to make sure we do that. However, we are in no doubt that all of those efforts, worth while though they are, only land to full effect in local areas where there is a clear local transformation plan for children's services, clear multiagency support for the plan that is regularly reviewed and updated, and a clear will to get on the front foot and proactively intervene before the point of crisis.

We do not want to medicalise our young. The NHS needs to be there 24/7, of course, and we need to do more, but what we want, and Manchester and other areas do this so well, is a shared plan and a shared set of agreements about who the most vulnerable are. They are trying to move their interventions from crisis to proactive identification of the vulnerable, and put support there.

If we have those clear plans, things fall out of them that help the system to work, clunky though it may be. There will be information-sharing agreements that we talk about, argue about, agree and then implement. We will have great third-sector links and will work with innovative charities that help us penetrate the inequalities and BAME space or other communities where we need a more diverse offering. It is great that statutory agencies want to see 345,000 more children a year by 2023-24, but that will be so much less than the sum of its parts unless we have good local transformation plans, clear information sharing and a will to intervene in the early years.

The Chair: I am getting a bit tied up with time. I know you want to come back in, Amanda, but I am going to ask you to hold that and feed it into your next response. I am also going to ask Baroness Pitkeathley if Baroness Tyler can come in first, as she has time restrictions.

Q32 Baroness Tyler of Enfield: I want to probe a little further into the impact of the role of technology that the crisis has brought about. Claire, you have already talked about digital in mental health. Could you say a word or two more about what that has told us about ways of providing mental health care, as well as education and social care, for children and young people?

Claire Murdoch: We have examples right across the country. As I said, there has been a 35-fold increase in the use of technology. We have Attend Anywhere platforms. In some areas, youngsters are able to download an app on their phone and refer themselves to speak to an expert. We are able to speak to whole families. I have seen examples, including in my own trust, from in-patient specialist units where because they are specialist the patient is far from home. They use iPads so that parents are able to participate in whole cookery sessions or bedtime stories or do an activity with their youngster. We have seen tens of thousands of appointments through that route. We have seen the multiagency use of Zoom and other such applications, where we have been able to talk about and plan for those we are most concerned about.

Technology has huge potential, but there are two or three things to say. First, we need to evaluate it because we have moved at pace. We have

done in a matter of days and weeks what would have taken us years, but we now need to evaluate it. Many youngsters and their families are really appreciative of it and prefer it, but it will not be for all youngsters and their families, and it will not be in all situations. The NHS is very proactively looking at how we stand up our face-to-face care where it is needed, or face-to-face interventions where we need them.

What it has enabled during this period has been pretty astonishing. We want to explore it more. We want it to help with freedom, choice and accessibility.

Anne Longfield: Much of what Claire said has meant that people could do stuff at speed. I have been doing virtual visits. I have been talking to groups of kids on the Isle of Wight. That has all worked very well. Obviously, children not in school have been able to access support online and have been able to take part in some of the resources there, but it is important to say that about 700,000 children do not have access to an iPad or a piece of tech, and about 60,000 of them do not have broadband. While we all love the idea of it, for a lot of people it is not part of their life.

The other part is that children have been able to keep in touch with their parents or their family when they have been an in-patient or in prison. That is a move that I hope will remain. The quality of a relationship over a screen is always going to be different. If it is a health visitor making the first contact with a new parent, that is not an established relationship. If there is a difficult decision or judgment to be made about a child on the edge of care, that is going to be difficult over a screen. Social workers have been really innovative, getting families to walk around the house, opening fridge doors, zooming in and all the rest, but that cannot replace the importance of a relationship or everything that you can pick up about concerns about a particular child or family.

When we talk about technology, we do not often talk about the experience of the user, or the child. There is a job to be done—I suspect it is by me—asking children what they have felt about it as users. One child said to me, “I see a lot more of my social worker now, because I can always get her.” [*Inaudible*] That is something we need to know more about.

Amanda Spielman: We have had several social care examples, so I want to talk about education. There has been a great clamour for tech-led education, and some good work has been done building online lessons. There is an enormous “but”, which is that we know that there are many children for whom it does not work particularly well.

Human interaction with teachers and the dynamic with peers is very important for human motivation. Children who cannot yet read, children who do not yet have much English, children who have various kinds of special needs and, of course, children who just lack motivation or lack a parent to keep their nose to the grindstone have very low compliance with a lot of online education. Completion rates on the big online courses

that have been around for a few years are very low indeed. None of it is a substitute for the classroom experience. They are things that can only work for a length of time as a complement to the classroom, not a substitute.

We have to accept that gaps are almost certainly widening in a way that we simply cannot tackle with online-only education. We cannot get over the fact that not every child has a quiet private space to work in at home, a supportive adult who can dedicate a lot of time to them, or a device and bandwidth. It is not a set of challenges that any Government can ever overcome entirely. Being back in school is the best thing for the vast majority of children. It is really important.

The Chair: I might come back to that, but Baroness Pitkeathley is going to ask her question.

Q33 Baroness Pitkeathley: I want to focus on the widening gaps that Amanda just mentioned. All of our witnesses have referred to how we tackle inequalities better going forward. Could you give me a couple of brief ideas about something specific on tackling inequalities in delivering services, particularly to vulnerable and disadvantaged children?

Claire Murdoch: It will never be straightforward; we know that. The use of digital that can do translation and be adapted to youngsters with different needs will help us. I wanted to say earlier that we have been working even now with youngsters who have been using digital and getting their view on what has worked and what has not. I am happy to share that with the Committee later.

You have to have a determination to do it. For example, we are rolling out mental health support teams in schools. We were massively oversubscribed with the areas that wanted to be trailblazers or go first. We explicitly built into the criteria for selection areas that had high socioeconomic deprivation, high BAME and high free school meals, and areas where we thought they could benefit most from having the services sooner. When introducing services, particularly when we have to prioritise, we as the NHS or statutory bodies need to be much more serious about targeting areas of high deprivation, and we are determined to do that. If the local transformation plans I spoke about earlier are properly owned and implemented, and we can get the money flowing into those areas, they have one of the best chances of tackling inequality.

If I might give an example from Grenfell, where my trust provided mental health support to schools and the local community, one of the things we did that was immensely powerful was to recruit some key people from local communities to work with us and help us translate a health offer to a very distressed community. We trained them and they trained us, and through that joint work we have been far more able to reach hard-to-reach communities and build trust. There is something about whom you recruit and whom you train, as well as how you flow the money, together with the strength of local partnership plans.

Anne Longfield: In broad terms, I would say start early. Look at the first few years in life and have a renewed focus on early years and pre-school. Think holistically and understand that it is not just about school. We have seen schools becoming even more important as community hubs over recent weeks. That is something I hope will continue. There has been an announcement over recent weeks about social workers in schools, and the mental health teams you heard about. We already have family support workers, and I think there is a real benefit coming through that people understand.

Data is important, as is understanding of shared data in a local area, so that the boards Claire talked about can work meaningfully. You can only help people when you know who needs help, and that is often what is missing. There needs to be real determination to make it happen, with creativity about what you are going to do.

There is lots of talk about summer schools at the moment and how they might or might not be able to run. I have seen lots of front-line people who have been furloughed over recent weeks. It would be great to get them involved. There are youth workers, sports coaches and artists who could bring their skills to a local infrastructure and help those who need it most.

Amanda Spielman: Much of what we do to reduce inequality happens at school, either through education or through the services schools refer children to. For me, that is most definitely on the list. Thinking back to where we were three months ago, we were already doing a lot of work. We need to renew the pace and ambition, and plan for the bulge of work we know that we are going to get with the extra referrals that are likely to come through. We need to focus on the preventive services. Of course, a good education is one of the best preventives there is, but there are wider preventive services that perhaps have had a bit less focus than they should in recent years.

It is tempting a lot of people with quite radical ideas to talk as though perhaps we should reinvent everything from scratch. We would put a lot of children at risk if we did that, but we need to keep the sense of energy and purpose.

Q34 **The Chair:** Let me throw something topical at you right at the end. It comes particularly from your last answer. What is your reaction to the announcement that we are not going to be able to get children into school before September at the earliest?

Amanda Spielman: It is terribly disappointing. It has really saddened me that so many people have perhaps become more frightened than they need to be and that so many people have been looking at it from the point of view of what they cannot do rather than what they can. I would love to see more people in local areas stepping up and saying, "I could make this happen", and getting as much on the road as possible this side of the summer, with a real ambition for what happens in the autumn.

Alongside that, given that some children's education is likely to be disrupted by their own or their parents' shielding for longer than that, we need clarity about what children who are not physically in school should expect to get. Parents need that, schools need that, and children themselves need that.

If there is one thing I want to come out of what I have said today, it is that in the huge priority that dealing with the medical and care home crisis has been, which has been very much about adults, mostly older adults, it has been easy to defer the interests of children, which do not look so pressing or so big. Yet there is a big and serious issue that I would very much like people to bring to the forefront of their minds, because children's lives have been disrupted a lot for a long time already.

Anne Longfield: I have talked about it quite a lot over the week, and I am obviously and genuinely very disappointed. I am dismayed both that we can think that it is all right and that we cannot resolve it. Actually, there are many models of approach. There are huge amounts of potential creativity and approaches that we could draw on from different countries. For instance, we could requisition different buildings and temporary accommodation on the kind of scale and with the determination we have seen across health and other areas.

I am not yet prepared to take no for an answer, to be absolutely honest. I want people to think again, and then think about it positively and start to look at what you could do. Clearly there are a lot of things that people need a lot of help on, and a lot of challenges, but I believe it is possible. It needs to happen for the period before the summer, which should be about getting as many children as possible into school for a period of time, supporting their learning and getting them a meaningful summer.

Then there is the huge issue about preparing for September. In the past, we all thought that in September it would all be back to normal, but it is becoming clearer day by day that that is not going to be the case. We need determination and will. It reflects the fact that children have not been at the forefront of the health crisis, but they should certainly be at the forefront of recovery. They have a whole range of secondary issues that are very dangerous if we let them lie.

The Chair: I am not going to come to you on this, Claire. I am sorry but we are at the end of our session. It has been a fascinating session. Thank you very much.

The reason why Baroness Wyld did not come in with a question is that she is on the board of Ofsted and properly felt that it was not right to ask a question in this session. She is, I am sure, going to contribute to our ideas and our thoughts about what we have heard today. We have had two very different, but very interesting, panels with some huge challenges for all of us to think about.

I did not get to ask my question on prevention, which we started to talk about earlier. If there is anything you want to say on that or if there are

other things that you have not had the opportunity to say, please send us a note. We would be really grateful.

Thank you all for participating and for sharing your views with us. I am sure that we will keep in contact with you over the next few weeks.

I thank the Committee. We now have to move to Microsoft Teams to discuss where we have got to today and where we go from here. Thank you, everyone.