

Science and Technology Committee

Oral evidence: [Evidence-based early-years intervention](#), HC 506

Tuesday 17 April 2018

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[Watch the meeting](#)

Members present: Norman Lamb (Chair); Vicky Ford; Bill Grant; Darren Jones; Stephen Metcalfe; Carol Monaghan; Martin Whitfield.

Questions 212 - 375

Witnesses

I: Dr Shirley Woods-Gallagher, Special Adviser on School Readiness, Greater Manchester Combined Authority; Professor Alan Harding, Chief Economic Adviser, Greater Manchester Combined Authority; Dr Caroline White, Head, Children and Parents Service Early Intervention; and Martin Pratt, Chair, Association of London Directors of Children's Services.

II: Professor Viv Bennett, Chief Nurse, Public Health England; Dr Jeanelle de Gruchy, President, Association of Directors of Public Health; and Katy Hetherington, Organisational Lead - Child and Adolescent Public Health, NHS Health Scotland.

Written evidence from witnesses:

- [Greater Manchester Combined Authority](#)
- [Children and Parents Service Early Intervention](#)
- [Public Health England](#)
- [NHS Health Scotland](#)

Examination of witnesses

Witnesses: Dr Woods-Gallagher, Professor Harding, Dr White and Martin Pratt.

Q212 **Chair:** Good morning, everybody. Welcome, all of you. Thank you very much for attending. Perhaps we could start with each of you introducing yourselves briefly.

Professor Harding: Good morning, Chair. I am Alan Harding. I am chief economic adviser to the Greater Manchester Combined Authority, and also a visiting professor at the Manchester Institute of Innovation Research at the Alliance Manchester Business School—a bit of a mouthful.

Dr Woods-Gallagher: I am Dr Shirley Woods-Gallagher. I am a special adviser on school readiness for the GM Combined Authority. I am seconded from Manchester City Council. I also sit on a Government What Works centre evidence panel for the Early Intervention Foundation.

Dr White: I am Dr Caroline White. I am a clinical psychologist, and I manage the CAPS early intervention service in Manchester, which is a multi-agency early intervention service delivering evidence-based programmes. We have had sustainable implementation for the last 20 years.

Martin Pratt: Good morning, Chair. I am Martin Pratt. I am executive director of supporting people at the London Borough of Camden and chair of the Association of London Directors of Children's Services.

Q213 **Chair:** Great. There will be a lot of questions. Don't feel that you all have to answer every one, or we will be here until midnight. Try to keep your answers succinct if possible. We have to keep to quite a tight timescale.

This is a general question for all of you. Overall, what do you think the opportunity is for early intervention to address childhood trauma at a much earlier stage than has traditionally been the case? What are the potential benefits from taking action on that front?

Dr Woods-Gallagher: If we are talking about childhood adversity, which could be current trauma or, from an adult perspective, unresolved trauma from childhood, which could then interfere with their capacity to parent, one pilot that is being done in Greater Manchester at the moment is in the ward of Harpurhey in Manchester. Within that, we are training every single member of the workforce at place level to better understand trauma-informed practice as part of routine inquiry questions. It is not done in a deficit way, to say, "What's the matter with you?" Rather, it asks people what matters to them, and helps them to make associations between current behaviours and past traumas.

Q214 **Chair:** Who would be the range of people receiving that training?

Dr Woods-Gallagher: At the moment, it would be everyone in either the voluntary or community sector or public service who self-identifies that they think it would be beneficial to their service. That includes



schools, further education colleges, children's centres, health visitors, midwives, youth services, the police, the fire and rescue service, and health and social care partners.

Q215 Chair: Excellent. Are there any other comments about what the opportunities are? On a related question, how well do you think we are doing across the country? You may not have a perspective from the rest of the country, but what is your view about how well we are applying evidence to address this issue?

Dr White: As I said, we have sustainable implementation in Manchester, and we have been delivering evidence-based programmes for 20 years. It surprises me that we still do not have many other services delivering to that.

The evidence base for early intervention is overwhelming, in terms both of child outcomes and cost-benefit analysis—that it is cost-effective. We do not even need to discuss the benefits of early intervention too much. We know about that, and there is a robust evidence base for which programmes work.

Where we fall down is in the implementation of those programmes. I have been involved in consultation with other services, both here and in other countries, and it seems to me that it is the implementation science that is missing. We know which programmes we want to implement, but implementation science is still relatively new. There are things that we know make implementation successful, and we are not applying that knowledge as effectively as we could be.

Q216 Chair: Do you get the impression that it is very variable around the country?

Dr White: Hugely variable, yes. Generally, we could be doing a lot better, even with the resources we have, before we even start thinking about additional resources. It makes perfect sense to be looking more closely at the science around implementation. I have some experience of that, and I can identify some of the key areas where I think there are gaps so far.

Q217 Chair: If you have been doing it for 20 years in Manchester, are you able to point to any evidence of the impact that you have had?

Dr White: Absolutely.

Q218 Chair: Would you like to say something about that?

Dr White: Our evidence in Manchester matches all the randomised control trials that have been done on early intervention, particularly around parenting programmes. There is a robust evidence base. Frances Gardner recently published a paper that is a meta-analytic review of all the evidence-based parenting programmes—14 randomised control trials across many countries in Europe. Overwhelmingly, looking at the data and pooling it all, the findings were that those programmes work



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effectively, regardless of culture, country or background. They work best for the families with the biggest problems. Our outcome data in Manchester, using standardised measures, matches that completely.

Dr Woods-Gallagher: When the National Academy for Parenting Practitioners was developed, it advised that areas with large areas of disadvantage within them would expect reach rates and impact rates of between 40% and 60%, but nearer 40%. In Manchester, which has high levels of deprivation—or it certainly did at the time, 10 years ago—our reach rates were 80%. We were above even the best areas in the country, as can be the case if you get the implementation science behind it right.

Chair: That is very interesting.

Martin Pratt: One of the things that we found about the implementation phase, in a number of London boroughs and more generally, is that, looking at each of the programmes individually, they clearly have the desired impact. There is a good, strong evidence base.

A programme approach is required: thinking about how a number of programmes are drawn together to create an overall movement or shift in the centre of gravity in public investment towards prevention and early intervention. I think you heard a presentation about the resilient families programme in Camden. We found that, although we could deliver the individual programmes, they were not necessarily sustainable, but if, across the partnership, we determined to shift the centre of the investment, being clear about what the evidence base said and investing in those things together, we were able to move the dial on some intractable problems. For example, over the last four years, the rate per 10,000 of children in care per in Camden has reduced to 42 per 10,000, broadly.

Q219 **Chair:** From what?

Martin Pratt: The national rate is 63, and the London rate is 57, I believe. I will have to check those figures, but it is a significantly lower rate. It is not the lowest in the country.

Q220 **Chair:** You do not know what it was in Camden.

Martin Pratt: Yes. Five years ago, it was 53.

Q221 **Chair:** You got it down from 53 to 42.

Martin Pratt: To 42 per 10,000.

Q222 **Chair:** You are managing to keep families together more effectively.

Martin Pratt: Absolutely. It does not mean that we have simply raised the thresholds for intervention. There was an Ofsted inspection last year, which was clear about that. We have been able to work with the



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strengths of families and communities, and intervene earlier to prevent problems from getting worse.

The key indicator for us is the proportion of families we become aware of who receive early help and who, a year later, are still free from further state intervention. The figure at the end of March this year is that 83% of families who were identified early and went into an intensive early help programme do not have a social work or child protection intervention a year later.

Q223 Chair: That sounds very impressive. We are clear that there is a correlation between children suffering trauma, abuse or adverse experience in early years or in later childhood and adverse health outcomes later on, as well as poor educational attainment and criminal justice issues. We are not necessarily as clear about the cause. There is a correlation, but we might question the cause. How clear and how confident can we be that the interventions that we are applying are working and are effective?

Dr White: The largest wealth of research lies in evidence-based parenting programmes. There is a robust evidence base that that is not only the best way to prevent some of those traumas but, where they are not preventable, it is an effective intervention in managing children's emotional dysregulation or behavioural problems. The evidence for that is robust.

I come back to the main point. We know what programmes can be effective, but we need to be better at implementing them and thinking about how we set up and implement services robustly and effectively.

From a commissioning perspective, people understand what an evidence-based programme is. In commissioning a particular programme, there can be an expectation that it will just happen by training a workforce. It is so much more complex than that. For example, a workforce might be trained in an evidence-based programme, but people are just left to deliver it, rather than having the high-quality supervision and consultation that is required with most evidence-based programmes to get the outcomes.

We have clear NICE guidance about which programmes work in early years. Our service models are highlighted as models of best practice for early-years social and emotional wellbeing. Looking at the NICE guidance, it is very rare for the key indicators to be implemented. Maybe one or two of them are—for example, training the workforce.

Q224 Chair: Does it feel to you that Manchester is the exception rather than the rule, almost?

Dr White: Yes, I have to say that.

Q225 Chair: Does that make you feel that there is a case for some greater clarity nationally about what needs to be happening everywhere?



Dr White: Around implementation science, yes. Definitely.

Q226 **Chair:** The implementation of evidence-based approaches.

Dr White: We know what evidence-based programmes are, but they are not often delivered to model fidelity. That is the next stage we need to learn about. I know many well-meaning practitioners who deliver evidence-based programmes quite poorly. People then think that the programme has not worked because it has not been implemented effectively.

The NICE guidance states a lot of this. We have the information, but it is not what is carried out. That happens for a number of reasons. One is that there is often short-term funding; we are very short-sighted in how to implement things, rather than building for sustainability. I am always thinking five years ahead, even though I have never had a five-year contract in my service; it has often been for 12 months.

Q227 **Chair:** Presumably, your view is that you are saving money in the longer term by applying the evidence.

Dr White: Absolutely, yes. It is more cost-effective.

Dr Woods-Gallagher: Often when people buy in evidence-based programmes or assessment tools, they are a bolt-on. Instead of saying, "This is your mainstream budget, and here are your mainstream services," you get additional funny money, grants, social impact bonds or money from a philanthropist—wherever it is sourced from. That might set up a specialist team in-house, or you might commission it as a separate service. When budgets then contract, the first things that go will be the non-statutory things. To deliver systemic, fundamental change in workforce practice, you need to change the mainstream workforce.

Q228 **Chair:** That is why the training of all those professionals you were talking about is so important.

Dr Woods-Gallagher: Yes, and the inward change that needs to take place to sustain evidence-based practice. We certainly think that the opportunity of the apprenticeship levy could be a mechanism and a means to do that. You could think about the pre-qualification programmes that people are trained in.

Q229 **Chair:** Have you used that levy to fund the training programme you talked about?

Dr Woods-Gallagher: We have an intention to consider that at the moment. We have standards that may exist within early years—on practice, for example—or within social work around What Works, for pre-qualification and continued professional development. We might then have a body of evidence that is different, where the best NICE guidelines and others tell us about evidence-based practice and what we potentially need to do, either to work with existing apprenticeship standards or to



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create new ones and use the opportunity of the levy to sustain change within the mainstream workforces.

From next year, external organisations have the capacity to gift 10% of their levy. We might immediately think of big, private companies that might be able to gift 10% of that levy around an early-years systemic change, to change the workforce for one generation or five years.

Q230 Chair: Does the money have to be spent solely on apprentices, or can it be spent on a wider workforce?

Dr Woods-Gallagher: It has to be spent on apprentices, but it depends on the definition. You could class it as continued professional development.

Q231 Chair: Everyone becomes an apprentice for this purpose.

Dr Woods-Gallagher: Yes, for the purpose of training. We are doing this at the moment within the health and social care domain for health and social care adult degrees. We have lots of staff who might have come into practice and are really good family support workers, homelessness workers or home care workers. You almost reach a roadblock at the level 2 or level 3 qualification and have to jump the Rubicon to graduate a qualification on the other side and to accelerate your career through social mobility. That is the mechanism we want to create.

Q232 Chair: Alan, do you want to come in on the economics of all this?

Professor Harding: Yes. You mentioned Manchester exceptionalism. I do not think that we claim to be absolutely unique, but one advantage we have is the transition to the combined authority, which has taken new impetus in the last year with a directly elected Mayor for the first time.

That enables Greater Manchester to pool resources. That is not just money; it is intellectual and analytical resources. There has been a 30-year transition period, when Greater Manchester built its own organisational capacity. You do not only need the means to understand source materials, research and the implications of research; you also need a way of pooling expertise in the design, delivery and evaluation of new models.

Q233 Chair: You are using resources more effectively.

Professor Harding: Exactly. The sorts of arrangements that we have seen through health and social care delegation are an interesting model in that regard. There is continuation of acute services. We cannot reduce spend on those, because we react to issues in the community, but there is a transformation fund, which enables all the activity that colleagues have been describing to be designed on an experimental basis, rolled out and potentially scaled up, to demonstrate the capacity to deliver.

Q234 Vicky Ford: It is hugely exciting to hear about what is happening in Manchester, but I wonder whether there is any evidence that it is unique.



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I know that in my own county, Essex, they are taking a family hub approach, which means that the early intervention, as I understand it, not only happens in the early years but continues through the adolescent teenage years. That seems to be very exciting.

Is anyone collecting evidence of best practice across the whole of the country, and how do we see that?

Dr Woods-Gallagher: At the moment, we have been looking to Essex. Clare Burrell, your senior commissioner in Essex, has done some fantastic work over the years. In particular, she has looked into a risk stratification tool for early years. We definitely have those linkages with other areas.

I would say, with an Early Intervention Foundation hat on, that it is the role of the What Works centre to collate evidence and best practice to show what is working in different areas around the country. Even though we might then look, and I might look, at particular research engines, it would never stop us then throwing out networks—for instance, working with Graham Allen, the former MP, who has a fantastic network of early interventioners—

Chair: He is sitting right behind you.

Dr Woods-Gallagher: Quite. That is why I looked over my shoulder.

There is a network of people. We work within our network of practitioners to throw out questions, or even using social media to do that. We would say that we are continually on an iterative learning journey, and we are happy to learn and share with others. Essex is great.

Vicky Ford: Just say that louder. She said, “Essex is great.”

Martin Pratt: I am sure Essex is great, but, across local government, we have excellent examples of local authorities and groups of local authorities working together on ideas for early intervention, definitely using the information from the Early Intervention Foundation. That is not just about gathering information about individual programmes. As I said, that is very important, but I do not think it is enough. You need to be able to mobilise that knowledge in an overall strategy, and that has to be locally delivered.

Being able to deliver it across health, education, care and the voluntary sector is also really important. The unique role of directors of children’s services in being able to mobilise that local partnership has been influential.

Q235 **Chair:** We will come on to the sharing of data later, but there is also an issue regarding collaboration between all the different parts of the system that you are talking about.

Martin Pratt: It is what we might call systems leadership. When we look at the areas where it has worked well, that seems to be one of the key factors.



Although it is true that, in many cases, specific programmes are funded by a range of external sources, and therefore are vulnerable, there are pressures on the core statutory services. I realise that, in a sense, we are constantly trying to close the gap between where we are and where we would like to be in this transgenerational early intervention approach, but we have to be able to invest sensibly and for the longer term. That is one of the problems we are constantly up against.

Q236 Chair: There is always a dilemma as to whether it is all the Government's fault for the funding situation, or whether it is audacious decisions made locally about long-term investments. Caroline, you pointed out that you have chosen to try to do that, despite the funding difficulties. Where does the responsibility ultimately lie to make sure that the money is being used in the most effective way and to apply the evidence?

Martin Pratt: It is a combination. The funding environment has been very challenging over the last few years, particularly for local government, but it is for local leaders to understand their population, and to mobilise and invest in the right things.

We see a high level of variability. One thing that we hope will begin to address that is the development of the What Works centres, as well as approaches such as partners in practice, which mobilise best practice across the sector for transmission of the things that are likely to be most effective from one area to another.

Obviously, each local authority has its own sovereignty, as it were, and I would not want to say that local government ought not to be able to make decisions for each area.

Q237 Chair: Shirley, could you say something more about the different agencies that have benefited from raised ACE—adverse childhood experience—awareness? This is no doubt part of the training work that you have been doing. For instance, have you seen by working with the police that there is perhaps a better understanding of the impact of trauma in early years? Does that help to inform their work? Tell us a bit more about the agencies that have benefited from that.

Dr Woods-Gallagher: In terms of the journey for Manchester at the moment, and the work in Harpurhey, when we secured the funding just before Christmas, we could have gone out en masse, bought the ACE training, got everyone in a room and trained them: "Off they go. Fingers crossed—we hope they understand it."

Over the last four months, we have taken great time and care, with two officers from my former team going out to spend detailed time with frontline police officers, health visitors, midwives, schools and so forth, saying, "If you were to do a routine inquiry in your day-to-day practice, what would that look like? What do your existing questions look like? What would the uplift be to include some extra questions? What are the systems that you record them on, and how could we do that?"



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It is only now, at this stage, that we are considering what the actual training package would be like, because we have taken all that time to work out the implementation science, noting that it will be slightly different for one or another workforce, thinking, "This is how we will record the data. This is how we will supervise it at place level." We are not at the stage of saying what the impact is, because we are only just beginning to do the formalised training. That is because we have been trying to get the system ready, to understand how they would do it in everyday practice.

We have significant experience in Manchester of using routine inquiry through the IRIS programme, under which every general practice in Manchester is trained, including the nurses, the receptionists and the doctors, on routine inquiry and domestic abuse, as are our three midwifery providers in the three hospital sites. We have learned a lot from that about the confidence that people need to be able to feel to ask the questions.

Q238 Chair: Do you ever think about extending beyond the routine inquiry about domestic abuse to other ACE-related relevant issues?

Dr Woods-Gallagher: Exactly. What we are trying to do at the moment in the Harpurhey pilot is to understand, at place level, which practitioners it works best with. It might not make a jot of a difference whether or not certain public services ask these questions, and it will not change anything; for others, it might make a fundamental difference. If it does, particularly in relation to potential health domains, how should we consider the implications of that for the health economy?

Q239 Chair: Martin, what are the main early intervention initiatives in place across London, and would you say that it is a very variable picture, both in the types of programmes that are being used and in the effectiveness of the application of evidence and the implementation that we have been hearing about from Caroline?

Martin Pratt: There is obviously some variability, but we are looking to address that through collaboration between the boroughs.

On the particular areas that we have focused on, particularly in the early years, the 1001 days programme is a fundamental building block in many boroughs. That was highlighted in the "Building Great Britons" all-party parliamentary group report of 2015, although it has not quite found its way into all policy yet.

Tower Hamlets, for example, has restructured its early-years services based entirely on the 1001 days programme, because of its importance in early intervention. It has also secured funding for health visitors to carry out a programme of structured home visiting for families with risk of poor maternal or child health and development. That is one of the areas.

We have found that there are four key characteristics when we look across the early-years programmes. There is a focus on attachment, on



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language acquisition, on nutrition and on the healthy child programme. We then get into more detailed and targeted approaches, particularly around parenting, but those are the key themes that run through it.

Ealing has set up early help services with multidisciplinary approaches, including clinical and educational psychologists and family therapists. Barnet has something similar to the Essex model, which is not surprising, as I think Essex is supporting Barnet in its improvement journey. It has established the early help hubs in localities.

I have probably referred to Camden too much already, and my colleagues will not thank me for that. Islington children's centres are bringing together nursery education, health services and family services, as well as employment advice and CAMHS, with a real focus on resolving parental conflict.

There has been a theme around perinatal and maternal mental health as regards children's development. One of the areas we are looking to improve across the board is engagement with fathers in early years. We have seen from some serious case reviews that have been published that that area of public policy has been lacking, certainly in delivery. There are programmes focusing on parental conflict, including the growing together programme in Islington, which is commissioned via the CCG. Merton uses evidence-based programmes and the early learning together programmes, which are locally developed programmes, but they rely heavily on the evidence base and the work from the Early Intervention Foundation.

Those are just some examples. We could probably provide some more. On the question of whether or not there is general agreement that early intervention is the way to go, it is absolutely that. Whether or not there are the means locally, and sometimes the clarity of planning locally, is an issue we are trying to address.

Q240 Darren Jones: I want to dig a little bit more into the funding detail and the history of some of the changes around that. You have talked about public investment and sustainability, which both sound very good, but I wonder whether either of those are actually true in reality.

I note from our homework that we had the early intervention grant, then there were start-up funding assessments, and it has probably changed again since. Can you tell me if those changes have had positive or negative consequences and what that has meant for the delivery of early intervention services?

Professor Harding: In the most general terms, cutbacks clearly give local authorities incredible challenges. They have been allowed to have a small increment of financing for public health purposes, but it does not really compensate for the withdrawal of resources. Clearly, those things have an impact. However, the sense of comments from colleagues is that it is not purely about resourcing. There are ways of introducing more



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resources into the system. It is very difficult, and we have to be very careful about that. We do not have an awful lot of fiscal levers at our control, as you know, in order to do that independently. You are left with the system change arrangements that we have begun to talk about this morning.

It is a difficult question. Is the restoration of funding going to get at the issues that we have started to talk about? History does not tell us that that is easily the case. Much of what we are talking about today involves issues that have gone unreported through the system, so the system needs to change, both to recognise that level of under-reporting and to adjust to it.

Through the work that has been done in Greater Manchester, particularly with some nationally accredited work on cost-benefit analysis, we have tried to put some figures, in nominal terms, against the cost saving for different agencies from the success of some of the initiatives that we are talking about. That is useful in many ways. It is certainly useful for us in negotiations with national Departments. It demonstrates to a whole range of providers that it is in their interests to collaborate. I do not have the figures in front of me, but I am sure we could provide you with the paperwork on early years, for example, which demonstrates that local authorities save X% and the NHS saves X%, but the police, the probation service—

Chair: A note on that would be very helpful.

Professor Harding: We have done the work on that, Chair, so we would be happy to share it with you.

There is a big-picture story; then there is the service transformation story. Resources are important in all of that, but they are not the absolute be-all and end-all.

Dr Woods-Gallagher: When we did cost-benefit work in 2013 on early years as an investable proposition, it was apparent that the system does not break even until children are aged seven. That does not fit any grant cycle or any kind of electoral cycle whatsoever, but we know that the biggest recipient of a strong, effective early-years system is the Department for Work and Pensions when young people are aged 16. None of the financing of the DWP currently goes into the early-years system, so that shows some of the inherent system issues.

Q241 **Darren Jones:** On the combined authority front, has that allowed you to do anything different as regards financing or in the flexibility with which you can spend that financing, compared with before you were a combined authority?

Professor Harding: I will let colleagues comment on particular issues in their service area. In theory, yes, that is the case, but we live within the constraints of what continues to be quite a siloed system of public



expenditure. Since the Mayor was elected last year, we have gone through an elaborate exercise of aligning his manifesto commitments with many of the programmes that we are continuing through the transition period. Associated with all that is a quite elaborate outcomes framework, with indicators against it. Over time, hopefully, that will enable us to measure the degree of difference that we are able to make and the outcomes that it helps to support in the broader community, as well as looking at the relationship between those two things.

It is on the basis of that sort of evidence that you can do some clever sums on whether investment in area A, rather than area B, would be likely to lead to better outcomes for the public purse. To some extent, we are still a young organisation, bringing together a whole range of service areas, and we are expanding all the time.

Q242 **Chair:** Would you like to see something decisive done to address that silo problem?

Professor Harding: Absolutely. Some of the devolution deals that have appeared in recent years have started to do that. If colleagues from further education or the college sector were here today, they would tell you in no uncertain terms about the devolution movement within that sector. What do we do about vocational education and people who are failed by the academic system? Devolution has gone so far in a minor part of the budget, but there is very little sign so far—we put on pressure all the time—for post-16, and what do we do about the schooling system?

That all relates to what colleagues are talking about. It is our belief that greater delegation would do a better job. Yes, we continue to live with a silo mentality. That is fairly clear.

Q243 **Darren Jones:** Just so that I am clear about this, there is nothing in particular in the Greater Manchester devolution deal, or any additional powers that you have, that has made your life easier on this. You just carry on doing what you are doing, but in a collaborative way.

Professor Harding: In this particular field, not directly.

Q244 **Darren Jones:** Is there anything else in the Greater Manchester model that you want to talk about?

In Camden, are you jealous of anything that Greater Manchester has?

Martin Pratt: Jealous is not quite the right word. We watch with interest as the northern powerhouse swings into action.

From a London perspective, two issues have been alluded to. First of all, the beneficiaries of the investment in early intervention—either particular budget holders or particular departments—are not necessarily those that have to make the investment. Secondly, it is not necessarily over a timescale that fits with either the electoral cycle or the priorities of those organisations. There are some inherent system difficulties with that.



One of the interesting things has been to see how the limited resource that has been provided through the troubled families programme has in many cases been used as part of the investment both in the system change and in developing specific and targeted earlier interventions. There are already families who have been identified as having had adverse childhood experiences and other pressures on them. It has been interesting to see how that programme and its funding have been utilised, in some cases as a way of testing a proposition and then shifting the model of wider investment.

The move to earned autonomy for successful authorities is welcome. It does not change the quantum, but it allows some greater flexibility to deliver the programme outcomes.

Q245 Darren Jones: Lastly, there are examples of social bonds and private sector collaboration. I like the idea about the apprenticeship levy gifting, which sounds quite good. Do you welcome those initiatives? Are there any drawbacks? If you were to design the funding system, would you have that as a part of it? If not, why?

Dr Woods-Gallagher: We certainly have some experience of using social impact bonds in Manchester. Arguably, the riskier the idea is, the easier it is to bring in meaningful investment. To give an example from Manchester, we did some financial analysis around the use of multi-systemic therapy and a multi-dimensional foster care treatment programme. For MST, the evidence came back that the risk was lower, because of the higher numbers for the meta-analysis around the randomised control trials. Therefore, why would we not use our own money to invest in those, because it was a safer bet? External money could be used against the thing that was riskier, where there was good evidence but not at as high a level, or as sustained with multiple cohorts, as for MST for the multi-dimensional foster care treatment programme.

Those can be complex to set up. It is certainly difficult to do the stuff that Martin and Caroline have alluded to—the multiple programmes—because you have to have a contract around one particular investor, rather than a super-SIB, which involves three or four different programmes. That is much trickier, because who gets the benefit then?

Q246 Vicky Ford: On private sector funding, I am aware that part of the funding for the family hub approach in Essex came from growth funding donations through the second-tier authorities. I just wanted to put that out there and ask you if you were aware of that sort of approach elsewhere in growth—

Chair: And you are going to tell us that Essex is brilliant.

Vicky Ford: In growth areas—just to make it clear that we are aware that there are public-private-type models.

Dr Woods-Gallagher: Absolutely. One of our intentions around our school readiness work is to do an investment round table, with a potential



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philanthropist coming to discuss ideas about what potential there could be in that space.

Q247 **Vicky Ford:** This is for development contributions.

Dr Woods-Gallagher: Yes.

Q248 **Vicky Ford:** Going back to the question of how we evaluate how different local authorities are looking at their programmes, what evaluations do they tend to do in advance, and then looking back?

Dr White: Evaluation of what in particular? The actual interventions?

Q249 **Vicky Ford:** Of the early intervention programmes that they are delivering. Do they do enough evaluation in advance and in arrears? I think you have already suggested that they—

Dr White: Evaluation is crucial. It is one of the key implementation pointers that needs to be in place. In our service, we use the gold-standard measures for behaviour problems, emotional difficulties and mental health problems in parents for the interventions that we deliver. We use that fairly robustly: pre, post and at follow-up.

Q250 **Chair:** Do you think you are an exception in doing that?

Dr White: Some of the implementation things that need to change are about agency readiness to do the work. For example, data collection and analysis of data are built into people's job descriptions. We have our own information analyst in a full-time post within the service, because data is so important. Without that, data does not get collected, analysed or reported on effectively.

Nationally, IAPT has demonstrated that. One of its key outcomes was to have routine outcome measures in all services. It has struggled massively with it after several years.

Q251 **Vicky Ford:** You cannot get the routine outcomes compared between different authorities.

Dr White: Correct. People use different measures. IAPT has promoted the use of free measures, but they are not the best tools, so you will not get the same outcomes as in the original research, because they are not using the gold standard.

Q252 **Vicky Ford:** Are you suggesting that the measures that IAPT is promoting need to be reviewed?

Dr White: They are using the free ones, because that would encourage people to use them. It is a question of organisations not wanting to spend money using the standardised measures that we would want them to use initially.

A lot of the things around implementation that make it work and make it successful get cut out of the NICE guidance—evaluations, for example.



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We were not getting data collected and analysed properly until we had that post, and it was written into people's job descriptions and written into service level agreements. We are a multi-agency service, and I sub-commission to other organisations. We have three third sector organisations, Manchester City Council and the NHS. It is in the service level agreements with all those agencies that data collection and analysis are robust and need to happen.

Q253 Vicky Ford: Do you believe that is because they have actual challenges in collecting the data in the first place? Is there a lack of willingness? What do you see as the barriers to collecting the data?

Dr White: It is hugely time-consuming. It is boring going out to find families, tracking them down and going through three questionnaires with families. Line managers often say, "Well, don't do that bit of the job. We would rather you had more face-to-face contacts." Those things get shaved off a lot.

Q254 Chair: But you are saying it is crucial so that we understand what is going on.

Dr White: It is crucial, yes.

Q255 Vicky Ford: Is there a way it could be made easier?

Dr White: We have changed the system. We have changed our entire multi-agency servicing system, and there are contracts in place to ensure that that actually happens. It is an obligation and a requirement; it needs to happen. We routinely report annually on our outcome data. Without doubt, there is no way our service would have survived the austerity measures had we not had that outcome data. It speaks for itself, because it is extremely powerful and effective.

Q256 Vicky Ford: Having the outcome data makes it clear that the early intervention is cost-effective.

Dr White: Absolutely, yes.

Dr Woods-Gallagher: We were talking earlier about the apprenticeship levy and the opportunity around standards. It is really clear when you look at any particular frontline practice that people tend to go into frontline practice roles because they passionately care about the work that they do, but they have not necessarily succeeded brilliantly at maths in a school environment. Therefore, analysing and interpreting data is "not really why I came into practice."

What can we do around the pre-qualification route and apprenticeship standards on understanding the importance of being able to interpret data, and how data is important and helpful for enhancing your practice? It is not something you do, which someone else then looks at; it matters to you as a practitioner.

Q257 Vicky Ford: It is obviously multi-agency, with impacts on the police,



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health and so on, but are there ways that one can make it easier to collect data across different services?

Dr White: Technological infrastructure. When I began several years ago, there was the idea that everybody would have an iPad, and the data would get uploaded to a mega-cloud somewhere and we would just be able to download it. In practice, we are years away from being able to do that. They tried several times and really struggled with it, but that would be the routine way to do it.

Q258 Vicky Ford: In order to understand that the early-years intervention has cost-benefits and societal benefits across the whole system, do you really need to collect data on all individuals, or do you just collect data on subsets?

Dr Woods-Gallagher: Our ambition in Greater Manchester is to use the ASQ-3—ages and stages questionnaire 3.

Vicky Ford: That was my next question.

Dr Woods-Gallagher: It was a Jedi mind trick.

ASQ-3 uses social and emotional learning to track children from two months up to the age of five and a half. That goes beyond the early-years foundation stage profile measure and almost bleeds into key stage 1. That would enable us to track child development from the age of two months all the way through to the age of 16, using a tracking system, with digitised means of doing that, for the best understanding of domains of child development, potential gap areas and things that we need to do and uplift on. We are not saying that the ASQ-3 SE tool gives the whole picture, but we have a plan in Greater Manchester to look at broader information we also need to collect.

Q259 Vicky Ford: What do you see as the advantage of having that really early-years—almost from birth—information? What is the advantage of going back to that stage?

Dr Woods-Gallagher: Babies are born with 20% brain capacity. As we know from what Martin alluded to, with 1001 critical days, by the age of two, brains are 80% formed. Caroline could go into greater depth on that, as a psychologist, but that is a huge amount of public service and investment where we just do not measure. Ordinarily, you would do the two-year-old check at that point, where you can absolutely do work, but it is arguably more difficult, and it is more cost-effective to have done it during gestation and pregnancy, and during the first two years of life. What we can do by way of tracking mechanisms to get in even earlier around that would be better.

The early-years system is measured by a binary measure at the moment, which is the stand-alone assessment of the early-years foundation stage profile in reception. Arguably, that is a huge amount of public expenditure for five years from a number of agencies, and that is the first time we



measure it. We understand the compelling evidence on the importance of early intervention in early years, so we think it is important to track earlier, so as to be able to target in a meaningful way earlier, building on some of the work in Essex with the risk stratification tool.

Q260 Vicky Ford: What would you like Government to do to help?

Dr Woods-Gallagher: Gosh.

Vicky Ford: In a targeted way.

Dr Woods-Gallagher: In a targeted way? There are some really important discussions going on locally in Greater Manchester about the digitisation of that tool. At the moment, if it was paper based, you would have health visitors filling in bits of paper, which is what we have; then you would have early-years settings filling it in for two, three and four-year-olds, and you would have reception teachers filling in bits of paper. That makes it very hard to track outcomes.

If it was digitised, and we already have conversations planned around that, it would mean that people had ready access to that data, not necessarily the cloud that Caroline talked about, but it would be a starting point for being able to track the data. If, for example, a child was developing brilliantly according to ASQ-3 but, for some reason, then had a low score at the early-years foundation stage profile, it would give us more interesting conversations to understand why that was a low score—or not—in the system of the school. There may be a child who performs brilliantly at key stage 2 at the end of school. That would allow us to do that.

Q261 Vicky Ford: Martin, can you comment from a London perspective?

Martin Pratt: Yes. Distinguishing between two different sorts of use of data, on the first one, where you are implementing a particular programme, you have to be able to gather sufficient data to be able to evaluate its effectiveness, not only making the case for its continuation but establishing whether or not you are implementing it in a way that is having the impact. The second is a broader use of data, which we were slipping into there. We refer to it as forensic visibility, thinking about the information that is gathered from the earliest opportunity. It begins to identify children who have had adverse childhood experiences, where there are developmental issues emerging and there may be other warning indicators.

This is not to get into a situation where we are thinking in a deterministic way, but a number of those indicators should cause us to pay attention and therefore to work with the family and think about that child's circumstances. We have a number of examples across London where those kinds of things are happening. It would probably be better if I gave a written submission afterwards, rather than checking off a list of boroughs.



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Q262 **Chair:** Could you also quickly say whether the issues relating to data and the digitalisation of the system are pretty much the same in London as they have been described in Manchester?

Martin Pratt: For digitalisation, they are variable. Where we are working across different agencies, each agency may be properly enabled, but sometimes the systems are not talking to each other very effectively. There are certainly problems.

The other issue, on the opposite side of the comments that were just made, is that in the busyness of trying to deliver a wide range of services, we have to be able to collect the right things simply; otherwise, we are deploying more resource on gathering the data than on delivering the interventions. That is the balance that we are constantly trying to strike. There is a gold-standard way of looking at individual programmes, but what information do we need and how do we make it as simple as possible to collect and as clear as possible to analyse? We are taking a number of approaches, but we are not getting anything like consistency, even across the capital.

Q263 **Chair:** Is your clear conclusion that your plea to the Government is to pay for the licence for the online data—for the online version?

Dr Woods-Gallagher: We are not individually here asking anyone to plead on anyone's behalf. We already have work and digitisation discussions planned with the Department of Health and ourselves, as GM-Connect within the combined authority. If we get digitisation on behalf of Greater Manchester, what a fantastic opportunity that could potentially be for the whole of the UK. I am sure that every local authority would want to track child development from the age of two months onwards in a digitised way. When we did an analysis of what that would mean for frontline capacity for health visiting alone, we found that it increased the capacity of the frontline to deliver by 40%, by stripping out the paperwork.

Q264 **Chair:** Caroline, on your repeated references to the vital importance of implementation and implementation science, is your role unusual in the local government health and care setting? What we are hearing about seems immensely impressive, in the way you are doing things in Manchester, relying on data and applying evidence, but is that pretty unusual?

Dr White: One of the things that is beneficial is that I am a clinician and I am trained in the evidence-based programmes that we deliver. I have a really thorough knowledge and understanding of every element of that delivery. As the head of service, I understand the strategy and policy, and I understand the funding streams. I also really understand the frontline work, because I have been there and have delivered it, and I still do that.

If you look at other implementations, that is one of the key successful indicators for an implementation. There is research supporting that. If



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you look at some of the implementations that have been successful in other countries, it is the same pattern. There are people in strategic and important positions, who can influence policy and practice. The research will talk about having a champion within a service, but, if that champion does not hold a budget and has no responsibility for anything, it is pointless.

Yes, I think there is something unique about it. The people in charge definitely need to thoroughly understand the interventions that they are delivering.

Q265 **Chair:** Is that quite unusual, would you say?

Dr White: I think it is in the UK. It is less unusual in other countries.

Q266 **Martin Whitfield:** Could I clarify something about that data? Am I right in understanding that the information that you collate for full case management purposes is—to put a percentage on it—95% of the data you need to make a judgment on the effectiveness of the system? If the case management side was tied up, the maths side of drawing out the data could go to a specialist, perhaps reducing the pressure on the frontline staff for that.

Dr White: There is some good evidence, though, that having practitioners collect data improves their practice.

Q267 **Martin Whitfield:** Yes, and that would be within the case management role as well—the evaluation of the evidence in front of them.

Do you think that social workers should be the main focus for the early intervention work? Is that where the emphasis should be, or is it far more cross-disciplinary? I think that is the answer you hinted it. Is it about embedding that within the whole structures of local authorities and councils to make it work at its best?

Martin Pratt: You have really hit the nail on the head. We need a systemic approach, which means that we mobilise the entire workforce. Whether that is at the earliest and most preventive end, whether it is the universal services or whether it is a range of targeted services, one of the ways that we have been able to ensure that our social workers who are practising in a systemic way are able to focus on cases where children are at the greatest risk is by mobilising the wider workforce and making sure that there is investment, certainly in early years but also in other forms of family support.

We are doing quite a lot regarding adolescents, too. I know that that is not the principal focus of today's hearing, but, thinking about those young people, we are using innovation funding to identify young people at the transition between year 6 and year 7—primary to secondary—who have a number of adverse childhood experience factors and therefore may go on, or are likely to go on, to have difficulties as they become older adolescents.



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We are putting in an intensive support programme, with the families. We have 158 children in that cohort, and not one of the families has said to us, "We don't want any help, thank you." They have all said, to different degrees, "Let's work together to do this." The point is that social work is a really important component, but it is not the answer on early intervention. For social work, having the same system leaders overseeing the whole system is really important, and having clarity about the model that is being implemented is also important.

Dr White: My thoughts are particularly about the early-years workforce, which is obviously multi-agency. I do not know what the figures are for how much of their role is delivering evidence-based practice, but I imagine it is very small. We could use that resource much more effectively.

I just had a thought about what you were saying before about my role within our service. I do not think it is imperative that someone has to do that, but that specialist expertise should be bought in for services if you do not have it. That is just to link those things up.

The point about the development of the workforce is really important. Training gets bought in, but not ongoing specialist supervision and consultation. That is the bit that is massively missing in most implementations, and it is crucial to success.

Q268 **Martin Whitfield:** Do you think there is scope not just for social workers? Reference has been made to the police, midwives and others. Do you think there is enough evidence to say that this training should be introduced pre-appointment in their training, so that the base is more uniform, hopefully, across the United Kingdom? Would that be a benefit, rather than you having to take on the training at the post-qualification stage?

Dr Woods-Gallagher: Yes. It is a twin-track approach. We have the existing workforce, so what can we do through the CPD route? That particularly involves maximising the opportunity of the apprenticeship levy. Other budgets are constrained, but the levy pot is there.

That begins to influence the system, so that we think about pre-qualification, too, rather than it all being through the CPD route. What is the pre-qualification for an early-years worker, for a midwife, a health visitor and so on? Yes, they will be taught about things such as the healthy child programme, and that is brilliant, but we know that the NBO and the NBAS are really important screening tools that should be used on wards, and it is really important to think about the home learning environment—past trauma of the parent as well as current trauma, and not just a safeguarding issue—as part of midwifery practice, so let's get that in the pre-qualification route, so that we are not just paying for it in employment.



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Martin Pratt: It is worth remembering that, certainly in the capital, quite a high proportion of the children's workforce did not qualify in the UK. The population is very mobile, too, so we might put a lot of investment into early years, but that does not necessarily mean that those children will be the same children who are growing up in those boroughs.

There is a strong argument for having a national approach and paying attention to the evidence base in qualification training is also absolutely essential. There should be multidisciplinary training, so that different aspects of different professional disciplines are contributing, but the same frame of reference is also important. That is why continuing local development requires investment and leadership.

Q269 **Martin Whitfield:** Again, that very much hints at the silo mentality that we have already heard about.

On the point about the apprenticeship levy, you said that Manchester has been considering it over the last four months or so. Do you have any insight yet on how on you are going to maximise the impact of the use of the apprenticeship levy, or is it still too early to say?

Dr Woods-Gallagher: It is too early to say as regards the early-years work. At the moment, we want to consider what the existing apprenticeship standards are within the early-years field, all the way from level 1 qualifications through to postgraduate level, and map that out, to see which of them are currently apprenticeship standards and which are not, and map out the existing providers and the quality of the provision.

We then need to think about what the compelling evidence tells us that people really need to know about. We have touched on data analysis as one of those things. There will be something about screening tools, something about pre and post measures, something about being system ready and something about being able to navigate your role as a professional in an interdisciplinary team, and being confident about that. Those are all really important component parts. There is also child development, and understanding the difference between chronological child development and neurological child development, and the disconnect between the two and what we can do to address some of those things. They are really important things.

Q270 **Martin Whitfield:** Would it be right to say that the apprenticeship levy is not the pot of gold that actually interests you? It is the input that you can have in relation to apprentices and the role that you have in that. Do you have a timescale by when this is going to happen?

Dr Woods-Gallagher: This particular mapping and planning piece of work will be taking place over the next 12 months.

Martin Whitfield: The next 12 months—excellent.

Dr Woods-Gallagher: I assume that other areas of the UK are considering this.



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Q271 **Carol Monaghan:** I have a quick question for Martin. You mentioned that much of the early-years workforce has trained outwith the UK. I suppose this is a bit of a sideways question, but do you have any concerns about the impact of Brexit on your ability to continue to deliver early-years provision?

Martin Pratt: Yes, in that any significant change means that the supply of staff will obviously change. That is not to make a political point in any sense, but simply to say that it will be a significant factor in terms of the workforce. Therefore, we need to think ahead. It makes it more important that we are thinking about local populations and the career paths and training and development of young people who are in school now. That is one of the areas, of both academic and vocational opportunities, where we should be thinking about the need to provide the children's workforce and the health and care workforce, making sure that we are giving prominence to the professions that will be delivering that crucial activity going forward.

Q272 **Carol Monaghan:** Are you confident that that is having some sort of impact?

Martin Pratt: I am confident that people are thinking very seriously about it. On the question of delivery, I am not yet in a position where I can say confidently that, either across the capital or across the country, we have got to grips with that, but we are certainly very much seized of the issue.

Q273 **Martin Whitfield:** If you had a wish for Social Work England, how could it improve the ability of the social care teams regarding evaluation, intervention and delivery? What would your "Please make it better by doing this" be?

Martin Pratt: When I look at the social work practice that I see every day in the authority where I work, I am seeing the best-quality practice that I have seen in 35 years in the profession. The first thing to say is that there have been significant investments, which have actually made a difference—just to fly the flag for social work.

One of the areas that requires attention is the application of evidence. We have moved to a degree programme over the last few years as the social work qualification. It is clearly focused on practice, but you cannot really develop your practice unless you understand both child development and the evidence base. They try to squash quite a lot in, and there should be greater emphasis on that area.

On the development of practice leaders, being literate in the understanding of the evidence base is increasingly important for lead practitioners, managers and practice leaders. That is something to pay attention to across the system, not just in initial training, although that is certainly where the foundations are laid.



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Dr White: That is what I would like to build on. We have spoken a lot about workforce development and training people, but there is a risk that we end up training everybody in everything and not being very focused on the interventions themselves. We have talked a lot about the development of training for social care staff, not just the basic training, but ongoing case consultation. People across the whole workforce often say, "Well, they get supervision." What they actually mean is that they get line management; they are not actually getting case consultation or theoretical supervision of their practice. That is hugely missing across the workforce.

Q274 **Martin Whitfield:** Is it right to say, Martin, that your request is for skill and a pool of knowledge that we have now and could roll out?

Martin Pratt: Yes, absolutely.

Martin Whitfield: Excellent.

Q275 **Chair:** Do data and basic statistics form any part of the training of a social worker?

Martin Pratt: Not that I am aware of. I have not reviewed the programme recently. I am not certain.

Q276 **Chair:** Presumably it ought to be.

Dr Woods-Gallagher: I worked on two of the bids for the Greater Manchester social work academy, which was our name for the teaching partnerships led by the two chief social workers. The intention around some of the workforce transformation within those was certainly to include evidence, interpretation and data interpretation within that, with social workers able to understand and use that. It is not just that it is important to record data because, at some point in time, 20 years or 10 years from now, the child, as an adult, might wish to read the words that you have used to describe them, as well as considering the accuracy of the information; critically, commissioners, the director of children's services, Ofsted and the treasurer might be analysing and interpreting the data and making fundamental decisions about service redesigns on the aggregate of what all of that means for your particular patch in your neighbourhood.

Q277 **Chair:** Presumably, that should all be part of a social worker's training.

Dr Woods-Gallagher: Yes.

Q278 **Chair:** On the issue of the use of the apprenticeship levy, are you basically wanting to use the part of Greater Manchester's apprenticeship levy that comes from your services, or are you doing a big land grab to try to get a greater share, because you see it as so fundamental to saving money in the longer term?

Dr Woods-Gallagher: I can only speak personally, but I personally would want to go for a big land grab. First, why wouldn't you? Secondly—



Q279 **Chair:** Is your argument that the authority can save money in the long term, investing to save?

Dr Woods-Gallagher: Not just the authority, but the whole of the partnership. If the DWP is the biggest recipient of the benefit with people aged 16, and if the system breaks even at age seven, which is the beginning of junior or primary school years, and we know that there are exponential savings for police and criminal justice, critically, given children's social care and the pressures on budgets for mental health and looked-after children's services, those children could actually have a fantastic opportunity to enjoy their childhood and have an untraumatised, happy childhood, with the potential for social mobility. Why wouldn't you do that? That is my personal view.

Chair: One that I tend to share.

Q280 **Bill Grant:** I will touch initially on the healthy child programme. How valuable or important is it to identify families with pre-school-age children who would benefit from early intervention? Does the programme have a valuable role in that regard to identify those who would benefit most?

Dr Woods-Gallagher: Certainly, the healthy child programme has really good evidence behind it, and we see that as important. Earlier, Alan touched on the transformation fund bid that we have at the moment in Greater Manchester. Part of that, through our eight-stage model on early years, is to look differently at what we call stage 1, which is midwifery screening, where you first book into the system—literally booking a bed. Is it midwifery-led care or obstetrician-led care, for instance?

Some of the additional questions in the healthy child programme will identify medical risk around pregnancy, and they will certainly identify current harm and current safeguarding issues. It does not look at the potential of past harm, which we have talked a little bit about. Critically, it does not consider the potential of a risk to school readiness if we are just looking at learning outcomes for children in terms of screening. If the parents themselves have a special educational need, we do not screen for that in pregnancy. If the parents themselves had really low language and literacy acquisition and outcomes at school, we do not screen around that.

What can we do from pregnancy onward, when everyone wants to do the very best for their care-dependent child, and people are not sleep deprived with a new-born baby? It is an opportune moment. That is the key learning that we should take from the family nurse partnership. People are awake, they want to do their best and they are engaged with services. What can we do around those domains now? That is why we want to extend and build on the brilliant learning from the healthy child programme, but widening it to think of the broadest potential of what we can screen around.

Q281 **Bill Grant:** The healthy child programme is a beginning, and there are



tentacles reaching into other aspects of concern.

Dr Woods-Gallagher: Absolutely.

Q282 **Bill Grant:** Moving on, how important are Sure Start centres for facilitating or harnessing resources under a multi-agency approach? Are they pivotal? Are they key for that?

Dr Woods-Gallagher: Yes. Other colleagues will wish to touch on this, but the original intention of the Sure Start local programmes involved working with families in the most disadvantaged communities to assist them in a true partnership way, with parents being part of the co-production model and the panel to influence decision making.

In Manchester, our partnership model, which Caroline articulated so well, is not just a children's centre. There is integrated delivery. That includes midwifery, work and skills and language and literacy. It might even have a library on the premises. There are toy libraries and so on. It draws in a package of support, with far more of a pedagogy approach to what the family or community needs, rather than just saying, "This is what we've got on offer."

Q283 **Bill Grant:** There is general consensus that there is value to the Sure Start centres.

Dr Woods-Gallagher: It is possible to deliver everything through the Sure Start children's centres. We have done some community capacity-building. At the end of interventions, parents often feel empowered and often want to go back into volunteering, education or employment. We are able to facilitate that through volunteering through the Sure Start children's centres.

Q284 **Bill Grant:** Having recognised there is immense value in them, we note that local authorities since 2010 have reduced funding for Sure Start centres. I will touch on three possibilities. Are they using the money to target directly elsewhere? Are they funding alternative early intervention systems? Is it simply an overarching lack of money?

Martin Pratt: I think two things have happened. One is that the financial constraints have meant certain very difficult decisions have had to be taken, not so much about where centres are open but where you save them. There has had to be a reduction in overall provision, and in most cases they have been concentrated in areas of the highest deprivation and need, but they have moved away from very broad universal approaches towards targeting children, and indeed parents, who are most likely to benefit.

One of the crucial things we have found is not just the importance of the delivery of parenting support and all of those things, but that, when we are working on child poverty for example, parents are using the support they get in children's centres to think about the opportunity to get back into work. They are being supported in employment and they are using



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the hours of child care they have flexibly, to be able to undertake training and those kinds of things. Poverty is a key issue, and the best way out of it is usually employment, although we know that there is an increasingly high level of working poor.

To make a general point, in almost all areas some children's centres have been saved. I do not think we should interpret the closure of children's centres as a loss of faith in the model but simply as the prioritisation of a shrinking resource.

Q285 Bill Grant: There is general agreement that Sure Start centres will continue to have a future, and that funding would help.

Caroline, I noted something between pride and enthusiasm when you talked about the 20-year journey in early intervention in Manchester. You came across very positively, but you used the words "sustainable over 20 years," and presumably for the future. Could you expand on sustainable? Is it because there is a need? Is it because there is a good outcome? Is it because you use data to convince elected members to secure funding? What made it sustainable, and what injects the pride and enthusiasm you displayed?

Dr White: Guilty as charged. It is all the things that implementation science tells us enables things to be sustainable. It is things like being programme-driven rather than practitioner-driven; collecting good data in the way I have described and being able to report on that data and interpret it for people so that it is meaningful and not just number-crunching; it is about understanding policy, practice and need. We have high levels of need, but it is about matching the right interventions to those levels of need and being responsive to commissioners.

One of the key things about sustainability is having strategic leads and commissioners understanding what we are actually doing—really understanding that—and it has to be a multi-level approach. That is not just by sending someone something to read, or a quick email or phone conversation; it is building relationships over a long time and helping everybody in the system to understand what early intervention means, what evidence-based means, what model fidelity means and what is involved in all of that.

Q286 Bill Grant: You gather data and use that data to support the good work that is going on.

Dr White: Yes, it is ongoing. You get austerity, and the 10 people you have worked with for 10 years disappear and you get new people with new ideas. It is an ongoing process; you can never stop the process of education, updating the research and understanding what we are trying to deliver. I could submit a note that outlines some of the key things around implementation and sustainability.

Q287 Chair: That would be very helpful.



Professor Harding: The things Caroline is describing are reflected in some of the transitions that the combined authority as a whole is making. The big penny that has dropped over the last half-dozen years is all about public service reform as a route to solving some of our economic challenges, and making those connections. We know that Greater Manchester has been on a positive economic trajectory for quite a long time. Challenged by the post-crisis period, we have none the less come to appreciate that, unless you tackle some of the entrenched problems that many in the potential workforce in Greater Manchester face, you run the risk of the benefits being extremely skewed towards particular groups, so all the comments about the need for a more joined-up and long-term sustainable approach to public service reform are absolutely written into the GMCA strategy.

Q288 **Chair:** You have stressed the importance and value of Sure Start. In 2015, the Government announced a consultation on the future of Sure Start. Ofsted suspended its inspections of children's centres in 2015, and three years later the consultation has not started. Is it important to resolve this question about the future? It seems to me there is a risk of a hiatus with people being uncertain about what the Government's intentions are. Does anyone have a brief comment on that? Nodding is going on.

Martin Pratt: From the perspective of London councils, we would want to see that consultation happen, so that we can be clear about the position Sure Start centres have in national policy going forward.

Chair: Presumably, the ongoing suspension of Ofsted inspections is not particularly satisfactory.

Q289 **Stephen Metcalfe:** I would like to start by talking a little bit more about the role of Government in all of this and where the balance lies between the role of central Government and the role of local authorities in delivering and targeting intervention. Where is the balance, and is it the right one?

Martin Pratt: I'll have a go at this one. As we were just saying, it is important that there is clarity about national policy, in particular that it is evidence-informed and that it is being supported. We have already talked about the What Works centres, the Early Intervention Foundation, and, you could argue, there is the Education Endowment Foundation as well. There is clarity that this is the direction of travel, but on local delivery it is important that local authorities have sufficient flexibility to be able to respond to the needs of local populations, and that they have a sense of the moral imperative for changing the lives of children locally.

If it is regarded as delivering a national model rather than a serious connection between families, communities and local representatives, we lose something. Setting the direction of travel and investment is a crucial part of the role of central Government, but to cut local government out of that sense of moral mission would be wrong.



Q290 **Stephen Metcalfe:** Is the balance right at the moment, or should it swing one way or the other?

Martin Pratt: The balance is different in a number of different policy areas, which I suppose is inevitable. I will touch very briefly on a number of quite positive developments through the Department for Education recently: the development of the Innovation Fund and the partners in practice approach. A greater move to sector-led improvement is showing a shift in the balance from what was previously quite a directive approach to one that is more collaborative. That is unleashing quite a lot of potential and a sense of shared ownership that is having a demonstrable effect.

Q291 **Stephen Metcalfe:** How significant is the support the Innovation Fund provides?

Martin Pratt: It is a relatively modest sum, but it is providing opportunities to test other models of working, principally moving away from a highly proceduralised bureaucratic process to one that focuses on evidence-based interventions and professional judgment. It helps to make the case for change, not externally but from within the sector. I think it is having a significant impact. I ought to declare that Camden is one of the beneficiaries, in the sense that we have innovation funding for a particular programme. You might say that I would say that, but that is my view.

Q292 **Stephen Metcalfe:** How useful is the Early Intervention Foundation? Is that equally beneficial?

Dr Woods-Gallagher: Obviously, I have a conflict of interest, having been on the evidence panel for the Early Intervention Foundation, so I declare an interest. It is hugely valuable to some of the discussions we have been able to have at the evidence panel, which is purely academic—I am the rogue practitioner on it—on questions such as whether, when you look at the original RCT evidence, that is the cohort it is used for, but from an innovation and local authority perspective I might want to use that intervention as a rehab home service to help a DCS with a looked-after children's budget. That is the innovation side of it.

Q293 **Chair:** DCS being a director of children's services.

Dr Woods-Gallagher: Yes. Apologies. Based on our implementation science, we know that we need to evaluate the living daylights out of where the benefits land in this because we are going beyond the remit of what the original research told us, but that does not mean that we cannot do it. If we were looking at it purely from an academic point of view, it would be: "edge of care"—not "once in care"—and going home. Why would you use that? We have been able to have some systemic conversations, changes and influences around academic practice and understanding, using that panel to think, "No, we can push at innovation if we have the implementation science right." Rome is burning and there are lots of children in the looked-after children system who could be



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rehabbed home, but we do not necessarily know what could work. Based on the evidence of, say, multi-systemic therapy, we think we should take a punt on that to rehab children home. Having done that in Manchester, we have had a good success rate.

Q294 **Stephen Metcalfe:** Would anyone else like to add anything?

Martin Pratt: Its real power is that it mobilises the evidence in a way that is accessible and, therefore, it is being used. When I asked my colleagues across London a number of questions in order to prepare for today, there was a pretty universal view that the Early Intervention Foundation was a good source of that information, that it was accessible and it was able to mobilise that information quickly into service design.

Q295 **Stephen Metcalfe:** Is there more the Government can do to incentivise or enable more widespread use of early intervention, particularly the programmes and then the evidence and evaluations, to spread best practice? What more can the Government do?

Dr Woods-Gallagher: Clearly, we are not the Government, or here to tell the Government what to do.

Q296 **Stephen Metcalfe:** Please do.

Dr Woods-Gallagher: Maybe an interesting question to the system is: at the moment, how many areas are looking at using the apprenticeship levy to embed evidence-based practice for early intervention, not just creating brand-new jobs for 16 and 18-year-olds in the system but using it as continued professional development? That would be an interesting query, because money is sitting with HMRC waiting to be used.

Q297 **Stephen Metcalfe:** As an aside, on that particular bit about apprenticeships, are you working up the standards? Are there trailblazer groups in place working up standards for continuing professional development?

Dr Woods-Gallagher: Not at the moment, but there will be an ambition to do that around early years.

Q298 **Stephen Metcalfe:** Forgive my ignorance, but which way round does it go? Do you have to set up the trailblazer group first to decide what you want the standard to look like and start working on the standard and how to evaluate it, and then you can start to apply for apprenticeship funding to fulfil that standard?

Dr Woods-Gallagher: It depends. For some of them, there might be existing trailblazer groups nationally, but not for others. For example, in the health and social care economy for adults, we now have 120 staff across the place, whether in hospitals, community teams or commissioning, going through a health and social care degree programme. We looked at the existing business administration apprenticeship standard, and there was sufficiency in that, because it talks about integrated professional practice, just to vary the contents



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slightly. You did not need to go through the trailblazer standard, so it depends on what is amenable.

Q299 **Stephen Metcalfe:** It would not be that much of a challenge to get this up and running.

Dr Woods-Gallagher: I do not think so.

Q300 **Stephen Metcalfe:** Changing track slightly, I want to ask about how the services that are currently provided are audited or examined. What external process is there to audit what is being delivered?

Dr Woods-Gallagher: Obviously, each local authority has an internal audit function. You have your external audit functions; you might have performance research intelligence teams that interrogate data; you might do dip samples, because you are trying to create a business case in a particular area. It would depend on each potential locality.

Martin Pratt: In terms of impact, each area is inspected by Ofsted and the CQC, so there are regulatory and inspectoral arrangements as well, which have become increasingly good at identifying the impact. Whatever the models that are being implemented locally, they ask the question: what impact is that having on children? We are getting a really serious body of evidence through that source as well.

Q301 **Stephen Metcalfe:** How good is Ofsted at examining the services you provide when it comes to early intervention?

Chair: You need to be very nice to them.

Martin Pratt: We were inspected last year, in November, and they published a report that was clear about the maturity of the partnerships. The focus on prevention and early intervention was identifying children early, preventing them from unnecessarily coming into the care system and reducing risk. There is an opportunity in that deep-dive inspection process to look at the impact of the cumulative decisions taken in a particular area. I might leave it there.

Stephen Metcalfe: I think I will as well.

Q302 **Chair:** Reflecting on the evidence you have given, and given the moral imperative Martin talked about earlier and the clear evidence you have accumulated over 20 years of the return on investment that you can achieve by applying these approaches and the enormous variability around the country in the extent to which evidence is applied and implemented, is there not an enormous opportunity to have a national drive to ensure that what is happening in Manchester and in parts of London is happening everywhere?

Dr White: It would be fantastic if that happened.

Dr Woods-Gallagher: Yes. You touched on Brexit earlier. I am not going to discuss the details of that, but we need to think about an industrial



strategy for the rest of the century. When you look at early years and when the system breaks even, it appears to us, certainly within Greater Manchester organisations, that the compelling evidence is there. The reason we had the Manchester independent economic review in 2009 is not that early years is an interesting thing to do for young children; it is part of our industrial strategy moving forward, and surely that is nationally of great significance at the moment.

Chair: Thank you very much indeed. It has been an absolutely fascinating evidence session, and we appreciate your time.

Examination of witnesses

Witnesses: Professor Bennett, Dr de Gruchy and Katy Hetherington.

Q303 **Chair:** Welcome, all of you. Apologies for the late start. Thank you for your patience. Could we start by each of you quickly introducing yourself?

Katy Hetherington: I am Katy Hetherington, child and adolescent public health lead at NHS Health Scotland, which is the national health improvement agency in Scotland.

Professor Bennett: I am Viv Bennett, chief nurse and director of maternity and early years at Public Health England. I am also chief nurse for public health nurses, midwives and health visitors for England—essentially, the chief health visitor.

Dr de Gruchy: I am Jeanelle de Gruchy. I am director of public health for the London Borough of Haringey. I am also acting president of the national Association of Directors of Public Health.

Q304 **Chair:** Can I start by asking you to what extent is early intervention a matter of public health? Does the public health role of local authorities and Public Health England focus only on preventing ACEs—adverse childhood experiences—or also on mitigating their impact?

Professor Bennett: Public Health England as a public health agency embeds this discussion in a framework around inequality, need and vulnerability. We would look at all those things around what we can predict, what we can assess and what people might express in terms of needing a response.

We would look at primary prevention. That might be on the wider determinants of health and a place-based economic prosperity model. We would look at individual intervention, either primary intervention, for example in the maternity pathway we have just heard about, or early assessment or response to express need after a baby is born, to try to provide the universal service, plus a bit of early help that avoids the need for further and more costly intervention later on.

We would also look at mitigation, where we have not managed primary prevention or have not managed to avert through early intervention



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further difficulties arising for a family. What kind of evidence do we have about mitigating the impact? As we heard in the previous session, that multi-generational point means that we might come in at different levels on any of those issues.

Dr de Gruchy: I agree with Viv. That is how directors of public health would see the issue locally. Our mission is about reducing health inequalities, and you have seen the evidence of the impact of ACEs on a baby and child across their life course and intergenerationally.

Q305 **Chair:** Does it concern you that only a tiny proportion of public health spend within local authorities is dedicated to public mental health?

Dr de Gruchy: I see the director of public health as being a system leader, so it is also about how we have wider influence, not just the budgets we hold. That is why I would say that having a public health team is really important. It is about providing a link to other services and policy areas. It is about policy areas, not just programmes or services. When you think about interventions, it is not just the one-to-one services; it is also things like the Sure Start centres or healthy schools programmes. All those kinds of community-type interventions are really important. How we help to link different partners in some of those policy areas or community interventions is important, as well as the commissioning of the services that we hold.

Katy Hetherington: In Scotland, the importance of early years is recognised across a number of policy areas. Our work as a national health improvement agency is based on the social determinants of health and the Marmot review. We have had a long-standing commitment from chief medical officers about the importance of prevention in early intervention. Currently, there is discussion about a new public health body being established in Scotland over the next year, and there is wide-ranging consultation and engagement with a range of stakeholders about what the public health priorities should be for Scotland. I am pretty sure that early years and the impact of early adversity across later life will be an important priority for us.

Q306 **Chair:** We have heard that preventive measures are relatively under-researched as an area of early intervention. What preventive measures are you prioritising in your work both in Scotland and nationally, and in your network?

Professor Bennett: We have done a considerable amount of work on areas of most impact. If I use the example of the health visiting service, which is responsible for delivering a lot of the primary prevention in England, we have identified a four-level model of service: the preventive elements of building community capacity and capability; the universal opportunities for the healthy child programme and two more early intervention levels.



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Within those, we have identified six areas of high impact where we know that, at the very least, there is correlation between input and improved outcome. They include things like perinatal mental health, to pick up your last question, and early mental health resilience-building prior to and during pregnancy and in the year after pregnancy. They include basic things like promoting breast-feeding, which is important for both nutritional and protective health factors, and can help to support early attachment. We have identified those six areas in prevention where we have good evidence of a correlation of activity with outcome, even if we cannot as yet measure direct causation.

We run a voluntary data-collection process, which is very well subscribed to, with local authorities. We collect a whole range of evidence that we publish on Public Health England Fingertips so that local authorities can see where they are in primary prevention.

Q307 **Chair:** What is your assessment of how widespread the application and effective implementation of that evidence is across the country?

Professor Bennett: The evidence we have, judged from responses by local authorities and the data collections we do, is that at least some elements are being implemented everywhere. If we look at the mandated health visitor reviews, which is how we would judge the progress of the universal healthy child programme, we know we have very high coverage generally, but that masks some individual variation. There are some elements everywhere and some local authorities probably provide more focus than others.

Q308 **Chair:** Jeanelle, is there any view from your network?

Dr de Gruchy: On the health visitors issue, since we took over commissioning, directors of public health are very committed to the healthy child programme and see it as really important. They are committed to working with providers to do the best in terms of improving the activity.

There are some signs of improved outcomes. The previous panel talked about transformation in the way we do services. It is also an opportunity to look at skill mix and how we do things—for instance, integrating effectively in children's centres or Sure Start centres, and making the join-up that certainly Manchester is looking at.

To complement Viv's focus, we also have adult services. When you are talking about prevention, it is really looking at drug and alcohol services, issues of violence against women and girls, domestic abuse, and mental health. Although directors have very small budgets for public mental health, a lot of money is going into the system generally. Are we getting right all the services that are addressing adults with the issues that are actually causing the ACEs? Are they thinking about the child? Are they joined up? We still have a job of work to do around that to make children visible. Even if it is an adult service, where are the children in the



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service? There are policy areas around some of the issues I have mentioned, but we also need to get the services right when those issues come to the fore.

Q309 **Chair:** Viv, what co-ordination is there on early intervention across Government, and how closely do you work with the Department for Education?

Professor Bennett: After discussion with the Department of Health and Social Care, it was agreed that PHE would take the lead in bringing together the cross-Government and national local work on early years, including early intervention. We have established the Children and Young People's Partnership Board. It is co-chaired by me and a chief executive of a local authority, Phil Norrey, who represents Solace. We have senior civil servant representation from the Departments for Local Government, Education and Work and Pensions, all the health arm's length bodies and the LGA. We try to negotiate that policy spread, draw out the themes as they impact on children and families, help support local areas with evidence and reduce the plethora of separate policy initiatives, and the work is conducted largely through that group.

Q310 **Chair:** How long has it been there?

Professor Bennett: Three years.

Q311 **Chair:** Jeanelle, you told us that early intervention has had a confused public policy approach. I think that was the wording you used. Why do you say that, and what changes would you like to see? Does it need more sense of a national imperative? We hear about the approaches in Scotland and Wales. Do you feel there is a clear enough Government strategy on early intervention and addressing trauma in childhood? Could more be done?

Dr de Gruchy: It would be very helpful to have a much more strategic, overarching approach to what we do in terms of early years and children. At local level, we can see how some of the policy directives that come down are not necessarily always joined up or focused on the early years of children, so that would be very helpful. What we are getting at is something about definition on prevention, early intervention and early help, but also something more pertinent, which is about the different Departments having a shared understanding of what we are trying to do and what the evidence is for that. If we had that national strategic direction, it would be a very helpful framework for what then comes down to local level, and for what we do and how we join it up locally.

Q312 **Martin Whitfield:** Am I right in saying that the healthy child programme is the only universal early intervention screening programme for children under five?

Professor Bennett: It is the national public health programme for children under five, and it reaches from the antenatal period, as it says, to five, and contains the outline of the interventions expected at each



stage. For example, we would do more detailed work in designing the care pathway for maternity if we wanted to focus on different things. It sets out the programme every child will have. It works from the premise that every child has the best start in life. Clearly, we are not starting in the same place; some children need more help than others to get there, but all children and families need some help some of the time, even if it is as basic as having immunisations so that they do not get sick. The programme sets out at different levels the kind of help that should be commissioned and provided.

Q313 **Martin Whitfield:** It is central. As you say, all children need some input and some help, so it is a central tool in identifying those children and at what level they get it. We had evidence that 20% of children are currently not receiving mandatory universal health visitor review assessments. Do you know why not?

Professor Bennett: I would make three points. One is that there are five reviews, and the data on the uptake on all of them are not the same. For example, very nearly 100% of babies get their new baby visit, but only about 75% to 80% of people may have an antenatal visit, and that is about prioritisation.

Q314 **Martin Whitfield:** That is prioritisation by the health workers rather than new mothers.

Professor Bennett: In terms of the way the programme is commissioned, local authorities at the point they took on commissioning were required to achieve a level of coverage at least that of the NHS, so there is some inherited gap. The second point is that, when the changes were made and the national programme finished, there was no formal data collection in place, so to fill the gap Public Health England instituted voluntary data collection. We do not have fully validated data so there may be data gaps. That will be improved—I suspect you will want to come back to data—by some of the new data systems that are being put in place. There is also national variation.

Q315 **Chair:** Is it voluntary rather than mandatory?

Professor Bennett: Nationally, we are not able to require local authorities to submit certain elements of data.

Q316 **Chair:** Do you think it needs to be mandatory?

Professor Bennett: That question will be obsolete once the new system starts to run, which is happening now. We have had very good relationships with local authorities and the submission of data has been very high. Almost all local authorities submit. Some have not been able to reach the level at which it can be published, but almost all local authorities submit data. In answer to the question, yes, we were concerned that that might mean that we did not have a good data flow, but working jointly with local authorities we are receiving that data. Does that answer the question?



Q317 **Martin Whitfield:** Given the absence of data, albeit data is coming in, are you able to identify any common characteristics in the fifth of children that are seemingly missed out in one of the five assessments?

Professor Bennett: For antenatal assessment, those people will be seen anyway. The one they are missing is the additional one by the health visitor. They will be seen in the maternity system anyway.

Q318 **Chair:** That is quite an important one to be missed, isn't it?

Professor Bennett: It is a very important one, and we would like to achieve 100%. The evidence we have, which is reported back from the services, is that people prioritise. If we go back to our list of need, they prioritise families that are likely to need more help and families having their first child, so if there is a prioritisation to be done it is done on that evidence.

Q319 **Chair:** In answer to Martin's question, is it the self-sustaining families who are missing? Is that the 20%, or actually are you missing out on families in need?

Professor Bennett: I do not have that data at that level.

Q320 **Chair:** But we need that data, don't we?

Professor Bennett: Indeed we do, and the datasets that will allow us to have the record level data that are starting to be produced now will enable us to link the family and child at an individual level. I think we heard from the previous witnesses that we do not have those systems in place now. Locally, a lot of the work in identifying families in need and ensuring that they are prioritised is practitioner-led, but nationally we do not have the system in place such that I could give you evidence in answer to your question.

Q321 **Martin Whitfield:** How long do you think it would take to get to a position where that could be answered, under the changes that are envisaged? Is it 12 months?

Professor Bennett: I asked that specific question because I thought I would be asked the question. I refer to the expert view. The bodies that need to make it happen are working closely together. This work is being led by NHS Digital, and the data will be collected through the community dataset, which will be a record at child and family level and will start in the maternity period. They are working with bodies such as Ofsted and the early years people—the national pupil database—around how we use ASQ to do the record level interventions, so that when the intervention happens it is recorded in the central system. It will record both the activity and the outcome, and, over a period of time, we will be able to do what was described earlier, which is to link from the very earliest days to school entry and beyond.

As to how long that will take, if there was a perfect system tomorrow, it would still take five years, because clearly it takes five years for children



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to reach that level of maturity. As to how quickly we think the system will start to do that work, I hope that within the next two years we will start to see some of that improvement. Some of it will depend on investment.

Q322 **Chair:** Does it have to take another two years to get there?

Professor Bennett: I would need to come back to you on that. I am not an expert in setting up the programme.

Q323 **Chair:** I would appreciate a note from Public Health England on whether there are opportunities to speed up the implementation of this.

Professor Bennett: The work is led by NHS Digital.

Q324 **Chair:** Perhaps you could have a word with them before you come back to us.

Dr de Gruchy: Directors of public health would absolutely welcome the work being done on data. To go back to the previous point about submitting the returns, it is not that directors of public health do not want to do it; it is our frustration as well. It depends on the provider systems in terms of data collection. There is also the historical situation that many of us have inherited in being able to get the data to submit, and for us to have robust data to inform our work locally.

Q325 **Martin Whitfield:** There was an online commissioning toolkit, wasn't there? Is that not used any more? Do we know what has happened to that?

Professor Bennett: I am sorry.

Q326 **Martin Whitfield:** I understand that under the healthy child programme the guidance talked about an online commissioning toolkit to advise local commissioners on what interventions to offer.

Professor Bennett: Public Health England has published a number of toolkits and guidance around the commissioning of the healthy child programme. Local authorities have requested things like a national model specification. All of those are available online and they were in our written evidence. The way that is communicated is through a number of mechanisms and networks, and we are now looking at online usage and pick-up of the latest version of that, so those commissioning tools are available.

Q327 **Martin Whitfield:** They are available and being used.

Professor Bennett: Yes.

Q328 **Chair:** I am confused. Our information was that it was no longer active. Are you telling us that the commissioning tool is active and available?

Professor Bennett: I am not sure if we are talking about a specific commissioning tool. What we are both saying, I think, is that there is a range of commissioning tools around the healthy child programme published by Public Health England, working with the LGA, which local



authorities are using. Whether it is the specific one that you are referencing I am not sure, because I do not know which one that is.

Q329 **Martin Whitfield:** There is no one toolkit you can go to in order to identify the strategies that would assist families. There is a variety of toolkits, depending on who approaches them and how they go about it, to help them identify what is available to commissioners. Is that right?

Dr de Gruchy: On the healthy child programme, there will be a specific toolkit that we will be using.

Q330 **Chair:** That is the one.

Martin Whitfield: It is that one.

Dr de Gruchy: Yes.

Q331 **Chair:** We are told it is not active.

Dr de Gruchy: I am just aware that there are lots of materials we make use of. I do not know whether it is called that. We would have to go back and have a look at it.

Chair: Viv, perhaps you could provide us with a note on that.

Q332 **Martin Whitfield:** Given that there has been a fall in health visitor numbers, is that not the cause of much of this problem?

Professor Bennett: The peak of health visitor numbers in this country was clearly at the end of the national health visiting programme. At that time, we were empowered to collect very detailed data on the number of health visitors employed in this country. I could have virtually told you their names, as the person who led that programme. We are no longer able to do that, so the only ongoing record we have is the number of health visitors employed in the NHS, and it is the NHS that completes the electronic staff record.

We know that health visitors are also employed by a range of other bodies, but we are not empowered to collect that information. We try to take snapshots. Our current understanding, based on the electronic staff record and reports from local authorities and professional bodies, is that there has been a fall in the number of health visitors. We are unable to tell you how big that fall is, because we are not empowered to collect that information. Some of the fall is due to local authorities being under extreme pressure and reducing commissions; some of the fall, however, is in the kind of things Jeanelle alluded to, which is the redesign of services and a skill mix workforce being introduced.

Clearly, if you reduce a workforce, it will have an impact on the level of service being delivered. The impact on the mandated elements of service is, anecdotally, less than the non-mandated elements. The commissions support all of those five critical reviews. What we are told by practitioners is that some of the other elements of work that they did are no longer



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commissioned. For example, we are seeing fewer clinics for babies at four months where previously people were advised about weaning and so on.

Dr de Gruchy: I agree with what Viv said, but taking health visitors as a workforce, recruitment and retention is such that we have vacancies and we struggle to fill them for a range of reasons. In the nursing workforce and health visitor workforce in particular, the focus that has been brought to bear has been really helpful, but it is about sustaining that. Sustaining the career choices and pathways of health visitors is important.

Q333 **Martin Whitfield:** If I can clarify that, there is a fall in health visitor numbers and there has been some effect on the quality of the health reviews, but that may hide other losses of services health visitors did—as you say, additional clinics—so other supports for families are being removed to try to maintain the reviews. Would that be right?

Professor Bennett: If we look at the level of coverage of the five mandated reviews before they transferred to local authorities and after, they are about the same. In some places, there have been gains. I do not think we can say that it contributed to a fall. We may have hoped that we could increase coverage and that has not happened, but for the most part local authorities have met their requirements in sustaining the level of activity.

Q334 **Martin Whitfield:** Maintaining the reviews.

Professor Bennett: Of the mandated elements of service.

Q335 **Martin Whitfield:** But that may well have been at the expense of non-mandated services.

Professor Bennett: From the evidence, the professional bodies say to us that it has concentrated things in two areas. It has concentrated on the mandated universal reviews and on families with higher levels of need, so those two things will be prioritised. Some of the other primary prevention activities that health visitors led before, they may not be able to lead now. In some cases, that may mean they are not available; in some cases, it may mean, for example, that a children's centre may have included that in some of its programmes.

Q336 **Chair:** Are there any other contributions?

Dr de Gruchy: Very briefly, there is a positive message about transforming the way health visitors undertake the healthy child programme and what comes out of that. There have been examples of health visitors identifying large numbers of children with speech and language needs. There are two examples just on that. We know how critical that is in terms of early years. This is about the two-year check.

In Devon, they had specific training for health visitors to become more skilled in speech and language, because they knew they could not refer all those people to a speech and language service. In my borough, Haringey, we worked with our CCGs to look at the capacity for speech



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and language. They have shifted their model to parent group approaches rather than one-to-one interactions. We are trying to get much greater capacity with the existing resource. What is important is how we can make the existing mainstream resource work more efficiently and effectively, notwithstanding that, as the previous panel said, it has to be evidence-based. We have to bear that in mind. There is room for innovation, but having the evidence base to inform that is really important.

Professor Bennett: In response to the question about working with DFE, and in response to Jeanelle's comment, a major focus for PHE next year, working with the professions, local government and across Government, will be closing the word gap at five, which is a kind of title for really intensive work around promoting early language development in all children, particularly those we know are lacking in exposure to speech and relationships and then struggle at school. This is a really big opportunity for health visitors, among others, and the DFE will be funding further training for health visitors in that field.

Q337 **Chair:** Have we seen a similar reduction in the number of health visitors in Scotland as happened in England?

Katy Hetherington: I do not have the numbers, and I would not claim to be an expert on health visiting. There is a commitment to increase health visitors in Scotland in order to implement the new universal pathway for health visitors, which is increasing the number of contacts the health visitor has with the family over the first few years of a child's life up to 11 contacts, and eight within the first year. Health visitors are being supported to build up relationships with families and work with them across a broad range of areas, including housing, homelessness and financial inclusion.

Q338 **Bill Grant:** Katy, thank you for coming all the way from Scotland to see us. This question is primarily but not exclusively to you. Looking at adverse childhood experiences, what has been the response and benefits in Scotland to the growing evidence base on adverse childhood experiences and their consequences, not in every case but some cases? Is there a difference between what we are experiencing in Scotland and elsewhere, in England?

Katy Hetherington: Thank you for asking us to come down and share the work we have been doing. Our work in Health Scotland has always had a focus on childhood adversity, recognising the impact that has on lifelong health and wellbeing. Specifically, work on adverse childhood experiences began probably two years ago. A report called "Polishing the Diamonds" was published. That was commissioned on behalf of all directors of public health in Scotland to summarise the evidence base around ACEs, including the work Mark Bellis has done, which I know you have heard about, and work in England, the States and other countries, and to set that within the context of recommendations for action in Scotland. That set out a number of areas of action for us.



Q339 **Chair:** That was led by the directors of public health rather than by Government, wasn't it?

Katy Hetherington: Yes. ScotPHN—the Scottish Public Health Network—undertakes work on various topics or areas of interest on behalf of all directors in Scotland. Health Scotland was asked to take forward the recommendations in that report. One of the first things we did was to set up a multi-agency group to help us think through the recommendations around that. We see the importance of this work as working with lots of different sectors. I do not think any one sector has all the answers, and it is a chance to work together and bring lots of people together to help us shape that. We feel that we have an important leadership role in taking forward the debate on childhood adversity in Scotland. The report was a real springboard for action around that.

What we have seen over the last 18 months is a blossoming of interest in this work. The ACE research has given lots of different professionals, sectors and communities a language that they understand. One of the areas for action was about raising awareness on ACEs, and we have been doing a lot of that over the last couple of years. We have been using the documentary *Resilience* as a tool to summarise complex public health information in an accessible format to people.

We do not just show the film; we have a panel discussion around it, with different sectors contributing. There was one at the weekend in Wester Hailes where GPs, people from justice and the community all came together to talk about what it meant for them. It has been a really powerful tool that we have used not just in communities but across Government. Ministers have seen the film, and there have been discussions with the First Minister and the Deputy First Minister.

Q340 **Chair:** Can you send us a copy?

Katy Hetherington: It is a licensed documentary, but we can talk to you about it.

Darren Jones: It is worth paying for.

Q341 **Chair:** It is pay for view.

Katy Hetherington: Not through us. They are all free.

There have been screenings across the civil service in Government, and there is now a Scottish Government network around ACEs to bring together different policy areas to talk about this. Our hub has been leading events and conferences to bring lots of sectors together. We have published reports from seminars. We had a conference in March with Education Scotland, because there has been real interest from the education sector about adverse childhood experiences, and what that means in a school setting. Given the focus on the attainment gap in Scotland at the moment, it has been very timely.



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There has been a lot of activity. The important thing for us is that we have political commitment; the focus on childhood adversity in the Programme for Government. The First Minister spoke recently in a speech in China about childhood adversity. She has talked about this being the most important thing we are doing across Government at the moment, so we have a political and civil servant commitment around it. In Health Scotland, with our public health community and lots of different agencies working with us around our hub, we are able to take that out to lots of different places to think about how we translate that policy intention and the research on ACEs into practice.

Q342 Bill Grant: Do your colleagues recognise any of that, or would they like a copy of the documentary for a modest fee?

As you said, there is a two-year timescale, so it would be fair to say that it is in its infancy. Has there been any evaluation of the impact of routine inquiry about adversity in childhood on child and adult welfare?

Katy Hetherington: No. As colleagues from Manchester said, we are scoping that out at the moment. One of the areas identified in our ScotPHN paper was about exploring routine inquiry. We have had two seminars with Dr Warren Larkin, who came up to talk about the work he has done in Lancashire. We have had a lot of interest from lots of different places around routine inquiry. On the back of seeing the *Resilience* documentary, some GPs asked whether that was something they could look at. We are working with some GP practices in Glasgow and Edinburgh. I think eight practices are interested in piloting this.

We had a meeting yesterday with our colleagues in NHS Education Scotland who have developed a trauma training framework to think about how we support the workforce around routine inquiry, because it is not something you would just want to drop in. In all our work on ACEs we do not want this to be seen as an add-on or something additional; it is very much part of our overall approach.

We are at an early stage with routine inquiry, thinking about workforce development and testing ways of doing that. Evaluation is really important, so that is something we will be thinking about right at the start. We are also looking to other parts of the country to learn what is going on around that.

Q343 Bill Grant: I understand that it is part of your role to bring on board elements of the health service provision and, within the health service and outwith it, to bring in the police, fire and other agencies. It is working, because the police in Ayr refer to me about ACEs. They have taken it on board in Ayr. Sometimes there is resistance by long-standing organisations to embrace things, so well done; you have convinced that element of the police.

Who manages this? How well integrated are we to recognise the value of knowledge about adverse childhood experiences? How far advanced are we? Is it working? Are they coming on board with you, and who manages



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that to get it across? I know it is a big question.

Katy Hetherington: I can talk about our role in Health Scotland, which I think is contributing to a national conversation about childhood adversity in Scotland. We have had no shortage of people coming to talk to us about it. The research resonates with people. The research has been around for a long time; it is not new, and lots of different professions have known about this. We have particularly used work that has been done in Public Health Wales—the modelling work of Mark Bellis on the impacts across the life course if we can prevent ACEs. It is not a hard sell for us in Scotland at the moment.

People from the Scottish Prison Service want to work with us on this. Education and the police are involved. We have a chief commissioner from Ayrshire police on our hub who has made a commitment to ACE-informed policing in Ayrshire. In Health Scotland, through our ACEs hub, we are trying to bring together a selection of those agencies to provide national leadership to work with Government, and with practitioners. The research resonates with their practice and what they are seeing in their day-to-day work. It is not just about early years and children's services. Although I work in child and adolescent health, it is very much applicable to adult services, as Jeanelle said, so homelessness and housing services are very interested in the work.

Q344 **Bill Grant:** Local authorities in Scotland have an immense role. Has GIRFEC—the getting it right for every child initiative—been helpful? Does that integrate with you, or does it run in parallel?

Katy Hetherington: As I said before, it is not seen as something that parachutes in over and above. We see it very much as part of the policy environment about getting it right for every child. COSLA and our local authority partners are very interested in the work we are doing, and we look forward to working with them more closely on this.

Q345 **Bill Grant:** There is a dovetailing of the initiatives.

Katy Hetherington: Yes.

Q346 **Bill Grant:** And the local authorities are key players.

Katy Hetherington: Yes.

Q347 **Chair:** Jeanelle, do you think that directors of public health in England would benefit from a hub approach similar to what you have heard about from Scotland?

Dr de Gruchy: Scottish directors of public health are part of the national ADPH, but we will definitely have a conversation outside and see whether we can share that best practice in England as well.

You emphasised the join-up between different sectors and services. That is really important. I want to mention the joint targeted area inspections that are taking place. We had ours recently on neglect. It was really



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good, in that it was asking all the different sectors locally, "How joined up are you?" It was not focused just on children; it was about adults and children. Were the adult services thinking about the child? That is happening as well.

Q348 Martin Whitfield: I want to come back to the GIRFEC element. With regard to adverse childhood experiences, in Scotland we are at the start of a potential rollout and join-up that has huge potential. We heard in the first session a lot about silo mentality. Is silo mentality present in Scotland, or do you find that more departments are open to listening to other areas? I am thinking in particular of education to health and health to justice, through the police and so on.

Katy Hetherington: I can only speak from where we are in Health Scotland. Although we are an NHS board, we very much work with lots of different partners. That is part of our work. The work on adverse childhood experiences has provided a real opportunity for breaking down some of those silos. We are having conversations with senior civil servants in Government about the impact of early childhood adversity in later life and what that means for work in criminal justice, the police and adult mental health services.

Q349 Chair: Do you see a willingness to break down barriers from all those different agencies?

Katy Hetherington: Yes. That is not to say that they are not still there, but the articulation of the importance of early years and the impact that has on later life being recognised in the Programme for Government has provided that opportunity.

Q350 Martin Whitfield: That strategy has allowed doors to be opened and professionals across the board to talk to one another about what is important for children and their future.

Katy Hetherington: Yes. I think it is providing the opportunity for discussion and some sort of national conversation about how early life is really important, and it matters. As colleagues from Manchester said, it is important to get that right for the future prosperity of our country.

Q351 Chair: Two sentences, Viv.

Professor Bennett: That kind of work is also going on in England. We have memorandums of understanding with the police; we have work going on in local areas joining up public health, mental health and the police. That is really good work that we are also embedding in this country.

Q352 Stephen Metcalfe: I would like to come back to the healthy child programme and ask how effective you think it is at identifying those who need early intervention.

Professor Bennett: The evidence is clear that a strong universal service will ensure that people are identified at the earliest possible opportunity.



In our reviews, there is no other known model that does better. By being in contact through the model we have set out under the healthy child programme and the transformation of the health visiting service, we can certainly say it is based on the best evidence, and there is no other system that identifies families better. As Jeanelle said, I am sure there is more we can do in transformation. We are certainly looking at the training of practitioners. There are huge opportunities around integration.

The healthy child programme sees children episodically. People working in nurseries and children's centres see people on a sustained and daily basis. Joining together those two inputs is really important. I have done work with DFE and others on the training of the early-years workforce. Giving that workforce, above all, confidence that they are experts in comparing groups of children and noticing children who need extra help is something very positive that we could do. The healthy child programme, based on the evidence, gives us opportunities at fixed points in life to notice children who have suffered adversity, or to prevent that adversity, and provide additional services targeted to those children, but it needs to be set in the context of the place-based development of work with services such as early years to be fully effective.

Q353 Stephen Metcalfe: What proportion of children seen under that universal system require additional support?

Professor Bennett: I would not be able to give you that. It depends. We describe a level of service called universal-plus. How many people would need extra help to breast-feed their baby? How many people would need extra help because they have post-natal depression? They are not figures we currently keep.

Q354 Stephen Metcalfe: Or collect.

Professor Bennett: That is exactly the word I was looking for. Thank you. Locally, people have done more work on commissioning pathways. They would be able to give you a local picture where, for example—this is entirely hypothetical—70% of their families receive universal services only; 85% receive universal-plus, which is one-off extra help; and 15% receive ongoing additional help, or something you might formally term early intervention. That information would be available through commissioning information locally.

Q355 Stephen Metcalfe: If you are not collecting detailed data, how do you assess the effectiveness of the interventions that you are providing?

Professor Bennett: We collect a range of indicators through the public health outcomes framework, which I have here. Most of those are factors relating directly to what you might term physical health, but they also identify a number of risk factors—for example, smoking status at the time of delivery. That is a physiological measure, but mothers who smoke are in very deprived communities; they are usually very young and are likely to need more help. Some of them are a direct measure, but some are sentinel markers for other needs.



Another one is tooth decay in children under five. That is highly correlated with inequality and the need for additional support, as well as the state of the children's teeth. If you wish, Chair, I can send you the list. I think it is in our submission, but we can resend you the metrics we keep for early years on the public health outcomes frameworks that are available to all local authorities.

Q356 Stephen Metcalfe: Thank you. How important is the data collected in helping local authorities plan for what public health measures they should deliver?

Dr de Gruchy: For a director of public health, data is always important, but data quality is the pertinent one. We have talked about the frustration that completion of the datasets is not as good as it should be and needs to be, including data linkage to other services so that you get a more rounded picture.

The importance of early years, early help and intervention and the focus on it in local authorities often gets skewed towards quite high-risk cases, and that is where a lot of the funding goes. I am sure your other panel touched on that. What we need are either data or evidence locally to make sure that money is also put into prevention and early help. That is where population level understanding locally, to make the case about how you can focus on larger cohorts and groups of children, who may go on to be that higher-risk and higher-cost case, is really important. That is why having that data is so important.

Professor Bennett: I failed to give you the two most important elements of the data. There are two that directly refer to everything we have been discussing this morning. We collect developmental information at age two through the ASQ domain score and we collect the school readiness indicators through the early years foundation status. It is that work that will inform the data linkage work we discussed earlier.

Q357 Stephen Metcalfe: To go back to the public health outcomes data, I think you said in your evidence that it was difficult to collect in a systematic, rigorous way. What would improve that? What could we recommend that might help to standardise that collection of data?

Dr de Gruchy: Viv can correct me if I am wrong. There is a children's digital health strategy. That is about collecting that data, but we can also link together other datasets. It goes back to the point about trying to get a more coherent strategic overview of what is happening to children and their journey over years. It is longitudinal understanding, as well as what happens to different cohorts of children. It is about reinforcing the importance of data and, if I am correct, the digital health strategy and making sure that that happens as quickly as possible.

Q358 Chair: You talked about the difficulty of collecting, which is the point Stephen is making. Why is that? We can connect it all up better, but why is it difficult to collect?



Dr de Gruchy: For instance, we are relying on providers, NHS trusts, and their systems and practitioners to input the data in particular systems. It might come from health visitors; it might be linked to the GP systems.

Q359 **Chair:** Is part of it the need to get buy-in from all of those different organisations?

Dr de Gruchy: It is an element. I know that in London NHS England has just recommissioned the whole digital system for children.

Q360 **Stephen Metcalfe:** Did you say NHS London has just recommissioned the way it collects data?

Dr de Gruchy: I would have to check, but what I am giving you is the sense that those systems are not necessarily all in place, so we are reliant on its happening within the services to be able to extract the data.

Q361 **Stephen Metcalfe:** I am looking for a comment rather than an answer. Is there not a danger? If NHS London is going ahead and changing the way it collects data and, therefore, metadata—data about data—so that it is more accessible, shouldn't there be national guidelines, so that everyone is at least moving towards the same data collection standards, rather than reinventing it all the time? Okay, the NHS London model may be great, but if we are going to invent a different system in Scotland, how will we ever get all this data into one place to see if the patterns and projections can be realised?

Professor Bennett: The work in London is part of the NHS Digital work to establish the child digital programme. It is not a stand-alone programme; it is part of the implementation. For some reason, the community dataset has changed its name from a child dataset, which is probably more clearly understood, but it is the same thing. Clearly, we are authorised to comment only on data collection in England, but NHS Digital's work is to provide a coherent single platform. There will be some local variation, for various complex reasons of supplier opportunity, but, essentially, exactly as you say, it is to standardise the way we collect the data, to be able to have an individual record level for each child and build that story as we go forward.

Currently, we have a breadth of indicators in the public health outcomes framework and we have to draw data from various sources. Some of those are automated and routinely collected; some of it has to be collected and provided, and that is perhaps the area where, as Jeanelle says, sometimes it can be more difficult than the automated systems, on immunisation, for example.

Q362 **Stephen Metcalfe:** There is probably still more investigation to be done about how we collect and analyse data. We have talked about the ASQ. Would you comment on whether or not you think there would be any benefit in extending its current use, and whether it would make a difference if the Government purchased a licence for the online version?



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Professor Bennett: We have encouraged strongly—let us say—all practitioners and local authorities to use the ASQ system, because of the opportunity it gives us. Our programme is premised on ready to learn at two and ready for school at five, and it allows us to standardise that data, and to standardise information and outcomes through a mandated contact. We are absolutely committed to using the ASQ at two.

Some areas are already using the ASQ for various other developmental programmes. I do not have the evidence to say whether it would be beneficial to make that almost mandatory across the country. You could argue that it would certainly help in understanding the picture.

The licensing is quite complicated. We have been involved with the Department of Health in obtaining licensing and translating that from the American licence to the English one. I think that would require more procurement-informed advice to the Committee.

Q363 **Stephen Metcalfe:** You said you did not have the evidence to back up whether or not it could be beneficial to extend its use. Does anyone have the evidence, or is that a piece of work that would need to be done?

Professor Bennett: It is a piece of work that could be done. We would need to say, "What models are people using at each of those developmental reviews? What would be the case control in using ASQ versus something else? Does everything that we believe to be the benefit of standardising this at two translate to the other reviews?"

Q364 **Stephen Metcalfe:** Who would undertake that piece of work, if it were to take place?

Professor Bennett: It would require research investment because it would be quite a big piece of work. We would need to commission that work. There would probably be a discussion between the Department of Health and Social Care and Public Health England if we were to commission it nationally in England.

Q365 **Stephen Metcalfe:** But it would be that route rather than through university research or a research grant.

Professor Bennett: The research design would need that initial discussion. As to who ultimately carried out the work, it could be one of any number of people. It could be the Early Implementation Foundation; it could be a university, Dartington or a number of providers.

Q366 **Chair:** Katy, is it a similar picture in Scotland?

Katy Hetherington: Yes. Health visitors collect data and that is fed through to the information statistics division, which is a national health board in Scotland.

Q367 **Chair:** Do you think you are further ahead, or are you in a similar place to us in terms of the need for more work in progress?

Katy Hetherington: I would not be able to comment.



Q368 Darren Jones: We had a useful discussion with the previous panel about funding at local authority level. The organisation and funding of public health has been somewhat of a movable feast over the past few years. In terms of the work you do in early intervention, has it become easier or harder for you to deliver that?

Professor Bennett: That is more a local question than a national one.

Dr de Gruchy: As you know, along with other funding streams, public health funding in England will be cut by almost 10% by 2020-21, so in real terms we are looking at about £530 million less than when we came across in 2015-16. That is a lot of money, so efficiencies will have been made.

We are committed to the healthy child programme to make sure, as far as we can, that we fund it. There are various other programmes, which will have had funding, that directors of public health are trying to protect—for instance, the family nurse partnership. The scope to start new programmes is very limited, so a lot of us will be looking at how we transform the mainstream services we have and make them more joined up, efficient and effective. The previous panel focused a lot on that and on training, but when frontline staff are stretched, to have people coming out to do training is a challenge. Even if the training is funded in some way, there is still backfill and added pressure to the frontline. I do not know whether I am answering your question, but I am painting a picture of how we are working within the confines we are in.

Clearly, we need sustained funding over time to be put into early years, because chopping and changing is really difficult as well. You spoke earlier about the Sure Start centres and the importance of where we are with that. That sends signals, because decisions get taken locally and things can change. It is about having some national steer; you talked about the strategic framework within which funding can be more coherently put to good use.

Q369 Chair: You would see the importance of a conclusion on the Sure Start issue. There is the suspension of the Ofsted inspection of children's centres and the announced consultation in 2015 that has not happened yet. You would urge Government to get on with making a decision on that, would you?

Dr de Gruchy: I would defer to my ADCS colleague on that, but I think we would agree with that.

My other point is that, while our budget is focused on the healthy child programme generally and health visitors, a large part of our public health money goes to drug and alcohol services and sexual health services. We also have teams that influence and support NHS commissioning, which is really important. We have that statutory function. We talked earlier about midwifery and mental health services and thinking about children within those, so we need to make the most of that. The system leadership piece



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was very well demonstrated by Scottish colleagues. Making sure that you have senior public health staff locally is really important so that you can do the system leadership piece and have greater influence across the piece.

As you know, the funding of local authorities is becoming restricted. Unfortunately, it is very difficult to prioritise prevention and early help, as with the NHS, and directors of public health are certainly a voice for that within our local areas.

Q370 Darren Jones: You answered my question about maintaining the foundations of the service, and that it was carrying on, albeit in a restricted way. The point that worries me slightly is about the flexibility now to be able to innovate and do new things, and to make sure that every child gets the support they need and we are not just funnelling it to those who need the most support. That flexibility is becoming challenging.

One of the interesting things from the Government's perspective is that, in my understanding, they want to move away from public health grant towards business rate retention at council level. Do you think that is a good thing? Will that provide you with more flexibility in how you can spend public health funds?

Dr de Gruchy: We are looking to Greater Manchester to see what happens there. That is the pilot for that, isn't it? Broadly, ADPH is supportive, in the sense that public health money should not necessarily be seen as a separate pot from all the other things that local authorities fund. I alluded earlier to needing a focus on prevention and early help. It is very difficult to make the case, whether you are in the NHS, local authorities or in other areas, for early intervention compared with the crisis stuff that is happening as well and is really high cost.

Professor Bennett: We need further research investment in specificity. We know that it is a good thing to intervene early. We know that, if you do not intervene early in a situation of adversity, bad things happen and there is a cost later on. One of the things we will be talking about to DHSC is the kind of research that might be commissioned around specificity, because at the moment we have a plethora of programmes, and without a doubt they all do some good to some people some of the time. What we do not know is whether that one will work best for you now.

However the money is organised within the new and emerging systems, being able to give that information to directors of public health and local authority chief executives will be a really important thing to do. In the whole debate, we need more specificity and that is an area we have not researched. When we were doing some of the work in the big national programme, we were clear that the evidence about who does what and when is not yet strong enough. We would certainly prioritise that work, alongside various return on investment tools that are being developed for



use with local authorities now, so that, whatever the system and budgetary envelope they are operating in, we can offer much more detailed commissioning support.

Q371 Martin Whitfield: Professor, to pursue that point, your problem is not with the strategies and whether or not they work; the evidential problem is about which one it should be, and when to implement it. Is that the challenge?

Professor Bennett: Yes, that is the next area we need to explore in more detail. Routine inquiry can be very important, but as the previous panel said, is it routine inquiry as to one of the elements of adversity in childhood? Should it be asked through one inquiry? The witness used the example of midwifery and domestic violence and abuse. We know that is a really important line of inquiry and we know the sequelae of not doing that. We need further work that allows us to be able to identify that much more specifically, and we need to link it to the work we talked about on the growing ability to tell a story through our data between the first 1001 days and up to five and beyond.

Q372 Martin Whitfield: Is the support currently provided by the Early Intervention Foundation to Public Health England useful?

Professor Bennett: Yes, it is extremely useful. There are a number of meta-analyses, on which we are doing some work that is to be published shortly. They look further at the healthy child programme and What Works. The What Works centre is very important for us and is part of the partnership board that we discussed earlier.

Q373 Martin Whitfield: What areas would you prioritise for future intervention research, either evidential research or intervention research? What is your wish?

Professor Bennett: My wish would be that we build on the excellent 1001 days work. As a slightly broader wish, I would like that message to be stronger and clearer across the whole system. It is conception and the early years; it does not stop when a child is two. I want to build on that work, looking particularly, if a child is in real difficulty at two, at what we can do before five. In an ideal world, we will be investing before the child gets to that point, but we are still picking up a number of children at two. If we are not able to be specific in what will help that family, the child will be behind at school and behind at the critical point at seven. All the evidence from Marmot onwards says that is when they start to get into a pathway that means there is a greater likelihood of them not being in employment and training and all the things that affect their health as an adult. There is a lot we could do, but a particular interest would be the two to five area.

Q374 Chair: Would you welcome a particular Government priority on this work? We have heard about it in Scotland. Do you think there is scope for a greater sense of a national imperative to focus attention on this, given the variability that we know exists around the country?



Professor Bennett: It would be very helpful to have a higher focus on children in general, because of all the difficulties and pressures that NHS and social care are under at the moment. We know from history—from Ian Kennedy’s study 30 years ago onwards—that, when that happens, we tend to lose the spotlight on children. Putting children back into the spotlight so that they are part of that consciousness, and building the story about the best start for everybody, with early help for those who need more, would be a very helpful thing.

Katy Hetherington: I agree with the focus on children. It is important not to forget that children do not live in isolation from their families. That is why the research findings around adverse childhood experiences are so powerful. They show that what happens in an adult’s life will have an impact on the child’s early life.

Q375 **Martin Whitfield:** Katy, one of the things we have heard a lot about in the evidence is the language used to describe things. Do you think a more agreed language would be useful in collating evidence from across areas? Does that make sense to you? I mean the language to describe ACEs. We have 1001 days and GIRFEC north of the border. A lot of different acronyms and descriptions are used. Do you think it would be a benefit if we could move together from an evidential point of view to an agreed language to describe it?

Katy Hetherington: We have certainly found it a useful way to draw lots of different sectors into the discussion about the importance of early life. Whether it is the police, prisons or housing providers, they recognise that this has implications for them in their services and the people they are working with. Language is really important, as is broader societal understanding in communities and among parents, so that it is not just people in public health or the professions. How can we share information with families and communities? From my experience of this work in Scotland, that language has been a powerful and important tool for us in the focus on children, children’s rights and the right to have the highest achievable standard of health.

Dr de Gruchy: Research on the programmes and so on is important, and I will not rehearse that. Picking up something Katy said, these are very complex issues. The research on ACEs has tried to bring to the fore a very complex world while saying, “Look, these things are really important.” That research needed to be done. We are now moving on to the question: what do we do?

Some of the research shows that it is about mental health, violence and substance abuse. We know about those. There are others that are linked to the next generation as well. There is a really high risk. That says a lot to me as a director of public health about where I might put my energies; it might say a lot to you and the community about where the policy imperatives might need to be. For instance, what does a community response to violence mean? What is the research around that? We need to look at a broader research agenda both on the methodology of how



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you research complex, multifaceted issues and on some of the other areas I have just mentioned.

Chair: Thank you all very much indeed for your evidence and your patience. The fact that it has gone on longer is a demonstration of our interest in what you have been saying. We really appreciate your coming along, in particular Katy who has come down from Scotland. Thank you.