All Party Parliamentary Group on Sure Start Children's Centres

Meeting, 20th November 2014

Integrated Health Delivery through Children's Centres

Minutes

Members Present
Lyn Brown MP (Chair)
Sharon Hodgson MP (Vice-Chair)
Earl Listowel (Vice-Chair)

Professor Vivienne Bennett (VB), Director of Nursing and Midwifery at the Department of Health and Public Health England
VB began her presentation by explaining that she had been asked to speak to the APPG about the Health Visiting Programme and how it supports the delivery of integrated services through Children's Centres. She also planned to touch on the issues surrounding information sharing, as she knew this was a significant issue. VB described how at the end of the last Parliament, both the Labour administration and the Opposition parties (who are now in Government) became very interested in services for children under 5 and concerned about the fall in the number of health visitors. When the Coalition Government came into office, one of the main commitments in the Coalition Agreement was to increase the number of health visitors by 4,200 – this meant increasing numbers from about 8,000 to around 12,000, which VB suggested was the biggest increase in a single profession in four years that they had found anywhere in the world. She added that it took four years to train a health visitor from scratch, as practitioners had to be a qualified nurse or midwife before entering health visitor training, so it was a considerable undertaking. Ultimately the objective was to pull the whole profession together to transform services in a way that supported integrated service delivery in local places, whilst also having a national programme to drive up health visitor numbers (as that was the only feasible way of achieving the increase required). VB summarised this as "professional service transformation through improved evidence, mobilising the profession and using levers in the system", although noted that changes in the Health and Social Care Act had created a very devolved system, so partnerships with key system bodies were essential to getting this delivered. Once this point was reached, the plan was to transfer commissioning of the Healthy Child Programme services for children aged 0-5 to local authorities (with local authorities already commissioning 5-19 services, they would now have the opportunity to commission all 0-19 public health services).

VB explained that the Health Visitor Programme was broken down into four parts. The Foundation Programme was the first stage, which involved understanding the numbers that had to be achieved as well as what a successful service transformation would look like. The second phase was national planning, termed "Early Implementation", which involved setting up a number of Early Implementer Sites (involving Children's Centres was a condition of being an

Early Implementer Site, so there were close relationships in place here). The Programme was now at a "System-wide Implementation" phase, and the final stage was focused on building a sustainable future – thinking about how to achieve this was now a key priority, and VB noted that the APPG had a key interest in how to do that. Having so far had a very nationally driven growth programme to achieve the increase in numbers required, what was now needed was a move towards locally driven implementation that is sustainable across the shift in commissioning.

An important part of the work that took place at the beginning of the Programme was asking parents what they wanted, said VB. This showed that parents wanted a set of "eminently reasonable" things: they wanted a community that supports children; from a health visitor they wanted services that they trusted from people that they knew, and to be able to contact them; if they ran into trouble they wanted to know they would get help and get it quickly; and where people were in trouble they wanted proper joined-up services where people talked to each other. Around this, a four level service model of health visiting was developed, which was broken down into: "Your Community" (an asset-based community development approach involving people In the delivery of services); "Universal" (which was about delivering the Healthy Child Programme including the necessary developmental reviews, immunisations and parenting support activities); "Universal Plus" (which was about rapid response, including two particular programmes around maternal mental health and domestic abuse, but also offered a range of other services, for example if someone was having trouble breastfeeding or getting their child to sleep); and "Universal Partnership Plus" (which was about working to join this all up and overcoming the difficulties that families were having using local services – Sure Start Children's Centres were seen to be important, for example).

VB then set out that, in responding to local need, the Programme recognised that health visitors would need to work with other types of public health practitioner in order to respond to three broad kinds of need: predicted need (the kind of need you can predict and know where to look), assessed need (which could be assessed by a health visitor or, equally importantly, another professional) and expressed need (where someone says "you've got to come and help me because X is driving me mad"). Providing a joined-up response to this need was crucial, and VB explained that this was where it would be essential for health visitors to work collaboratively with other professionals, such as Children's Centre staff or specialist services.

Taking this need piece together with what families said they wanted, VB outlined a "4, 5, 6 model" which had been developed over the last four years of the Programme to create a sustainable service. This would involve transforming commissioning to deliver the four level model (combining "Your Community", "Universal", "Universal Plus" and "Universal Partnership Plus" elements previously discussed) in order to ensure that there was universal access with no post-code lottery to five key aspects of the Healthy Child Programme (antenatal health promoting visits, the new baby review, the 6-8 week assessment, the 1 year assessment and the 2-2½ year review). These five aspects would be mandated for 18 months, meaning local authorities would have to deliver them, in order to ensure that ground was not lost in the transition and that local authorities would have time to consider how they localised things

without losing pace on the universal delivery. The final part of the model constituted six high impact areas where it is known that health visiting services could have a significant impact, as well as the metrics to show that there is an impact (these were the transition to parenthood and the early weeks; peri-natal maternal mental health; breastfeeding; healthy weight; managing minor illnesses and reducing accidents; and health, wellbeing and development at 2 years and support to be "ready for schools").

VB then discussed the role of the Children's Centre team within efforts to achieve integrated health delivery, emphasising that Children's Centres were a really important local place for children's services and that the relationships in and through them were vital. VB stressed the importance of having local outcomes, local leadership and linking up with other services (including specialist services) – she noted that one of the key messages from other presentations she had given was "Together We Will" which she felt really summed things up.

Moving to touch on issues around information, VB said that there were a number of shifts taking place in the way the NHS handled its data, including moving medical records in 2018, and that it was important to strike a balance between having protocols that are not overly bureaucratic, respectful of people's privacy, but that also enabled the sharing of information that people needed to know. VB added that sometimes a detailed level of data was not needed (for example, aggregated data was usually needed for commissioning purposes) but that at a provider level some analysis was required and identifiable data would therefore be needed to provide bespoke services for children and families.

Finally, VB ran through some broader "hot issues", beginning with the sharing of new birth data – she clarified that this was technically feasible, and the main issue was finding the right safeguards to make it possible. VB added that the Health and Social Care Information Centre have this on their list of work for 2015, although their final work programme is not yet confirmed so she was unable to say whether this had made it in. Moving on, VB discussed other enablers within the system including the Early Years Profiles which are now available and allow local authorities to benchmark themselves against an England average and against each other across a whole range of measures around healthy children under 5. VB also mentioned the Maternity and Children's Dataset which will come online in 2015 (although she noted that it can take time for such facilities to become fully effective) and the Child Health Information System (which, while part of the Healthy Child Programme, will not transfer to local authority commissioning and will remain nationally commissioned until 2020 because of improvements that need to be made to the programme). Finally, VB highlighted the National Child and Maternal Health Intelligence Network run by Public Health England which contains a lot of useful information and resources on its website, before taking questions.

<u>Question and Answer session with Professor Vivienne Bennett</u>

*The first question of the session was from **Allison Jones (Merton)**, who asked whether the level of aspiration outlined in VB's speech would be achievable given the uncertainty that surrounded Children's Centres, and whether the assumption of expecting them to respond at a universal level would be possible given the pressure on services that could be experienced in the coming*

few years. In response, VB said that she had been meaning to talk about inter-relationships rather than necessarily the strength of those relationships, but very much recognised that in a limited resource environment, things like joint outcomes would have to be negotiated, and might not be as far reaching as would otherwise be hoped. She added that she was absolutely sure that in order to maximise the resources available it would be crucial to work together, and that it would also be essential to crack the information issue as well as the some of the technology issues. VB reiterated however that she appreciated that everyone was working in a tight resource environment – health visiting was one of the few growth areas, and she wanted to use it to the best effect to support place-based services for everybody.

Anne Longfield (4Children) *then asked a follow-up question, noting that while Phase 3 Centres are most likely to be at threat of reduction, they often have very strong health bases, and suggested that it would be very interesting to see if health visitors reported changes around services in those Centres in the coming months.* In response, VB said that health visitors were expressing a lot of concern for their Children's Centre colleagues and how the downward pressure on services would work out. She had not received any feedback on working through Children's Centres or the principle of having a health lead in a Children's Centre as a local place, but health visitors were mindful of the pressures Centres were under, as well as the implications of the commissioning transfer for the retention of a universal service, and the subsequent impact this could have for early intervention and preventative initiatives.

The Group's Chair ***Lyn Brown MP*** *then commented that she had been slightly surprised that, firstly, the five aspects of the Healthy Child Programme mandated as part of the "4, 5, 6 model" needed to be mandated at all and were not viewed as "core business", and secondly that they were only mandated for 18 months. She asked whether there might be similar concerns to those expressed by public health professionals around local government undertaking public health budgets.* Referring to the example of local government commissioning of 5-19 services, VB said that this had been a "mixed piece" – there had quite a lot of status quo while authorities waited to get the whole 0-19 package, some re-tendering without reduction, some cost improvement which had led to reduction, but also some increases where authorities realised they did not have the necessary capacity and decided to spend more on that. In terms of mandating, VB explained that there had been extensive negotiation around this between DH, DfE and CLG. The rules under which a mandate could be applied were when a universal approach to a service was required, and there were two main reasons why it had been decided to mandate the services set out in the "4, 5, 6 model" – firstly, local authority commissioners would initially be inexperienced at commissioning universal health services, so a mandate was enabled because these needed to be done universally; and secondly was the fact that some boroughs and local authorities wouldn't have their extra health visitors until right at the end of the Programme, so 18 months would be needed to get that workforce up to speed, integrating and delivering the key elements of the Healthy Child Programme at a reasonable level. CLG were concerned about local authorities being able to act for local people, and also about additional burdens, so eventually the position was reached where a case for mandating over transition was made, and that there would be a review of the mandated elements to see if progress had been made at 12 months with a view to a sunset at 18 months, which will go into regulation.

Jackie McCormick (Northumberland) *explained that she had a really strong relationship with health in her local authority and had been sharing birth data for about the last 10 years which was really positive – she was now talking to health about the Healthy Child Programme and the universal offer, and asked VB how she could move these conversations on from talking about outputs to actual outcomes, as this is something that Ofsted were now interested in.* VB noted that this was a really important point. She said that the easiest thing to measure is access and coverage, the next easiest is experience (as tools such as questionnaires and surveys can be used), but after that became about improved outcomes which can be more difficult. VB explained that the public health outcomes framework included a list of outcomes for this age group which can be used, and the Early Years Profiles referred to in her speech also had some metrics. She also advised Googling the term "Personalised Care Population Health Framework" – the first item this brought up would be an interactive facility including a whole set of information at the around "Beginning of life, first 1001 days" which includes material around two-year olds and outcomes which can be measured.

The next question was from ***Elizabeth Taylor (Southampton)*** *who noted that while she was delighted about where health visiting was now as a profession, in her local authority there was now a lower ratio of health visiting staff to population than there had been in 2002, and that while staff were more qualified there were fewer people on the ground. Combined with the fall in Children's Centre staff, were there concerns around reducing numbers? There was then a follow-up question from the floor, observing that due to the pressure to roll-out health services to level 3 families in particular, the strain in terms of the universal offer often came in a reduction in services to level 2 families – while it was absolutely right to see further integration with health visiting, VB was asked about what conversations are taking place with senior managers and leaders within local authorities about that agenda?* Responding to the first question, VB said that this was a really good point and that it had been recognised at the start of the Programme that, based on the experience of previous single professional growth programmes, there could be an impact on skill mix and on other members of the team. She emphasised that she did not believe that the Health Visitor Programme had had any impact on Children's Centres, because the financial streams were different, but realised that changes had been happening at the same which left the same problem. She explained that when she was given the national lead, which had been a genuine honour, her main concern had not been to argue whether 4,200 was the right number but to try and get the best deal for children and families out of it, given that in some cases it might result in more health visitors but less of something else, and that there could be a reduction in overall numbers as a result. She added that throughout the Programme she had tried incredibly hard to keep the profile of the service and the children high, taking the approach that it's not just about the numbers it's about what you do with the numbers. Turning to discuss how this translates to local authorities, VB suggested that for various reasons (including the way they commission and the way they are regulated) local authorities do not start the "prevention clock" at universal. Therefore, in the 5-19 transition there had been a need to work with the likes of Directors of Public Health, Directors Children's Services and senior managers in local authorities to say that when commissioning something like children's school nursing, local authorities now had responsibility for primary prevention, so there would be a need for them to start the clock at universal

prevention services and primary prevention, and to help them find ways of doing so. VB mentioned that DH and PHE had just done ten roadshows with the Local Government Association around the transition in commissioning, and there had been significant interest in questions such as "what does the service look like" and "what is the evidence around the universal parts of the service". VB added that she recognised that this sort of work would be really difficult because of the downward resource pressure on all public services, but that her experience was that people were actually really keen to solve problems and use the investment in health visiting to get the best for children. She ended by recognising that health visiting had been a very privileged profession to get the investment it had, even though numbers had previously fallen substantially, so it was the professional responsibility of her and her health visitor colleagues to make sure that this was channeled into improved outcomes.

Professor Bennett then left the session as she had to attend another engagement in Oxford. The next section of the meeting comprised three short presentations by Donna Molloy (Early Intervention Foundation), Helen Berresford (4Children) and Lucy Capron (The Children's Society).

<u>Donna Molloy (DM), Director of Implementation at the Early Intervention Foundation</u>

DM began by explaining that she planned to talk about a report that EIF were about to publish on integration in the early years, "*Getting it Right for Families*", which would help to highlight some of the key opportunities for bringing together health services with Children's Centres. She noted that the work EIF do is driven 20 Pioneering Places that they work with to support the delivery of early intervention, virtually all of which were struggling with how to bring together health and local authority services in the early years – while there is a national emphasis on integration, there is also a lack of clarity locally about how to achieve this, especially in a very complex landscape with responsibilities across CCGs, NHS England and various local authority budgets. A key issue was how to bring together the Healthy Healthy Child Programme and the Early Years Foundation Stage requirements in a coherent way to create a Better Start offer, and this was something EIF had been able to explore with their 20 Places (the report was being published to coincide with announcements from DfE and DH on the progress on the integrated review for two-year olds).

DM noted that one of the big barriers to integration that consistently came up was the fact that there is a lack of common language and understanding about what matters for children's development across the different professionals who operate in the early years. She referred to an approach that originated in Hertfordshire, one of the Pioneering Places, called "Five to Thrive" – this is based on concept of providing parents with very simple "five a day" messages about what matters for their children's development, which condenses the neuro-science into very easy to understand format. Practitioners in an area are trained simultaneously in what the neuro-science tells them, which enabled parents to be supported more effectively as they were getting consistent messages from all the different professionals that they encountered. This approach was gaining momentum with a number of Pioneering Places using it, while Barnardo's were rolling it out in their Children's Centres and the DfE were considering getting behind it.

Another issue in terms of creating an integrated system, DM continued, is that there isn't a consistent way of assessing vulnerability across the different professions in the early years. She referred to work being undertaken in Greater Manchester to create a single assessment pathway, covering the key requirements of the Healthy Child Programme and Early Years Foundation Stage, which will be used consistently by health visitors and Children's Centre staff. This was being tested by some early adopter authorities, but the aspiration was to roll it out across all of the 10 Greater Manchester authorities in time.

DM then turned to consider the issue of the take-up of services in Children's Centres, which she recognised was an important concern for the APPG, and suggested integrating health services in Children's Centres was key to solving this – delivering universal services in Children's Centres provided a way to draw families into Children's Centres through the universal Healthy Child Programme in order to access wider family support and other services. EIF had come across some really good examples of this, such as in Nottinghamshire (where health visitors are managing multi-disciplinary teams in Children's Centres) or Islington (where health visitors run baby clinics in Children's Centres so that families can find out about wider services while they're in the Centre, something that very much aligned with 4Children's proposal for Hubs). In terms of information sharing, DM noted that EIF's experience was that this continued to be a major issue for many areas – across the 20 Pioneering Places, roughly 10 had effective arrangements in place and 10 did not. On the bright side, where information sharing agreements and exchange of live birth data were in place they often worked really well (for example, in Islington midwives ask for consent at the time of booking an appointment, which addressed issues that might emerge later – such as families not turning up at immunisation appointments – that could then be followed up with support offered through Children's Centres).

Finally, DM reflected on some of the opportunities for better integration, noting that the transfer of responsibility for 0-5 public health felt like a really good opportunity to bring things together – given that many local authorities were re-commissioning their Children's Centres, DM suggested that this provided an opportunity to look at the whole 0-5 system across a place. There were also some very interesting approaches emerging of how to engage families who don't tend to use services – some areas were developing models of early years key workers where there was a named lead for families who co-ordinates services, while in Nottingham (one of the areas which has secured Big Lottery Fund Better Start funding) 66 family mentors were being recruited from the local community and trained in the best practice and evidence around child development, with a specific focus on building relationships families in order to develop services in Children's Centres and the wider community. DM added that the encouragement from Government for local authorities to conduct an integrated review at age two had real potential, and represented an opportunity to create a rounded perspective on child development at a crucial time and help join things up for families. Lastly, DM pointed to work that EIF understood was being undertaken by Ofsted and the Care Quality Commission looking at the potential for an integrated inspection framework – at the moment, the fact Ofsted inspected Children's Centres and the CQC inspected health was a really significant barrier to integrated delivery, with many sites delivering health visitors and Children's Centres feeling that they were effectively penalised for good practice within the current framework, so the

opportunity to think about what a joint inspection process might look like was something with significant potential that needed real momentum behind it.

Helen Berresford (HB), Head of Public Affairs at 4Children

HB began by noting the huge potential for integrating the work of health and Children's Centres which had been highlighted in VB and DM's presentations, and explained that her speech would aim to give an overview of what was happening right now in Children's Centres and what future developments might look like, based on the findings of 4Children's "*2014 Children's Centre Census*". Initially HB highlighted two key headlines from the report which showed that demand for Children's Centres continues to increase – the figures showed that over a million families use them regularly and that, on average, they work with two-thirds of vulnerable families.

In terms of health specifically, the Census showed that there were already quite strong existing relationships between Children's Centres and health. The data indicated 87% of Centres offered health check-ups with health visitors; 75% offered midwifery services; 74% offered pre-natal support, recognising the importance early support for families; 53% offered some kind of mental health support; and 66% provided support to parents with post-natal depression – so there is already significant work taking place between health and Children's Centres together.

Turning to look at partnerships, almost all Centres said that they frequently worked with health partners, while 91% work with midwives on a regular basis and 97% worked closely with social care. Indeed, HB noted that in many cases these relationships were ones that Centres intended to build upon in future – of those Centres who expected their partnerships to change, 71% expected to engage more with health, 75% said they would engage more with social care, and 40% would expand links with midwives. Interestingly, HB added, even amongst those Centres which are under extreme pressure and looking at reducing their partnership working, very few anticipated that they would cut back their relationships with health, suggesting that this was recognised as a really important area.

Finally, HB emphasised that with strong existing relationships between Children's Centres and health already in place, developments such as the roll-out of the Health Visitors Programme and the transfer of the commissioning of 0-5 public health services provided opportunities and motivations for further collaboration. There was clearly a desire across the board to deepen that collaboration and much to build on for the future. HB noted that 4Children had set out a vision for how the integrated model of Sure Start Children's Centres could be taken forward in the future as Children and Family Hubs, and explained that this could represent a springboard for greater integration across the board by bringing together different parts of services including health and social care, and looking at both universal and targeted services from early intervention through to intensive intervention.

Lucy Capron (LC), Senior Local Public Affairs Officer at The Children's Society

LC began by explaining that she would be discussing a report launched by The Children's Society earlier in the year, which examined two issues that the APPG had previously recommended as best practice for Children's Centres – the provision of live birth data (which would be the main

focus of her presentation) and the registration of births in Children's Centres. The report was based on Freedom of Information requests which asked local authorities simple questions about whether or not they were able to provide Children's Centres with live birth data, and if not went on to ask about the main reasons that this information wasn't being provided. The findings showed that almost half of local authorities do not currently share live birth data with Children's Centres on a regular basis (meaning monthly or more frequently), which appears to be a pattern that is replicated across the country. This was worrying in and of itself, LC added, because the statutory guidance from the DfE sets out that local authorities should share live birth data with Children's Centres ("should" being quite a crucial word), while both the APPG and the Jean Gross report on information sharing had recommended that sharing live birth data should be taking place. However, at the local level many local authority officers and staff in local health services were struggling to grip the issue within local agreements. Around 37% of local authorities did not share data at all, while some were able to gather the data quarterly, and some said that they were able to share it annually (which, from an early intervention perspective, was largely useless).

LC explained that the report looked at those local authorities which were not sharing data at all in order to explore why, and found that 6 in 10 local authorities said they had quite significant difficulties in obtaining this information from their local health service. The main challenge that emerged was a misunderstanding of the legal situation around sharing data, with uncertainty around whether or not it would breach data protection to share the information because it was identifiable. While most local authorities received aggregated data which, as VB had discussed, was really helpful with commissioning, providers who wanted to access families needed to know that a child has been born, where they had been born and how to get in touch with that family for the first time – the report identified recurrent concerns around patient confidentiality, consent and broader data protection issues on the part of local authorities. As a result, LC continued, The Children's Society had worked with Policy in Practice to undertake qualitative interviews with six local authorities which had successfully brokered information sharing agreements to find out how they had gone about this – these revealed that every local authority that is sharing data has a different information sharing agreement, and these are largely the result of close working relationships between those in the health service and particular officers within the local authority. Some received live birth data after the 10 day visit, some through midwifery services and some through the registrar service given up trying to talk to the local health service altogether.

However, LC noted that there is a broad recognition that the number of local areas that are struggling to broker this kind of agreement might warrant a national solution – she returned to the point raised by VB that the Health and Social Care Information Centre may look at prioritising live birth data as one of their areas of work for 2015, and suggested that The Children's Society would push quite hard for this, as a lot of local authority officers were trying to broker those agreements and encountering difficulties because the national guidelines are unclear about what can and can't be shared at a local level. Meanwhile, based on their conversations with local authorities, The Children's Society's report had considered what could be done in the short-term to help local authorities and local health services to progress a data

sharing agreement. LC suggested that in most cases parental consent was being sought in some form (be it from the first midwifery appointment, the 10 day visit, or an opt-out box to enable health visitors to bring the issue up), and so the important thing was to find ways to help local authorities have the sorts of conversations that they needed to with their local health service, adding that in many cases parents were actually expecting birth data to be shared and were surprised if they found out it was not.

Finally, LC summarised some of the report's key recommendations, noting in particular that The Children's Society felt there was a need for the statutory guidance to be strengthened to change a "should" to a "must", and that it was important that a national solution was pursued quite vigorously as many local authorities are quite frustrated, as are the local health services, that they can't provide this information.

Question and Answer session with Donna Molloy, Helen Berresford and Lucy Capron

*The Group's Chair, Lyn Brown, began the final Question and Answer session by taking three questions from the floor. The first of these was from **Jonathan Rallings (Barnardo's)** who said he was delighted at the mention of "Five to Thrive" in DM's presentation, which Barnardo's were currently embedding in their services, but emphasised that this should be seen not simply as a "programme" but as an "approach" that provides a means of understanding how brain development is happening. More deeply, he suggested that this reflected the difference between an evidence-base and a science-base, and stressed that waiting for an evidence-base around early intervention could take a very long time because of the nature of the programmes – in this context, initiatives based on a firm science-base such as "Five to Thrive" were worthy of investment, and he urged the members present to do whatever they could to push this forward.*

*The second question came from **Earl Listowel**, who emphasised the need to recruit good staff as health visitors and midwives, allow them the space to develop expert judgement over time, and then trust that expert judgement and allow it to guide policy. He then drew comparisons with the findings of Lord Warner's 1993 report into children's homes – this had recommended the need for a seamless partnership between mental health and children's homes, something that had ultimately not happened, and he questioned whether there might be lessons to be learned for the relationship between Children's Centres and mental health services such as CAMHS. Finally, Earl Listowel highlighted the key findings from the recent report of the Maternal Mental Health Alliance, which suggested that the overall cost of failing to address maternal mental health issues could be in the region of £8.1 billion per year.*

*The third question was from **Allison Jones (Merton)** who asked what could be done to support those children who were still not reaching the expected level of development on the Early Years Foundation Stage Profile by the time they reached age 5, which was quite high in some areas. Was it time to think differently about 0-5 services and how Children's Centres work with health visitors, including a different understanding of what Children's Centres can realistically achieve and a greater role for specialists?*

The panel then responded to these points. DM began by welcoming Jonathan Ralling's praise for "Five to Thrive". With respect to his point on evidence, she noted that while EIF was a "What Works" Centre it didn't only tell people to deliver programmes which had been subject to randomised control trials. In her view the most important thing was to be clear about the evidence around the programmes you deliver, but reiterated that it was great that "Five to Thrive" had developed such strong support. LC then picked up the points that had been raised around mental health services, and stressed the importance of co-located services. The Children's Society had looked at families presenting at Children's Centres with problem debt and the impact this had on children's mental health, and LC emphasised that while staff might not be debt or mental health specialists, it should be the responsibility of the programme manager in that local authority to make sure that Children's Centres operate as the hub of services and provide access to mental health support or debt advice to families in these situations. The benefits of this would be two-fold, both improving early intervention and enhancing take-up of services by enabling Centres to offer the sort of holistic, community-based provision we all want to see. Finally, HB reiterated the importance of the hub model in this context, and of Children's Centres not simply delivering services but co-ordinating them to ensure a "one stop shop" approach when someone comes through the door.

A further set of contributions were then taken from the floor. ***Earl Listowel*** *began by offering a follow-up point to his original question, emphasising that it was the role of staff to work day-to-day with parents and children, and the role of professionals such as mental health specialists to help staff manage those relationships – this might require staff to periodically take time away from parents and children to reflect and develop with the help of professionals and peers.*

Sharon Hodgson MP *then expressed her frustration at continued difficulties that Children's Centres were experiencing in accessing live birth data, and suggested that she might put down some written or oral questions around the need for stronger statutory guidance. She also said that she might re-visit the issue of birth registration with the Group's former Chair Andrea Leadsom MP, as she was unsure what the blockages to this were.* ***Jonathan Rallings*** *noted that Barnardo's had undertaken some work around this issue, and discovered that one of the issues was around the size of local authorities and the difficulties that this created in terms of capacity in some smaller areas – he suggested that there might be some kind of a solution around getting local authorities to pool registrars.*

Following up on Sharon Hodgson MP's point about live birth data and the strength of the statutory guidance, DM noted that she had been told by Jean Gross (an EIF trustee) that one of the outcomes of her report on information in the early years was that DH lawyers were meant to clarify the legality of transferring live birth data – Ministers had requested that that was taken forward but progress had been very slow. DM asked whether anything could be done to build momentum behind this and welcomed Sharon Hodgson MP's offer to table questions.

A further contribution from the floor noted that there might also be certain systems issues around sharing live birth data, particularly around marking consent – for example, situations

had arisen where hospitals had been unable to record consent on their system, so that when data was transferred to health visitors the consent to share did not show up.

Vicki Lant (Barnardo's) *then raised an additional point around the connectivity of information in the context of Ofsted inspections, particularly around groups of Centres – evidence was showing that grouped inspections were achieving far lower outcomes, and there was a challenge around whether the right things were being looked at. She noted that the DfE's Grants Programme included an extremely good "Reach Out" framework which she felt needed to be the dialogue document between local authorities and commissioners, in order to make the right judgements about what needed to be done in a local authority context.* **Anne Longfield (4Children)** *followed up on this point, noting that she had been at a seminar on the "Reach Out" framework earlier in the day, and that there had been a great deal of interest in this – she suggested that the key question was how we can move from talking about the structures and systems at Children's Centres onto how you use what goes on in them to support children and families.*

Jackie McCormick (Northumberland) *then briefly commented on the proposed Hub model, suggesting that it was important to reflect on how this would work in very rural areas, such as some of the places in her local authority. She also noted that following a previous APPG meeting she had discussed the issue of birth registration with registrars in her local authority – this was now taking place in all 4 counties in Northumberland, and she described the registration staff as "born again registrars" who now wanted undertake registrations in all Centres.*

The final contribution was from **Helen Cameron (Islington)** *whose local authority was one of the Early Intervention Foundation's Pioneering Places – she noted that Islington had become quite good at using co-location to support integrated working, but added that until there was some sort of shared ownership of outcomes and potentially joint inspections, it would be difficult to get full integration in multi-agency teams.*

Before the session closed, Lyn Brown MP invited the panel to make brief concluding comments. DM picked up on the inspection process, saying that her understanding was that Ofsted were looking at the potential for a single inspection process from 2016 when a new regime comes in, but was unsure how much momentum was behind this, so suggested that it would be helpful if the APPG could help keep the issue high on the agenda. She also agreed with the points made by Helen Cameron, and said that one of EIF's key asks for any incoming Administration would be around supporting multi-agency working within the early intervention workforce. LC then briefly discussed birth registration in Children's Centres, saying that The Children's Society had found that this was taking place in around 10% of Centres, and had explored various different models, such as cross-cluster approaches or examples of where a Children's Centre was actually located in a registrar's office. She then followed up on the point about systems issues and information sharing, emphasising that this was why The Children's Society were keen to raise the issue nationally and push the Health and Social Care Information Centre to tackle it, and welcomed any action that the APPG could take to progress this. Finally, HB agreed on the importance of shared outcomes and stressed the significance of sharing data, before concluding by reiterating VB's point that "The only way is together". **The meeting then closed.**