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Public Services Committee

1st Report of Session 2019–21

A critical juncture for public services: lessons from COVID-19

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Public Services Committee

The Public Services Committee was appointed by the House of Lords on 13 February 2020 to consider public services, including health and education.

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Declaration of interests

See Appendix 1.

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Q in footnotes refers to a question in oral evidence.

SUMMARY

The COVID-19 pandemic represented an unprecedented challenge to the United Kingdom's public services. This report describes how service providers responded. Some of the responses that witnesses described to us were prompt and successful. At the national level, the NHS rapidly upscaled its acute care capacity with the construction of Nightingale hospitals; at the local level, 15,000 rough sleepers were safely re-housed. Many public service providers developed remarkable innovations to meet the challenge of COVID-19. Decisions which before the pandemic took months were made in minutes. Good personal and organisational relationships broke down longstanding barriers between the statutory and voluntary sectors. New ways to deliver services flourished. Digital technology was used more widely, and more successfully, than ever before.

But we also heard that the United Kingdom's public services had entered the COVID-19 pandemic with low levels of resilience. The virus further disadvantaged many who were already left behind. Black, Asian and Minority Ethnic and Gypsy, Roma and Traveller people suffered disproportionately, the result of historical underfunding of preventative health services. Disadvantaged children fared worse during the pandemic, too; the educational attainment gap between the poorest children and their counterparts grew wider. The overall public health response was at times hampered by over-centralised, poorly coordinated and poorly communicated policies that were designed and delivered by central Government, even though local-level providers were often better equipped.

This report makes recommendations for how public services can hold on to the advances that they achieved during the pandemic. It argues that despite the formidable efforts of many, without fundamental reform to address the weaknesses that we identify, this good work will be lost. Our proposals therefore focus more on how to reform and transform public services than on how well public services responded to COVID-19.

We are by no means alone in recognising the pandemic as a 'critical juncture'—an opportunity to deliver lasting and transformative reform of public services. The Prime Minister, Rt Hon Boris Johnson MP, has made a similar case. This report therefore calls on the Government, and on other public service providers, to follow eight key 'principles for public service reform' when undertaking this essential task:

- the Government and public service providers should recognise the vital role of preventative services in reducing the deep and ongoing inequalities that have been exacerbated by COVID-19;
- central Government and national service providers must radically improve the way that they communicate and cooperate with local-level service providers if they are to deliver effective public services. They should analyse where services are best delivered from the centre, where local-level service providers are better placed, and where visible accountability sits. The Government should acknowledge that local providers are equal partners in the delivery of services;
- charities, community groups, volunteers and the private sector must be recognised as key public service providers, and given appropriate support to deliver services effectively;

- the resilience of public services to the challenges posed by the COVID-19 pandemic and ongoing demographic changes will require a fundamentally different, vastly more flexible approach to the sharing of data;
- the integration of services to meet the diverse needs of individuals and the communities in which they live is best achieved by public service providers working together at the local level, and should be supported by joined-up working across Government departments at the national level;
- local services and frontline workers must be given the resources and autonomy to innovate and improve the delivery of public services, while mechanisms to ensure the accountability of local service providers should be improved;
- advances in digital technology should be used to increase access to public services, particularly for hard-to-reach groups, but should be applied intelligently. Online services should never replace face-to-face services if to do so would disadvantage the service user;
- users must be involved in the design and delivery of public services.

The Government has promised an independent inquiry into the pandemic, and how services responded. We make a number of proposals for how it might assess what worked well, and what worked less well. This is the first report of the House of Lords Public Services Committee, and we present it as a starting point from which to learn the lessons of COVID-19. We will return in future inquiries to some of the issues of public sector reform identified in this report.

A critical juncture for public services: lessons from COVID-19

CHAPTER 1: INTRODUCTION

A 'critical juncture' for public service reform

1. This is the first report of the House of Lords Public Services Committee. The Committee began its work in February 2020, soon after the first case of COVID-19 in the UK was recorded, and before the Prime Minister, Rt Hon Boris Johnson MP, announced a national lockdown on 23 March.[1] A second lockdown for England began on 5 November 2020, just before this report was published.[2]

2. The Committee was established to "consider public services, including health and education".[3] With the outbreak of COVID-19 and the subsequent first lockdown it became clear that the pandemic would have an enormous impact on the delivery of public services in the years to come.

3. We therefore launched an inquiry to examine what the experience of the coronavirus outbreak can tell us about the future role, priorities and shape of public services. COVID-19 has exposed ongoing fundamental deficiencies in the delivery of public services that prevent or hinder people from accessing the support on which they rely, but it has also encouraged public services to introduce highly innovative approaches. This report makes recommendations on how public services should be transformed to address these fundamental weaknesses, and how public service reform should build on the innovations seen during the pandemic. In later inquiries we will investigate these issues in more depth.

4. COVID-19 represents a 'critical juncture' for the UK's public services.[4] At certain moments, institutions have the opportunity to choose different development paths. The Second World War is often presented as one such 'critical juncture', facilitating the post-war creation of the modern welfare state.[5] On 6 October 2020, in his speech to the virtual Conservative Party Conference, the Prime Minister, Rt Hon Boris Johnson MP, presented COVID-19 as such a moment:

> "History teaches us that events of this magnitude … are more often than not the trigger for an acceleration of social and economic change … We

1 Prime Minister, 'Statement on coronavirus (COVID–19)' (23 March 2020): https://www.gov.uk/government/speeches/pm-address-to-the-nation-on-coronavirus-23-march-2020 [accessed 6 November 2020]

2 Cabinet Office, 'New national restrictions from 5 November' (31 October 2020): https://www.gov.uk/guidance/new-national-restrictions-from-5-november [accessed 6 November 2020]. We refer to the lockdown announced on 23 March 2020 as the "first lockdown".

3 House of Lords Select Committee on Public Services (Public Services Committee): https://committees.parliament.uk/committee/430/public-services-committee/ [accessed 29 October 2020]

4 Q 7

5 Howard Glennerster, *The post war welfare state: stages and disputes*, London School of Economics (LSE) (12 August 2020): http://sticerd.lse.ac.uk/dps/case/spdo/spdorn03.pdf [accessed 23 October 2020]

see these moments as the time to learn and to improve on the world that went before."[6]

5. This report describes how COVID-19 has already encouraged a radical reassessment in many areas of public policy.

Key conclusions

6. We argue that five fundamental weaknesses must be addressed in order to make public services resilient enough to withstand future crises and to improve outcomes for the people who need and use public services:

- insufficient support for prevention and early intervention services (Chapter 2);
- over-centralised delivery of public services, poor communication from the centre, and a tendency for service providers to work in silos rather than integrate service provision (Chapter 6);
- a lack of integration especially between services working with vulnerable children and between health care and adult social care (Chapters 3 and 5);
- an inability and unwillingness to share data between services (Chapter 8).
- inequality of access to public services and a lack of user voice (Chapters 3 and 4);

7. Unless these weaknesses are tackled, the significant opportunities for innovations in public service delivery which have developed since the beginning of the COVID-19 pandemic may be lost. Some of the most impressive achievements include:

- rapid early responses from the centre, including the expansion of NHS critical care capacity through the construction of Nightingale Hospitals to meet the acute health crisis caused by the pandemic, and the prompt delivery of targeted support for the businesses and individuals most affected (Chapter 2);[7]
- the "Everyone in" initiative, where the Government worked with local authorities to provide accommodation for rough sleepers in their area (Chapter 7);
- the dedication and innovation of frontline workers, who under testing circumstances overcame bureaucratic hurdles and adopted flexible ways of working to continue to provide, and in some cases improve, public services (Chapters 7, 9 and 10);
- the response of the private and voluntary sectors, which were often able to fill the gaps in public service provision caused by the demands of the pandemic—and particularly at the local level (Chapters 7, 9 and 10);

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6 Conservative Party, 'Prime Minister Boris Johnson delivered his keynote speech today to wrap up Conservative Party Conference' (6 October 2020): https://www.conservatives.com/news/boris-johnson-read-the-prime-ministers-keynote-speech-in-full [accessed 29 October 2020]. See also Q88 (Professor Tony Travers, Paul Johnson, Sarah Arnold).

7 Economic Affairs Committee, *Universal Credit isn't working: proposals for reform* (2nd Report, Session 2019–21, HL Paper 105) p 10 and oral evidence taken before the Economic Affairs Committee, 8 September 2020 (Session 2019–21); Q 2 (Kate Bell).

- the space given to local-level public services to integrate, share data and coordinate with the voluntary sector to meet the specific needs of people in their area (Chapter 8);
- the Cabinet Office's decision to issue new guidance to commissioners which put greater emphasis on the social value that commissioning can create, and gave greater autonomy to frontline service providers (Chapter 9);
- the delivery of services to hard-to-reach users through digital platforms and new technology (Chapter 10);

Principles for public service reform

8. Our recommendations aim to "lock in" these and other innovations in order to transform public service delivery. **We suggest that the Government and other organisations prioritise the following principles for public service reform:**

- **the Government and public service providers should recognise the vital role of preventative services in reducing the deep and ongoing inequalities that have been exacerbated by COVID-19;**
- **central Government and national service providers must radically improve the way that they communicate and cooperate with local-level service providers if they are to deliver effective public services. They should analyse where services are best delivered from the centre, where local-level service providers are better placed, and where visible accountability sits. The Government should acknowledge that local providers are equal partners in the delivery of services;**
- **charities, community groups, volunteers and the private sector must be recognised as key public service providers, and given appropriate support to deliver services effectively;**
- **the resilience of public services to the challenges posed by the COVID-19 pandemic and ongoing demographic changes will require a fundamentally different, vastly more flexible approach to the sharing of data;**
- **the integration of services to meet the diverse needs of individuals and the communities in which they live is best achieved by public service providers working together at the local level, and should be supported by joined-up working across Government departments at the national level;**
- **local services and frontline workers must be given the resources and autonomy to innovate and improve the delivery of public services, while mechanisms to ensure the accountability of local service providers should be improved;**
- **advances in digital technology should be used to increase access to public services, particularly for hard-to-reach groups, but should be applied intelligently. Online services should never replace face-to-face services if to do so would disadvantage the service user;**

- **users must be involved in the design and delivery of public services.**

Our inquiry

9. In this inquiry we used a broad definition of public services: we heard from private- and third-sector organisations which had provided services during the first lockdown. We organised focus groups with users of public services, who reinforced the need for us to hear from people with lived experiences. This approach to evidence-gathering will inform our future work.

10. We received more than 100 written submissions which reflected a diversity of viewpoints, including organisations based in rural, suburban and urban localities across the UK. We took evidence from groups working with children, older people, ethnic minority and Gypsy, Roma and Traveller (GRT) people; and from people facing multiple disadvantages. We drew on comparative evidence from the devolved administrations where relevant. We also heard from witnesses working in Taiwan, Germany and New Zealand to learn how countries with different models of public service delivery responded to the pandemic, and how this contrasted with the UK experience. We are very grateful to all our witnesses.

11. We invited Rt Hon Michael Gove MP to give oral evidence on behalf of the Government. We also invited the Cabinet Secretary, and the Permanent Secretary of the Cabinet Office. None agreed to appear, although on 2 November 2020 we received a letter from Lord True, Minister of State at the Cabinet Office, offering written evidence.[8] Unfortunately, the Government's offer arrived too late to include its evidence in this report.

12. As well as the longer-term changes that we propose, we hope that our conclusions will help public services deal with looming short-term challenges. At the time of publication, COVID-19 case numbers were once again rapidly increasing across the UK, with the winter of 2020/21 likely to cause additional difficulties for public services.[9] We present our recommendations knowing that the battle against COVID-19 is far from won.

13. **The Government's decision not to give oral evidence to the Committee is disappointing. Our aim in this report is not to apportion blame for past failings but to make constructive suggestions for future reform. The Government has stressed the importance of reforming public services after the pandemic; we hope that this report will assist it in this task.**

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8 Letter from Rt Hon Michael Gove MP, Chancellor of the Duchy of Lancaster to Baroness Armstrong of Hill Top, Chair, Public Services Committee, responding to an invitation to give oral evidence for the Committee's inquiry, Public Services : lessons from coronavirus (26 August 2020) : https://committees.parliament.uk/publications/3141/documents/29269/default/ [accessed 29 October 2020] and letter from Baroness Armstrong of Hill Top, Chair, Public Services Committee, to Rt Hon Michael Gove MP, Chancellor of the Duchy of Lancaster, responding to his letter of 26 August 2020 (4 September 2020) : https://committees.parliament.uk/publications/3143/documents/29271/default/ [accessed 29 October 2020]; letter from Lord True, Minister of State, Cabinet Office to Baroness Armstrong of Hill Top, Chair, Public Services Committee, (2 November 2020): https://committees.parliament.uk/publications/3249/documents/30661/default/ [accessed 7 November 2020]

9 Q 102

CHAPTER 2: INSUFFICIENT SUPPORT FOR PREVENTION AND EARLY INTERVENTION

14. Rosie Lewis is Deputy Director of the Angelou Centre, a charity working with Black, Asian and Minority Ethnic (BAME) women in the North East of England. She underlined how the pandemic had affected different groups of people in different ways:

> "COVID has reflected already inherent inequalities. The socioeconomic inequalities are so important; we have to think about them in parallel to health, because we know health outcomes are linked to diet, exercise, wellbeing, mental health, stress and environmental factors at work. We cannot look at just one strand or the other; we have to look at those multiple conflicting factors.
>
> "Bangladeshi communities are the highest-affected group. That correlates with them also being the most socioeconomically deprived, and it has gone on for a couple of generations. It has equally affected African-Caribbean communities, and again correlates with that."[10]

15. This chapter asks why the pandemic has had an unequal impact on different groups. It considers the role that prevention and early intervention can play in health, education and justice services, in order to deliver better outcomes and correct the inequalities that many of our witnesses described.

Poor health prevention and the impact of COVID-19

16. The initial NHS response to the pandemic was widely viewed by witnesses as effective. However, the UK went into the pandemic with poor national health; it has been described as one of the "sickest" countries in Europe.[11] We heard that in the years preceding COVID-19, a lack of investment in services that prevent ill-health had resulted in the prevalence of chronic diseases such as obesity and diabetes. This meant that the country lacked resilience when the pandemic hit, which placed additional pressures on the NHS. People with preventable chronic diseases were more likely to be hospitalised than others.

17. But the health impacts of COVID-19 were not felt equally. While avoidable ill-health is widespread, it disproportionately affects poorer people. The chronic diseases which made people more susceptible to COVID-19 are concentrated in deprived areas, where death rates from the virus were highest. Many of these deaths could have been avoided if there had been a greater investment in preventative services.

Initial NHS response to the COVID-19 pandemic

18. Witnesses such as the British Medical Association (BMA) and Josh Hardie, Deputy Director-General of the Confederation of British Industry (CBI), praised how the National Health Service had responded to the immediate

10 Q 63

11 Gunther Deuschl et al, 'The burden of neurological diseases in Europe: an analysis for the Global Burden of Disease Study 2017', *The Lancet*, vol 5, (October 2020): https://www.thelancet.com/action/showPdf?pii=S2468–2667%2820%2930190-0 [accessed 7 November 2020] and Richard Horton, 'Alarming new data shows the UK was the "sick man" of Europe even before COVID', *The Guardian* (18 October 2020): https://www.theguardian.com/commentisfree/2020/oct/18/alarming-data-britain-sick-man-europe-before-covid?CMP=Share_iOSApp_Other [accessed 7 November 2020]

health crisis precipitated by COVID-19—for example by constructing Nightingale Hospitals.[12]

19. Saffron Cordery, Deputy Chief Executive of NHS Providers, the membership organisation for NHS hospital, mental health, community and ambulance services, described how the additional capacity created in the NHS included 30,000 new Intensive Care Unit beds and 30 per cent more ambulance vehicles to deal with the expected surge of patients. There was an increase of 105 per cent in the number of calls received by the NHS, which developed new mental health accident and emergency services and 24-hour mental health lines in order to lessen the burden on acute trusts.[13]

Underfunding of prevention

20. We heard, however, that support for the NHS during the initial response to the pandemic, while necessary, should not have come at the expense of preventative and public health services. Dr Jeanelle de Gruchy, President of the Association of Directors of Public Health, said that "in the earlier days, a lot of the response was an NHS response, not a public health response to the pandemic".[14]

21. Our evidence suggested that the COVID-19 crisis would not have been as acute if preventative services had received sufficient funding and emphasis in the past. Dr De Gruchy reported: "We have had to play catch-up because of the cuts over time to the public health system."

22. Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London, described how the historical underfunding of preventative services had had a disproportionate impact on the poorest communities.[15]

23. Chris Naylor, Senior Fellow at the King's Fund, a health think tank, made a similar point:

> "Some of the place-based inequalities we talk about happen at a very local level. If we … take the example of two neighbouring areas of Clapham in south London that are directly adjacent to each other, the gap in healthy life expectancy for men is 12 years and for women it is seven years."[16]

Health inequalities and COVID-19

24. We heard that the historical failure to fund and support prevention had led to adverse outcomes for COVID-19 patients from disadvantaged areas, which had put further pressure on the NHS. For example, a high proportion of those who died from COVID-19 were living with obesity or Type 2 diabetes, or both—preventable conditions which are overrepresented in the UK's most deprived communities.[17] Public Health England reported that:

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12 Q 51, Q 96, written evidence from NHS Providers (PSR0005), British Medical Association (BMA) (PSR0071) and Claire Kennedy and Simon Morioka, PPL (PSR0110)
13 Q 19
14 Q 35
15 Q 66
16 *Ibid.*
17 Written evidence from the Richmond Group (PSR0029)

- diabetes was mentioned on 21 per cent of death certificates where COVID-19 was also mentioned;[18]
- diabetes was more likely to be mentioned on the death certificate in deprived areas. In the most deprived areas, 26 per cent of COVID-19 deaths also mentioned diabetes. This compares with 16 per cent in the least deprived;[19]
- one study found that for people classed as obese, the risk of death from COVID-19 increased by 40 per cent compared with those at a healthy weight. For those classed as morbidly obese, it rose by 90 per cent;[20]
- obesity prevalence is highest in the most deprived areas in England, at 34.6 per cent of women and 36.5 per cent of men. This compares with 20.4 per cent of women and 20.6 per cent of men in the most affluent areas.[21]

25. Type 2 diabetes and obesity are particularly prevalent among BAME people, meaning that they are more likely to die from COVID-19 than are the wider population.[22] The Richmond Group, a coalition of voluntary organisations working in England's health and care system, warned that "those communities with higher levels of multimorbidity" were "more vulnerable generally" to the virus and would be "at higher risk in the case of a … future pandemic".[23]

26. The pandemic revealed the significant health disparities affecting BAME people. For example, we heard that:

- almost a third of all patients critically ill with COVID-19 in hospitals were from BAME backgrounds—despite making up just 13 per cent of the UK population;[24]
- Black Caribbean and African people represent three per cent of the UK population but accounted for 12 per cent of COVID-19 intensive care unit patients;[25]
- per capita deaths with COVID-19 among Black Caribbean people were almost three times those of White British people;[26]
- people of Bangladeshi background in England were twice as likely as White British people to die if they contracted COVID-19;[27]

18 Public Health England, *Disparities in the risk and outcomes of COVID-19* (August 2020), p 7: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf [accessed 7 November 2020]
19 *Ibid.*, p 63
20 Public Health England, *Excess weight and COVID-19: insights from new evidence* (July 2020), p 26: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907966/PHE_insight_Excess_weight_and_COVID-19__FINAL.pdf [accessed 7 November 2020]
21 *Ibid.*, p 21
22 Written evidence from Dr A Ercia (PSR0003)
23 Written evidence from the Richmond Group (PSR0029)
24 *Ibid.*
25 Written evidence from Dr A Ercia (PSR0003)
26 *Ibid.*
27 Written evidence from Our NHS, our concern (PSR0035)

- despite making up only three per cent of the population of care homes, BAME care home residents made up approximately half of all care home deaths during the pandemic.[28]

27. Prevention would help reduce health inequalities for BAME people in other ways. Dr Angelo Ercia of the University of Manchester wrote:

> "Another important aspect [of] the unequal impact of COVID-19 … on BAMEs is the role of social determinants of health. Social determinants … include economic, environmental and social conditions in which BAMEs live, work, learn, play and socialise. For example, a higher proportion of BAMEs experience poverty and deprivation compared to their White counterparts."[29]

28. The Richmond Group called on the Government to look further than the health system if it is to make prevention a priority. It proposed that any strategy that considered greater funding for preventative health and care services should recognise the importance of the provision of transport and employment services in addressing the wider social determinants of physical and mental health. [30]

29. Professor Sir Michael Marmot said that the NHS Long-Term Plan,[31] NHS England's 10-year strategy, put insufficient focus on these social determinants:

> "The health service accounts for between 10 per cent and 20 per cent of the health of the population, and that could be enhanced because the healthcare system could be doing more to address the conditions in which people live … 'Why treat people and send them back to the conditions that made them sick?' The COVID-19 pandemic has exposed that to a much greater degree."[32]

Policy responses

30. We heard how public services could work together successfully to deliver preventative strategies. Greater Manchester Combined Authority (GMCA) had put in place or accelerated several such strategies during the COVID-19 pandemic. An anti-smoking programme aimed at rough sleepers continued with modifications to ensure social distancing, and moved services online. The programme built on opportunities to "engage at scale with rough sleepers as part of humanitarian support efforts". Its aim was to help smokers

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28 Written evidence from the Muslim Council of Britain (PSR0108)

29 Written evidence from Dr A Ercia (PSR0003). Shortly before this report was published, the Office for National Statistics published a report which argued: "Ethnic differences in mortality involving COVID-19 are most strongly associated with demographic and socio-economic factors, such as place of residence and occupational exposures, and cannot be explained by pre-existing health conditions using hospital data or self-reported health status." Office for National Statistics, *Updating ethnic contrasts involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020* (16 October 2020): https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/deathsoccurring2marchto28july2020 [accessed 23 October 2020]. The ONS report appeared too late in our inquiry for our witnesses to comment; however its findings would appear to strengthen witnesses' arguments that the social determinants of health must be taken into account when designing preventative strategies.

30 Written evidence from the Richmond Group (PSR0029). See also Q 67 (James Bullion).

31 NHS, 'The Long-Term Plan', (January 2019): https://www.longtermplan.nhs.uk [accessed 20 October 2020]

32 Q 67 (Professor Sir Michael Marmot and Chris Naylor)

to quit, "given emergent evidence of a link between smoking and more severe COVID-19 illness and outcomes for smokers".

31. The GMCA argued: "As we move into a recovery phase, these strategies will remain of significant importance, particularly in mitigating the impacts of a 'second wave' of the disease and protecting the city region's health infrastructure."[33]

32. While Dr Jeanelle de Gruchy recognised that services would need to respond to people's immediate needs, she suggested that preventative and early intervention services would be central to reducing inequalities in the longer term. Other witnesses called on the Government to set out a comprehensive response to the 2019 green paper *Advancing our health: prevention in the 2020s*[34] that would take the effects of the pandemic into account.[35] They proposed that the response should reflect the findings of *Health equity in England: the Marmot review 10 years on*, a major recent review of health inequalities.[36]

33. In its 2019 general election manifesto, the Government promised to "invest in preventing disease as well as curing it". It planned to achieve this aim by dealing with the "underlying causes of increases in NHS demand, for example via a long-term strategy for empowering people with lifestyle-related conditions such as obesity to live healthier lives, as well as tackling childhood obesity, heart disease and diabetes". The aim of this approach is encapsulated by the Government's commitment "to extend healthy life expectancy by five years by 2035, and to narrow the gap between the richest and poorest".[37] The Richmond Group told us that the Government shift away from the prioritisation of acute services towards greater funding for services that focus on obesity, smoking and alcohol consumption.[38]

34. On 18 August 2020, the Government announced that it planned to replace Public Health England with a National Institute for Health Protection (NIHP).[39] The NIHP will be modelled, in part, on Germany's national public health agency, the Robert Koch Institute (RKI). We heard from Rudolf Henke, Member of the German Bundestag and COVID-19 lead for its Health Committee, that the RKI works closely with local public health networks to deliver a preventative health strategy and strengthen community resilience when health crises arise (see Box 1).[40]

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33 Written evidence from Greater Manchester Combined Authority (PSR0017)

34 Cabinet Office and Department of Health and Social Care, *Advancing our health; prevention in the 2020s—consultation document* (22 July 2019): https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s [accessed 20 October 2020]

35 Written evidence from the Richmond Group (PSR0029), Action on Smoking and Health (ASH) (PSR0065) and the Association of Directors of Public Health (ADPH) (PSR0069)

36 Q 8, Q 43, written evidence from Association of Directors of Public Health (ADPH) (PSR0069); Professor Sir Michael Marmot et al, *The Marmot Review 10 years on, The Institute of Health Equity* (February 2020): https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on [accessed 23 October 2020]

37 Conservative Party, *Conservative Manifesto 2019* (November 2019): https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba_Conservative%202019%20Manifesto.pdf [accessed 20 October 2020]

38 Written evidence from the Richmond Group (PSR0029)

39 Department of Health and Social Care, 'Government creates new National Institute for Health Protection' (18 August 2020): https://www.gov.uk/government/news/government-creates-new-national-institute-for-health-protection [accessed 20 October 2020]

40 Q 157

Box 1: The German public health system

Rudolf Henke, COVID-19 lead for the Bundestag Health Committee, described the public health system in Germany. He said that there were 375 local health offices, or *Gesundheitszentrum*, which "take their own decisions".[41]

John Kampfner, an author and journalist who is an expert on German public policy, outlined the health offices' role in responding to the pandemic:

"They were there to protect public health in case of a pandemic such as one caused by water treatment problems, the possibility of swine flu, this or that. … They had these 375 offices that were underfunded, that were not really doing things, but they were there. They had an infrastructure there.

"What was remarkable in the early period of COVID was that they then sprang into action. People were seconded from across the public sector, from across the municipalities: people who worked in forestry departments, in museums or at swimming pools; traffic wardens; anybody who was doing work that was not really needed at the time."[42]

For Kampfner, the system "speaks to a country that thinks ahead on the basis of what possible crises might befall it". He suggested that the UK should adopt a similar approach, by prioritising "long-term planning and provision for future crises rather than salami-slicing. Now, that is not an exhortation for a spending free-for-all, but it is about building slack into any health and social care system on the basis of a rainy day principle, which we have not done for reasons of fiscal prudence but which has come back to bite us."[43]

35. It is unclear whether the NIHP will play the same role in supporting preventative services as its predecessor organisation.[44] The Government has announced the formation of an advisory group of public health stakeholders who will make recommendations on the future of Public Health England's preventative role.[45]

36. **Preventable long-term diseases disproportionately affect the UK's poorest communities. People who are obese, who smoke, who are diabetic and who live in unhealthy social, economic and physical environments are at higher risk of dying from COVID-19.**

37. **An approach to public health that focused on preventing health inequalities over the long term would pay dividends by increasing the resilience of communities and reducing pressures on the NHS when a crisis occurs. If such an approach had been adopted before the pandemic, it would have reduced the number of deaths resulting from COVID-19.**

41 *Ibid.*
42 *Ibid.*
43 Q 161
44 Department of Health and Social Care, 'Government creates new National Institute for Health Protection' (18 August 2020): https://www.gov.uk/government/news/government-creates-new-national-institute-for-health-protection [accessed 20 October 2020]
45 Department of Health and Social Care, *The future of public health : the National Institute for Health Protection and other public health functions* (15 September 2020): https://www.gov.uk/government/publications/the-future-of-public-health-the-nihp-and-other-public-health-functions/the-future-of-public-health-the-national-institute-for-health-protection-and-other-public-health-functions#the-future-of-health-improvement-prevention-and-wider-phe-functions [accessed 20 October 2020]

38. **The Government's commitment in its 2019 general election manifesto to extend healthy life expectancy by five years by 2035—and to narrow the gap between the richest and poorest—is welcome. It should now publish its strategy to achieve this manifesto commitment and its response to the green paper *Advancing our health: prevention in the 2020s*. Both documents should set out how central Government will work in active partnership with individuals, communities, local government, the NHS, businesses and charities to design and deliver preventative services to improve the health of the poorest communities.**

39. **The Government should confirm as soon as possible how preventative services will be delivered, either through the new National Institute for Health Protection or other agencies. It should also confirm how the National Institute for Health Protection's relationship with and accountability to the Department for Health and Social Care will differ from that of its predecessor, Public Health England.**

Prevention and the criminal justice system

40. People who interact with the police and justice services are often vulnerable; they might have underlying issues of trauma, addiction and mental ill-health. We heard how the number of people taken into custody had not significantly reduced since the lockdown. Rick Muir, Director of The Police Foundation, a think tank, called on the police to use the pandemic as an opportunity to explore a "trauma-informed" preventative approach.[46] This would involve training police officers to recognise where offences might have been influenced by the complex needs of the people with whom they were interacting. Police services could then divert individuals to appropriate community-based, harm reduction interventions and help people access a range of services to prevent re-offending.[47]

41. Revolving Doors Agency, a charity working with people who come into contact with the criminal justice system, also argued that the wider public service system needed to take a preventative approach when dealing with those with complex needs. It suggested:

> "Too often the criminal justice system ends up being a 'service' of last resort that ends up trying to support people with a range of mental and physical health issues, substance misuse, homelessness, poverty and assorted childhood abuse and trauma. That service is ill-equipped to manage these issues effectively."

42. Instead the organisation recommended greater cooperation between the justice system and preventative services. This would include "rolling out alternatives to custody that focus on treatment and better services that focus on rehabilitation and preparation for release from prison".[48] Collective Voice, an alliance of drug and alcohol treatment charities, wrote that "even before the crisis there were serious issues" with the integration of the prison system

46 See Q 75.
47 Elsa Corry-Roake, 'COVID-19: The role of policing in recovery', *Revolving Doors* (17 April 2020): http://www.revolving-doors.org.uk/blog/covid-19-role-policing-recovery [accessed 12 November 2020]. See written evidence from Clinks (PSR0053) on the criminal justice response to COVID-19.
48 Written evidence from Revolving Doors (PSR0090)

and preventative addiction services, which "impeded continuity of care from prisons to community treatment".[49]

43. Revolving Doors therefore advocated diverting people into relevant services. It pointed to the NHS Health and Justice Liaison and Diversion Service as an example of an effective preventative service that "should be embedded into local services to spot need before it reaches crisis point".[50]

44. **We recommend that the Home Office and Ministry of Justice draw up joint guidance on how the police, the prison system and National Probation Service should work with homelessness, mental health and addiction services to support people whose complex needs may have deteriorated during the pandemic. It should also outline the level of resource that the police and justice system should invest in preventative services**

Early intervention in education

45. Early intervention can provide valuable support for disadvantaged pupils.[51] The Early Intervention Foundation, an organisation which supports early intervention to improve outcomes for disadvantaged children, set out how cuts to local authority budgets over the last decade had affected local authorities' ability to provide early intervention services. "Most prevention expenditure is non-statutory and therefore had been de-prioritised to ensure statutory duties were met," it wrote. It called for "resourcing for children's services" to be at a "sufficient level to enable meaningful investment in early help and targeted services in addition to statutory social care".[52]

46. The Children's Commissioner Office (CCO) told us that disadvantaged children were at a higher risk of school exclusion. It stated: "The Department for Education has invested millions of pounds in looking at different responses to children who have been permanently excluded;" this money would be better spent on preventative services "to intervene before a child reaches the point of exclusion".[53]

47. The CCO argued that this approach would also improve outcomes for disadvantaged children. Its research had found that:

- 59 per cent of under-14s permanently excluded from school did not return to mainstream education within three years;
- only 4.5 per cent pass GCSE English and Maths;
- 40 per cent become NEET (Not in Education, Employment, or Training) when they leave school at 16.[54]

48. School attendance plays an important role in early intervention for vulnerable children because education is central to determining children's opportunities

49 Written evidence from Collective Voice (PSR0050)
50 Written evidence from Revolving Doors (PSR0090)
51 A pupil is classed by the Department for Education as disadvantaged if they have been eligible for free school meals within the five years before sitting GCSE exams, or if they have been in care or adopted from care. See: Children's Commissioner, *Briefing: Tackling the disadvantage gap during the COVID-19 crisis* (April 2020): https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-tackling-the-disadvantage-gap-during-the-covid-19-crisis.pdf [accessed 10 November 2020]
52 Written evidence from the Early Intervention Foundation (PSR0020)
53 Written evidence from the Children's Commissioner's Office (CCO) (PSR0106)
54 *Ibid.*

in later life. Missing school can affect vulnerable children more than others. Research suggests that children from disadvantaged backgrounds fall behind their peers during the regular six-week summer break.[55]

49. Only 10 per cent of children defined by the Government as vulnerable attended school or early years education during the first lockdown.[56] The Early Intervention Foundation highlighted the education attainment gap that affects disadvantaged children and warned of an increased risk that such children would fall further behind due to school closures during that lockdown. It argued that to close the gap, support should be targeted at the "local level for the children who are particularly vulnerable to a sustained impact … on their cognitive and social and emotional development".[57]

50. **There is a serious risk that disadvantaged children will fall further behind as a result of school closures during the pandemic. The Government should set out how it will support early intervention in education services to close the attainment gap, reduce exclusions and ensure that disadvantaged children's education will not suffer adverse long-term effects from the first lockdown. The Government should consult with Ofsted and the Children's Commissioner on how to hold schools to account and measure progress made in supporting disadvantaged children to catch up.**

51. **Successive governments have failed to invest sufficiently in a preventative approach to health, education, justice and other public services. Investing in future potential can be difficult for governments due to a political cycle that prioritises immediate returns over long-term benefits to future generations; cost over social value; and the measurement of increased outputs over improved outcomes.**

52. **The Government should recognise that investing in prevention and early intervention can reduce the pressures placed on the NHS and the justice system, and that supporting children to avoid poor life outcomes brings financial savings and economic benefits. A future inquiry might investigate further a preventative approach to public services.**

55 Children's Commissioner, *Tackling the disadvantage gap during the COVID 19 crisis* (April 2020): https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-tackling-the-disadvantage-gap-during-the-covid-19-crisis.pdf [accessed 20 October 2020]

56 Department for Education, *Coronavirus (COVID-19) attendance in educational and early years settings in England* (24 April 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881662/COVID19_attendance_in_education_settings_240420.pdf [accessed 12 November 2020]

57 Written evidence from Early Intervention Foundation (PSR0020). See also Equality and Human Rights Commission (EHRC), *How coronavirus has affected equality and human rights* (October 2020), p 24: https://www.equalityhumanrights.com/sites/default/files/equality_and_human_rights_commission_how_coronavirus_has_affected_equality_and_human_rights_2020.pdf [accessed 23 October 2020]

CHAPTER 3: INEQUALITY OF ACCESS TO HIGH-QUALITY PUBLIC SERVICES

53. Ryan Wise is a qualified social worker who now works in higher education, training social work students. With the Centre for Public Impact he helped facilitate a focus group of frontline social workers. Participants stressed the importance of agencies working together to ensure that users can access services. But Mr Wise recounted:

> "The main reflections from what we … heard [were] about the support systems for children, and social care—the interactions with the health visitor service, with the midwifery service, and with hospitals. What we are hearing from social workers is that they are very much alone.
>
> "I recall one anecdote. Someone phoned up a health visitor: 'Have you visited this young child who is two? We are worried about them.' 'No, our policy is not to go out.'"

54. The child was unable to access the services that they needed because the pandemic meant that health visitors had stopped home visits.[58]

55. In this chapter we consider the underlying reasons for pre-existing inequalities of access to high-quality public services. Such reasons include a lack of integration between public services, and a failure by public services to identify the specific needs of certain groups. Since the beginning of the pandemic these inequalities have continued to prevent users from accessing the services that they depend on, making access even more unequal. Such failings have been felt particularly acutely by Black, Asian and Minority Ethnic service users, Gypsy, Roma and Traveller groups, and vulnerable children.

The consequences of poorly integrated services: vulnerable children

56. Our evidence suggested that a lack of collaboration between public services meant that even before the COVID-19 pandemic the needs of vulnerable children[59] were not sufficiently met. The first lockdown widened inequalities of access to public services between vulnerable children and other groups.

Numbers of vulnerable children

57. The Children's Commissioner's Office (CCO) warned that in 2019 an estimated 829,000 children from a vulnerable family background were "invisible" to services. They did not have access to children's social care or to statutory support from local authorities such as the Troubled Families Programme, which conducts targeted interventions for families experiencing

58 We heard that during the pandemic health visitors and midwives had worked hard, in difficult conditions, to keep children safe. This example from the Centre for Public Impact focus group with social workers reflects a broad consensus among focus group participants that children's services are insufficiently integrated. See written evidence from Centre for Public Impact focus group (PSR0113) and Q 155.

59 The Children's Commissioner's Office defines child vulnerability as being at risk from a range of difficulties, including physical or mental illness, to going hungry; being homeless or excluded from school; being at risk of neglect or abuse; or living with parents with health problems, such as mental ill health or substance abuse. See: Children's Commissioner, *We're all in this together: local area profiles of child vulnerability* (April 2020): https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-were-all-in-this-together.pdf [accessed 10 November 2020).

multiple problems.[60] An estimated 2.3 million children were classed in 2019 as "vulnerable due to their family circumstances". The Children's Commissioner's Office suggested that this number was likely to have increased substantially during the first lockdown.[61] More than 750,000 children were absent from school in the second week of October 2020, giving an 89.9 per cent attendance rate, compared with 95 per cent the previous autumn.[62]

58. The Children's Commissioner, Anne Longfield OBE, described how vulnerability may be widespread among children:

> "The emergency has … exposed … the scale of vulnerability. We are talking potentially about one in six children with significant vulnerabilities, many of which were hidden before the actual crisis and have remained hidden."[63]

59. Witnesses were concerned that families who were already experiencing difficulties before the first lockdown could be pushed to "crisis point".[64] Such pressures are likely to be felt most severely in parts of the country with high levels of deprivation. For example, in Manchester 18 per cent of children live in families where one parent has a severe mental health problem; in Blackpool, 13 children in 1,000 are currently on a child protection plan; and in Hackney, over 10 per cent of children live in households where domestic abuse is occurring.[65] Many such areas were recently placed under 'local lockdowns', which may have worsened conditions for vulnerable children living there.

60. We heard that for children experiencing abuse and serious harm, school can be a reprieve. When vulnerable children attend school, teachers and social workers can detect problems early.[66] However, with most vulnerable children unable to attend school during the first lockdown, many had little support from public services.[67] For Children England, school closures and the reduction in social workers' home visits as a result of COVID-19 exacerbated vulnerable children's existing inequalities.[68]

61. **Before COVID-19, vulnerable children were falling through the gaps between public service providers, "invisible" to social services, the NHS and the education system. Many more have become "invisible" during the pandemic since losing contact with public services.**

Inadequate integration between service providers

62. On 24 April 2020 the Government announced that just over £12 million would be spent on 14 projects across the country to tackle the increased risk to vulnerable children during the first lockdown. The money supported

60 House of Commons Library, The Troubled Families programme (England), Briefing Paper Number 07585, September 2020
61 Written evidence from the Children's Commissioner's Office (CCO) (PSR0106)
62 Sian Griffiths et al, 'Teachers search for lost children of COVID', *The Sunday Times* (18 October 2020): https://www.thetimes.co.uk/article/teachers-search-for-lost-children-of-covid-bgjkbmpz5 [accessed 30 October 2020]
63 Q 27
64 Written evidence from Marie Curie (PSR0092)
65 Written evidence from London Borough of Hackney (PSR0098) and Q28 (Amanda Spielman).
66 Written evidence from Early Intervention Foundation (PSR0020)
67 Children's Commissioner, *Childhood in the time of COVID* (September 2020): https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/09/cco-childhood-in-the-time-of-covid.pdf [accessed 10 November 2020]
68 Written evidence from Children England (PSR0013)

children at risk of abuse; community volunteers working with families; children in care and care leavers; and children's mental health. It included £1.6 million in funding for the National Society for the Prevention of Cruelty to Children helpline, to which people can report concerns about vulnerable children.[69]

63. While this additional funding is welcome, we heard that a lack of integration between services and a tendency for siloed working could limit the ability of public services to protect vulnerable children. The CCO outlined how separate targets mandated by different Government departments for schools, local authority children's social care services and NHS children's mental health services could result in a situation where "three agencies believe they are acting in the best interests of a [vulnerable] child, but are pursuing different ends, or considering one elements of a child's needs as both discrete and the responsibility of someone else".[70]

64. The CCO highlighted areas where an existing lack of coordination between services could have a negative impact on vulnerable children. It described how services did not work together effectively when vulnerable children moved from accessing children's to adults' social care services, and the lack of Child and Adolescent Mental Health Services (CAMHS) professionals working in schools to identify vulnerable children. The CCO argued that in order to "identify, and then ameliorate, the broad range of risks to children", it was "necessary to have a shared understanding of the needs of children and an integrated approach across the different partners involved".[71]

65. Todd Krieble, Deputy Chief Executive of New Zealand's Institute of Economic Research, outlined how that country had successfully encouraged the kind of cooperation that the Children's Commissioner advocated. The New Zealand government has set up "joint ventures". These are coordinated strategies to tackle complex social problems which do not fall within any single departmental remit.[72] We describe this approach in Box 2.

69 Department for Education, 'Multi-million support for vulnerable children during COVID-19' (24 April 2020): https://www.gov.uk/government/news/multi-million-support-for-vulnerable-children-during-covid-19 [accessed 20 October 2020]. The Government also announced that this money would be spent on better data-sharing between all safeguarding partners, to ensure that the NHS, police, social workers, school nurses and health workers had the information that they needed to protect children at risk of abuse. The role of data-sharing in keeping children safe is discussed in Chapter 8.

70 Written evidence from the Children's Commissioner's Office (CCO) (PSR0106)

71 Written evidence from the Children's Commissioner's Office (CCO) (PSR0106). See also Local Government Association (LGA), 'A child-centred recovery' (10 September 2020): https://www.local.gov.uk/child-centred-recovery#executive-summary [accessed 29 October 2020]

72 Q 123

Box 2: Breaking down silos: learning from New Zealand's "joint ventures"

The funding for joint ventures is allocated in New Zealand's annual budget. In Budget 2020, $202.9 million was allocated to a "joint venture" on "family violence and sexual violence".[73]

Responsibility for addressing family violence and sexual violence was previously distributed across at least 10 government agencies. "Family violence and sexual violence" comprised ministers from the departments of Justice, Social Development, Children and Māori Development, and a senior civil servant from each department.[74]

A lead minister is appointed, who decides how funding is spent. For "Family violence and sexual violence" it was the Parliamentary Under-Secretary to the Minister of Justice (Domestic and Sexual Violence). A senior civil servant acts as "chief executive" of the "joint venture", to provide a single point of accountability and leadership.

66. **The Government should urgently develop a cross-agency strategy which would support vulnerable children in, or at risk of, crisis and ensure that public services do not lose touch with children during future crises such as the COVID-19 pandemic. As part of this strategy, the Troubled Families Programme and community services that facilitate multi-agency support for families such as children's centres and family hubs should be extended. Schools should have Child and Adolescent Mental Health Services professionals, police liaison officers and youth workers who can collaborate to address vulnerable children's needs.**

67. **The Government should study New Zealand's "joint ventures" to understand better how central Government can encourage cross-agency collaboration on complex social problems.**

Black, Asian and Minority Ethnic and Gypsy, Roma and Traveller service users

68. In May 2020 the University of Manchester Centre on Dynamics of Ethnicity and the Runnymede Trust warned that:

- BAME people's inequalities in experiences of health care were substantial and had not changed over time;
- disparities in educational outcomes showed persistent disadvantage for Black Caribbean, Pakistani and Gypsy and Irish traveller groups, including significantly higher levels of permanent exclusion for Black and Gypsy and Irish traveller groups.[75]

73 Q 116

74 Q 123; New Zealand Ministry of Justice, 'Family violence and sexual violence work programme', (13 August 2020): https://www.justice.govt.nz/justice-sector-policy/key-initiatives/reducing-family-and-sexual-violence/work-programme/ [accessed 21 October 2020] and Public Service Commission, 'Machinery of Government—Organisational Forms', (11 May 2018): https://www.publicservice.govt.nz/resources/mog-organisational-forms/ [accessed 7 November 2020]

75 University of Manchester, 'Report highlights extent of UK's race inequality with COVID-19 likely to worsen problem' (4 May 2020): https://www.manchester.ac.uk/discover/news/extent-of-uks-race-inequality/ [accessed 20 October 2020]

69. Such inequalities of access have grown since the beginning of the first lockdown. Lord Woolley of Woodford, Director of Operation Black Vote, stated that while COVID-19 did not "target race or ethnicity",[76] it did target "those areas within our society that I would describe as deeply racialised. … I mean those areas in which a disproportionate number of black and minority ethnic individuals are on low pay, on zero-hours contracts, in poor housing, in overcrowded housing."[77]

70. Dr Angelo Ercia told us:

> "The lockdown has disabled many BAMEs to access healthcare services that are essential to help with managing and treating their health conditions. For example, a diabetic BAME patient may have not seen a dietician for weeks. Therefore, they are unable to thoroughly discuss their food intake, receive assistance with meal plans, and review their blood tests. Health education and one-on-one support is an important aspect of managing diabetes. The patient may have also experienced limited or no communication with their GP … about their diabetes and other health conditions."[78]

71. Lord Woolley argued that a "COVID-19 race equality strategy" was urgently needed: "we desperately and immediately need a plan to ensure that Black, Asian and Minority Ethnic communities are not doubly, triply, devastatingly hit again."[79] Professor Claire Alexander, Associate Director of the Centre on Dynamics of Ethnicity at the University of Manchester, said that such an approach should be "led from the top". She called for a Government race equality strategy: "There needs to be a very strong commitment from the Government to tackle this in a real way."[80]

72. Sarah Mann, Director of Friends, Families and Travellers, a charity working with Gypsy Roma and Traveller groups, described how the pandemic had underscored the exclusion of GRT people from public services: "It took a long time for any guidance to get out to local authorities to remind them that they may have a duty to support Gypsy and Traveller families as they would other families in this situation."[81]

73. She explained that moving education provision online during the first lockdown had caused problems for GRT families:

> "Gypsy, Roma and Traveller families are more likely to be digitally excluded … and children are less likely to have literate parents within a household. Accessing remote education was virtually impossible. We had a case of a family being told that one mobile phone was sufficient

76 Operation Black Vote, 'Official: COVID-19 devasting impact on BAME. Now act!' (2 June 2020) https://www.obv.org.uk/news-blogs/official-covid-19-devastating-impact-bame-now-act [accessed 20 October 2020]
77 Q 125
78 Written evidence from Dr A Ercia (PSR0003)
79 Q 125
80 Q 128. The Equality and Human Rights Commission (EHRC) also called for such a strategy. Written evidence from the EHRC (PSR0107)
81 Q 60

access for four children to follow their education programme during lockdown."[82]

74. Sarah Mann recommended "specific targeted catch-up … for Gypsy, Roma and Traveller children, who already experience the worst attainment of any group in the UK".[83]

75. **COVID-19 should be a wake-up call for the Government that the designers and providers of public services have paid insufficient attention to the specific needs of minority groups. The Public Sector Equality Duty has had limited success; Black, Asian and Minority Ethnic and Gypsy, Roma and Traveller groups experience significant inequalities of access. These inequalities have worsened since the beginning of the pandemic.**

76. **The Government should introduce a race equality strategy that would apply across public services and address inequalities of access for Black, Asian and Minority Ethnic and Gypsy, Roma and Traveller people. Such a strategy should include joint targets, shared by all relevant service providers and supported by voluntary sector organisations working directly with these groups, to tackle persistent inequalities in health and educational outcomes. The strategy should investigate the links between such inequalities.**

77. **Service providers should respond to race equality targets by developing clear implementation plans to meet them. The Government should set out the role of regulators in holding public services accountable for these implementation plans and targets.**

82 Q 60. The EHRC also highlighted digital exclusion among GRT families and argued that online education provision risked widening GRT children's education attainment gap. It wrote: "In England, In 2016/17 72.5 per cent of White British children achieved a 'good level of development' at Foundation Stage (as assessed by a teacher), higher than Black (69.6 per cent), Bangladeshi (67.1 per cent), Pakistani (64.3 per cent) and Other White (63.9 per cent) children. Attainment was lowest, by a large margin, for Gypsy, Roma and Irish Traveller children (33.2 per cent)." Written evidence from the Equality and Human Rights Commission (EHRC) (PSR0107).

83 Q 60

CHAPTER 4: 'CO-PRODUCTION' AND USER VOICE

78. A number of witnesses stressed the importance of involving people with 'lived experience' of public services in conversations about how those services are used, and how they can be developed. David Knott, Director of the Office of Civil Society (OCS), which is part of the Department for Digital, Culture, Media and Sport, told us how a focus on 'lived experience' had helped the work of the OCS:

> "It is actually going out and hearing the experience of real people who interact with services, particularly young people. Through various panels, we have brought young people into the heart of some decision-making. That is incredibly revealing, not only about what young people want but about their experiences of interacting with services.[84]

79. This chapter describes how the voices of service users can support public services to integrate better, meet individuals' needs, and tackle the inequalities of access to high-quality services facing some groups. Nathan Dick, Head of Policy at Revolving Doors, said that "so many of the people we talk to refer to someone who had lived the same sort of thing and was able to turn round and say, 'We can do this differently. I've been there. We can change this', and that has helped them to engage with services."[85] The National Council for Voluntary Organisations (NCVO) linked 'lived experience' with the successful delivery of services: "Organisations with deep roots in a community or … led by people with lived experience often pioneer approaches that build … strength and capacity, reaching those who are disengaged from 'mainstream' services."[86] Debra Baxter, a user of disabled people's services, said that such an approach was cost-effective: "You can spend £1,000 on this, that and the other service, but the ideas that disabled people have themselves … cost less."[87]

80. Many witnesses advocated 'co-production'—where the users of a service are involved in its design—as the best way to capture 'lived experience', "lock-in" reforms to public services, and ensure a cultural shift in public service provision towards more collaborative approaches.

Box 3: What is 'co-production'?

'Co-production' is where providers work with service users as equal partners to design a new, or reform an existing, service or system for an agreed collective outcome. The approach is based on the principle that those who are affected by a service are best placed to help design it. 'Co-production' contrasts with a transaction-based method of service delivery in which people consume public services that are designed and delivered by providers.

Source: Involve, 'Co-production': https://www.involve.org.uk/resources/methods/co-production [accessed 7 November 2020]

84 Q 59
85 Q 73
86 Written evidence from National Council for Voluntary Organisations (NCVO) (PSR0052)
87 Q 144

81. We heard that 'co-production' should be embedded at every stage of the evaluation and reform of public services.[88] Collective Voices said that 'co-production' should have been used to evaluate the initial public service response to COVID-19. It argued that greater consultation with service users "could have helped predict potential issues, such as a lack of female-specific accommodation" for rough sleepers during the first wave of the pandemic.[89]

82. Asking users about their experiences of these innovations can help to embed the innovations that worked best. Revolving Doors contended that while service providers had reported benefits of the new methods of service delivery, it was important for providers to assess whether the changes had been "welcomed by people accessing these services".[90]

83. Using 'co-production' to design public services can help resolve the fundamental weaknesses of public services that the pandemic has exposed, thereby improving their resilience. Rosie Lewis of the Angelou Centre argued that involving BAME people in the design of services would have made services more responsive to minority communities' needs in the years before the pandemic. And it would have helped to identify the health inequalities that have made BAME people disproportionately vulnerable to COVID-19. She believed that it was important to:

> "Think about who is at the table, who is making the decisions and who holds the power. We have had decades of 'delivery to'—delivery to communities rather than 'co-production' … It is not just about our response to people in need; it is about changing systems, and we need to do that together."[91]

84. **The pandemic has shown that designing public services without consulting the people who use them embeds fundamental weaknesses such as inequalities of access. Users often have a better understanding of the outcomes that they would expect to see from public services, and involving user voice in service design increases the resilience of those services.**

85. **Local authorities and central Government should set out how they will support homelessness, mental health and addiction service providers to involve people with 'lived experience'—and the voluntary organisations that advocate on their behalf—in the design and delivery of services.**

86. **'Co-production' can embed service delivery innovations of the kind that have developed since the pandemic began, and in a cost-effective manner. In its response to this report the Government should confirm how it will encourage 'co-production' in the commissioning of public services, and how it will measure the levels of involvement in service design by groups of service users such as disabled people and those from BAME backgrounds.**

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88 Written evidence from Healthwatch England (PSR0115), Q63, Q65 (David Isaac; Sarah Mann), Mental Health Foundation (PSR0056), Locality (PSR0074), Muslim Council of Britain (PSR0108) and Anna Fowlie, Scottish Council for Voluntary Organisations (SCVO) (PSR0097)

89 Written evidence from Collective Voice (PSR0050)

90 Written evidence from Revolving Doors (PSR0090) and Revolving Doors–supplementary written evidence (PSR0112)

91 Q 63

CHAPTER 5: THE FRAGILITY OF ADULT SOCIAL CARE

87. Debra Baxter, from Wigan, has cerebral palsy. She participated in a focus group of people with complex health and social care needs that was facilitated by HealthWatch, an organisation which represents users of health and social care services.[92]

88. She told us: "If it wasn't for the support of my daughter during lockdown, I wouldn't have been able to cope." Debra needs help with daily tasks such as getting washed and dressed. Even before the first lockdown she was struggling to get the support that she needed. The poor wages and conditions in social care result in around a third of employees leaving the sector within 12 months of starting work. We heard that Debra's carers would often leave in quick succession, with little or no notice.

89. Once the pandemic began, the lack of adequate Personal Protective Equipment [PPE] and testing for the domiciliary care system meant that Debra felt forced to rely on her daughter:

> "I eventually found a care agency that was prepared to come in, but because they were visiting other residents who could have COVID-19, I was very worried for my own health, even for my life. If it was not for my daughter being furloughed from her full-time job, I would have been left struggling."[93]

90. While the crisis in acute health care caused by the COVID-19 pandemic was dealt with relatively successfully, it was followed by a devastating crisis in adult social care. Older people and the working-aged disabled with care needs were left particularly vulnerable. The large number of deaths among these groups was frequently presented by our witnesses as the most significant public service failing during the pandemic.

91. We heard that several pre-existing fundamental weaknesses contributed to the high mortality rate. These included a lack of integration between health and social care, and successive governments prioritising funding for NHS acute services and neglecting to fund social care adequately. Ministers have direct responsibility for the NHS, while responsibility for the commissioning and funding of social care services rests with local authorities. This chapter explores how the fundamental weaknesses of social care provision increased the vulnerability of people like Debra during the pandemic.

Care sector fragility before COVID-19

92. The Association of Directors of Adult Social Services set out how, prior to the pandemic, adult social care was already facing "significant and ongoing challenges". These included "short-term and time-limited funding settlements"; growing demographic pressures which led to increasing unmet need; a lack of funding for prevention and early intervention; and difficulties in recruiting and retaining care workers due to a lack of career progression and structure.[94]

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92 Written evidence from HealthWatch focus group (PSR0117)
93 Q 142
94 Written evidence from Association of Directors of Public Health (ADASS) (PSR0089); see also Care Quality Commission (CQC), 'State of Care' (16 October 2020): https://www.cqc.org.uk/publications/major-report/state-care [accessed 16 October 2020].

93. Parliamentary inquiries have focused on the need to fund adult social care more effectively, and to integrate the NHS and social care systems. The House of Lords Economic Affairs Committee called for a long-term funding solution in a 2019 report; the House of Commons Health and Social Care Committee came to a similar conclusion in October 2020.[95] Kate Terroni, the Chief Inspector of Adult Social Care at the Care Quality Commission (CQC), told us: "Poor integration of services remains one of the drivers of unmet need and concerns about access to services, which impacts on person-centred care."[96] A promised white paper on social care has now been delayed until 2021 at the earliest.[97]

The effects of COVID-19

94. The Nuffield Trust, a health think tank, suggested that "the COVID crisis" had highlighted "the stark inequities between the health and social care services".[98] Age UK wrote that the pandemic had "laid bare the deep and systemic inadequacies of the current social care system" and revealed the "true extent of the impact that underfunding, structural issues and market instability have had on the system's ability to respond and protect older people at a time of crisis".[99]

95. The result was "a tragic loss of life". The Office for National Statistics (ONS) reported that between 2 March and 12 June 2020 there were around 20,000 deaths of care home residents attributable to COVID-19 in England and Wales; and between 10 April and 19 June, there were 819 deaths from COVID-19 of people receiving domiciliary care in England (care provided at home by a registered care agency).[100] Age UK suggested that the true figure of domiciliary care deaths could be higher because recipients were less likely to have had their deaths attributed to COVID-19 than care home residents.[101] Overall, between 10 April and 19 June, the number of deaths of domiciliary care recipients was 6,523. This was 3,628 deaths more than the average for the same period (2,895 deaths) in the previous three years.[102]

96. We heard from ADASS that the historical tendency to prioritise acute health care had influenced the response to COVID-19. It suggested that "the initial

95 Economic Affairs Committee, *Social care funding: time to end a national scandal* (7th Report, Session 2017–19, HL Paper 392) and Health and Social Care Committee, *Social Care: funding and workforce* (Third Report, Session 2019–21, HC Paper 206). At the time of the publication of this report, the Government had not responded to the Economic Affairs Committee. The Government is required to respond to Parliamentary Select Committee reports within two months of their publication.

96 Written evidence from Care Quality Commission (CQC) (PSR0086)

97 Heather Jameson, 'ADASS issues stark warning as White Paper faces further delays', *Municipal Journal* (17 September 2020): https://www.themj.co.uk/ADASS-issues-stark-warning-as-White-Paper-faces-further-delays/218653 [accessed 23 October 2020] and HL Deb. 15 September 2020, col 1121

98 Written evidence from Nuffield Trust (PSR0041). See also Q44 (Professor Dame Donna Kinnair).

99 Written evidence from Age UK (PSR0028)

100 Office for National Statistics, 'Deaths involving COVID-19 in the care sector, England and Wales: deaths occurring up to 12 June 2020 and registered up to 20 June 2020 (provisional) (3 July 2020), section 8': https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional#deaths-of-recipients-of-domiciliary-care-in-england [accessed 7 November 2020]

101 Written evidence from Age UK (PSR0028)

102 Office for National Statistics, 'Deaths involving COVID-19 in the care sector, England and Wales: deaths occurring up to 12 June 2020 and registered up to 20 June 2020 (provisional) (3 July 2020), section 8': https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional#deaths-of-recipients-of-domiciliary-care-in-england [accessed 7 November 2020]

pandemic response made protection of the NHS a priority", which had a "detrimental impact" on social care. Patients were "discharged from hospital [into care homes] as quickly as possible, often without testing" and a "lack of PPE" for care workers contributed to the high death rate.[103] The Nuffield Trust highlighted the "rapid clearing of hospital beds in the early stages of the crisis", which revealed "too little consideration of the fragility and lack of preparedness of the care settings into which many people were being discharged".[104]

97. The Nuffield Trust underlined funding disparities during the pandemic response. While the NHS "received generous emergency funding from the Treasury" at the early stage of the outbreak, which enabled "dramatic expansions in acute capacity", care providers "raised concerns that extra funding was not reaching them".[105]

98. Our evidence suggested that the failures in adult care resulted from insufficient planning. The Nuffield Trust noted that although the Government's 2016 pandemic planning exercise, Exercise Cygnus,[106] had shown that care homes and domiciliary care "would be in need of significant support in a pandemic scenario", no advance arrangements were put in place to meet those needs:

> "Even when the need became clear at an early stage in the coronavirus pandemic, the national response appears to have been confused and inadequate. The action plan for social care was published on 15 April. This was almost a month after the action plan for health services which was issued on 17 March and had important implications for the social care sector."[107]

99. The Nuffield Trust's description of Exercise Cygnus was confirmed in a Government paper on the UK's pandemic preparedness, published on 20 October 2020.[108]

100. The Nuffield Trust concluded that integration between health and social care hinged on reform in three key areas: "COVID-19 demonstrated that effective integration requires parity of resource, equal visibility and priority in policy-making, and commitment to better data collection and sharing."[109] In Chapter 7 we describe how local-level Integrated Care Systems achieved effective integration during the pandemic. The devolved administrations have made several attempts to integrate health and social care, with varying

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103 Written evidence from Association of Directors of Public Health (ADASS) (PSR0089)
104 Written evidence from the Nuffield Trust (PSR0041)
105 *Ibid.*
106 HL Deb. 9 June 2020, col 1636
107 Written evidence from the Nuffield Trust(PSR0041). The adult social care action plan can be accessed from the Department of Health and Social Care, 'Coronavirus (COVID-19): adult social care action plan' (15 April 2020): https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan [accessed 7 November 2020]. The 'Next steps on NHS response to COVID-19' is at Letter from Sir Simon Stevens, NHS Chief Executive and Amanda Pritchard, NHS Chief Operating Officer to Chief Executives of all NHS trusts and foundation trusts on next steps on NHS response to COVID-19 (17 March 2020): https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf [accessed 30 October 2020]. We discuss the importance of data collection and sharing in Chapter 8.
108 Department of Health and Social Care, *UK pandemic preparedness* (5 November 2020): https://www.gov.uk/government/publications/uk-pandemic-preparedness/uk-pandemic-preparedness [accessed 7 November 2020]
109 Written evidence from the Nuffield Trust (PSR0041)

degrees of success. We outline the pandemic response of their health and social care sectors in Chapter 12.

101. **The COVID-19 pandemic has accentuated the systemic frailties in the care sector, with the tragic consequence of a large number of deaths in care homes and domiciliary care settings. Reform is now more urgent than ever.**

102. **In recent years much has been written about the lack of integration between health and social care and the need to provide adequate funding for social care. The problem of fragmentation of services is understood, but no priority has been given to creating coordinated services on the ground.**

103. **Closer integration and equality between health and social care will require Government action in three key areas. The fragility of adult social care should be addressed by providing the sector with adequate funding; the Government should give social care equal visibility and priority to health care; and the two sectors should integrate data collection and share data more effectively.**

104. **The Government should commit at the earliest opportunity to an interim sustainable funding settlement for adult social care. The Government has delayed the publication of its white paper on the long-term funding, integration and reform of the sector. This should be published as a matter of urgency.**

105. **We are concerned that the Government's own pandemic planning had identified that social care would need significant support during the outbreak of a disease like COVID-19, yet social care was the poor relation to the NHS when it came to funding. In reviewing its pandemic planning processes the Government should explain how it will ensure that the social care sector receives adequate funding, resources and support while COVID-19 continues, and in any future pandemic.**

CHAPTER 6: OVER-CENTRALISED DELIVERY OF PUBLIC SERVICES

> "Because of my age and health … I had a letter from the Government telling me that I should officially shield, but nothing happened … It was about four weeks into lockdown before I was actually recognised, only because I persisted … If I had kept quiet and done nothing about it, I have a feeling that I might have been completely forgotten."

106. This is what Agatha Anywio, 76, from London, told us about her experience of the early days of the first lockdown.[110] Her experience was not uncommon; we heard how the Government's disjointed communications strategy with local and frontline services led many people to feel that they had been forgotten and left without support.

107. Debra Baxter said that local organisations would have been in a better position than national agencies to understand her situation and coordinate services around her needs: "I believe in local organisations and keeping things local, because what might work in one end of the country might not work in another." [111]

108. Rt Hon Michael Gove MP's June 2020 Ditchley Annual Lecture made the case for the kind of devolution to the local level that Debra Baxter advocated.[112] But the public service response to COVID-19 demonstrated that little such devolution has yet occurred. Witnesses maintained that central Government attempted to coordinate too many services during the pandemic. This chapter analyses the lack of integration between central Government and local service providers, and how this affected people using services during the first lockdown.

Poor central Government coordination and communication

109. We heard that frontline public service providers were often required to interpret and implement the Government's public announcements on COVID-19 without prior consultation.[113] There was no coordinated communications strategy across Government; local authorities often received divergent messages from different Government departments. Sarah Pickup, Deputy Chief Executive of the Local Government Association (LGA), told us: "Guidance came out in dribs and drabs. One of my [local authority] colleagues said it was like trying to construct a piece of Ikea furniture with a piece missing and the instructions being posted daily in bits and pieces."[114]

110. NHS England's Volunteer Responders Scheme, delivered in partnership with the Royal Voluntary Service, saw over 750,000 people sign up in just four days when it launched in April 2020. This was three times the original target. Volunteers were recruited to deliver medicines and equipment, drive patients to and from appointments and make regular phone calls to check on people isolating at home.[115]

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110 Q 136
111 Q 144
112 Cabinet Office, '"The privilege of public service" given as the Ditchley Annual Lecture' (1 July 2020): https://www.gov.uk/government/speeches/the-privilege-of-public-service-given-as-the-ditchley-annual-lecture [accessed 20 October 2020]
113 Q 19
114 *Ibid.*
115 Written evidence from Richmond Group (PSR0029)

111. However, the Institute for Volunteering Research wrote that such national-level attempts to coordinate volunteers had "limited impact, were not aligned to locally organised and coordinated responses and overall made a limited positive difference".[116] Witnesses also reported that the centralised structure of the NHS England's Volunteer Responders Scheme meant that it took a significant length of time to respond to local volunteers, which diminished their enthusiasm to volunteer.[117] In particular, the social care sector could have benefited significantly from the support of volunteers, who would have relieved some of the pressure on social care workers.

Public health

112. England entered the COVID-19 pandemic with a public health system that had both devolved and centralised components. The local system is led by directors of public health based in local authorities, who are responsible for a range of community and public health services in their area. This local network operates alongside Public Health England, a national executive agency of the Department of Health and Social Care (DHSC) which is responsible for health protection and improvement in England.

113. We heard that the national response to the pandemic largely depended upon centralised executive agencies and failed to use local resources effectively. The Association of Directors of Public Health (ADPH) pointed to the extensive experience of contact-tracing in local authority public health teams. But local councils and public health teams had little involvement in the design and delivery of NHS Test and Trace, the national COVID-19 contact-tracing service.[118]

114. Dr Jeanelle de Gruchy told us that her colleagues from central Government often failed to draw on local resources because they were unaware of the role played by local authority public health teams: "There was a really poor understanding and recognition of the role of the director of public health, the local public health system and indeed local government as a key partner in managing this pandemic."[119]

115. This lack of understanding resulted in poor communication from the centre:

> "If you do not know that directors of public health exist or what our role is, you are not going to communicate with us … in the first weeks we got nothing directly communicated to us, which put us—we have a statutory responsibility for our local populations on health—on the back foot in how announcements were made, how we were left to interpret and translate them into local areas. Bearing in mind that we were supporting and advising … care homes, schools and mortuaries, we were a bit in the dark in being communicated with."[120]

116. Such poor communication and engagement, at least in the earliest stages of the pandemic, created a fragmented public health response. Directors of public health were often required to coordinate the different elements of the Government's strategy—for example on PPE and testing—to ensure that

116 Written evidence from Institute for Voluntary Research (PSR0014)
117 Written evidence from Locality (PSR0074) and Dr Chris Cocking (PSR0033)
118 Written evidence from Association of Directors of Public Health (ADPH) (PSR0069)
119 Q 35
120 *Ibid.*

they joined up across local health and care systems.[121] Dr de Gruchy told us that many national initiatives such as the NHS Track and Trace scheme were "designed nationally in silos and landed locally. We had to knit [them] together."[122]

117. **COVID-19 has demonstrated that certain key public service functions are best delivered locally. These include the pandemic response of public health systems, the recruitment of volunteers and contact-tracing. To increase the resilience of public services in any future health crises, the Government must give more decision-making responsibility to its partners at the local level.**

Funding for local service delivery

118. We heard that past public expenditure reductions following the global financial crisis had hampered service delivery at the local level. Anna Round, Senior Research Fellow at IPPR North, a think tank, pointed to "local authorities having come from a long period of extremely constrained funding". This retrenchment, she argued, had left local authorities poorly equipped to deal with the pandemic: "Financial austerity over a long period … has had the knock-on effect on staffing and the amount of resources and assets that local authorities have to work with" in dealing with COVID-19.[123]

119. While central Government had promised more funding since the onset of the pandemic, it had not always been forthcoming. Jessica Studdert, Deputy Director of the New Local Government Network (NGLN), a think tank, claimed: "Local government was told early on by the Secretary of State that it could spend whatever it takes to get needs met in communities, but there has since been a significant rowing back of that early commitment."[124] She said that although £3.2 billion had been allocated to local government during the pandemic, "the overall costs of outlay of the service response and lost income for local authorities" were estimated at "about £10 billion to £13 billion".[125]

120. Jessica Studdert contrasted the experience of local government with that of the NHS, which had "its costs met in full. Trusts have had their deficits written off, unquestioningly. That puts a public service in a much more secure place to be able to plan for the future." Nick Davies, Programme Director at the Institute for Government (IfG), a think tank, compared the funding received by organisations working at different levels of public service delivery, arguing that solving this disparity would be key to the reform of public services after COVID-19.[126]

121. Witnesses criticised central Government for providing only short-term funding. The NLGN decried the "UK Government's growing tendency to fund local authorities with random one-off short-term single-issue funding pots" which do not "aid local strategic planning" of the kind needed to deal with crises such as COVID-19, and "take resources away from local

121 Written evidence from Association of Directors of Public Health (ADPH) (PSR0069)
122 Q 37
123 Q 14
124 Q 12
125 *Ibid.*
126 Q 9

authorities by requiring them to bid for the money and report on how it is used".[127]

122. The NLGN contended that the pandemic had underlined the need for local government to "secure [a] long-term funding settlement to remain sustainable in its current form". A "multi-year funding settlement" would allow local authorities "to plan strategically and make the best decisions for their residents and area while stepping outside central Government's shadow".[128] Jessica Studdert argued that the current funding model made planning difficult:

> "Cuts to its funding, and a lack of certainty over the future of its funding, makes it much harder for [local government] to plan, to have a four-year investment plan in the area, to collaborate with other services, and to think about how to do things differently and innovate."[129]

123. The current model embeds the lack of integration of public services that has been exposed by COVID-19. This "disjointedness will be embedded much more if we do not put local public services on a much more sustainable footing", Jessica Studdert told us.[130]

124. One solution would be to permit local authorities to balance budgets over multiple years, which according to the NLGN "would give them some breathing space to recover from the financial impact of COVID-19". "This is something the Chancellor of the Exchequer can already enable at the national level, but is currently not allowed at the local level," the NLGN noted.[131]

125. Eamonn Boylan, Chief Executive of the Greater Manchester Combined Authority, sought a "relationship with Government that did not consistently have cliff-edges in it". He said:

> "I have a cliff-edge on public transport funding on 4 August. I have no idea what will happen to public transport funding in Greater Manchester after that point. We are continually working on relatively short-term budgets for relatively short-term competitive processes in order to move forwards to make strategic priorities. That needs to change."[132]

126. The year 2021 will be important in the development of devolution in England. The Government has committed to publishing a white paper on English devolution[133] and eight out of 10 devolved mayoralties are due to hold elections.[134] The next chapter describes how giving more responsibility to local public services and communities paid dividends during the first lockdown. In Chapter 12 we outline how the devolved administrations have worked with local government during the pandemic. The Government

127 Written evidence from the New Local Government Network (NLGN) (PSR0039)
128 *Ibid.*
129 Q 12
130 *Ibid.*
131 Written evidence from the New Local Government Network (NLGN) (PSR0039)
132 Q 39
133 Andy Bounds, 'Plans for further English devolution shelved until next year', *Financial Times* (30 September 2020): https://www.ft.com/content/e1e2c392-a2e6-4ac5-9f0e-51e2926b1785 [accessed 20 October 2020]
134 House of Commons Library, 'Coronavirus: how might devolution in England be affected?', (11 May 2020): https://commonslibrary.parliament.uk/CORONAVIRUS-how-might-devolution-in-england-be-affected/ [accessed 20 October 2020]

should study their experiences as it considers granting more powers to the local level.

127. **It is clear that the underfunding of local services in recent years left them ill-equipped to deal with the resource pressures of the COVID-19 pandemic. For too long Government has prioritised services delivered from the centre, when many of the services that people use every day are organised at local level. The pandemic offers an opportunity to rethink how central Government funds and supports local services.**

CHAPTER 7: EMPOWERING LOCAL PUBLIC SERVICES AND COMMUNITIES

> "I have been amazed at how the Government and councils have managed to get the entrenched homeless off the streets. The help that these guys are getting in the premises they happen to be in, whether hotels or hostels, has given them a start in life and a chance to get access to addiction services and support workers. This might be the first step to getting a roof over their heads permanently."

128. This is what we heard from Shay Flaherty, who is nine years into recovery from alcohol addiction and volunteers with Revolving Doors to support homeless people in Birmingham.[135] The Government's March 2020 "Everyone in" initiative requested that all local authorities provide accommodation for rough sleepers in their area, often in hotels or hostels.[136] The Government reported that by May 2020 a total of 14,610 people in England who were sleeping rough, or who were at risk of sleeping rough, had found emergency accommodation.[137]

129. The pandemic has revealed long-standing fundamental weaknesses in public services, and exposed and exacerbated inequalities. But the evidence that we heard from people like Shay gave us cause for hope. We heard examples of how innovation by the Government, local services and frontline workers overcame structural hurdles. Providers continued to deliver—and in many cases improve—the services that people depend on.

130. The second part of this report describes how public services can build on such innovation. We argue that the Government and public services must now act to ensure that the progress made is not lost. Shay warned that some innovations were already being abandoned, such as the accommodation, addiction and mental health support for people facing homelessness:

> "The Government and the councils have proved that they can and have the resources to do this … it would be brilliant if they could continue … Slowly but surely, the guys are coming back out on to the streets … The guys who for four or five months you would see around Birmingham city centre looking fit and healthy are now going back to square one because the accommodation is being withdrawn."[138]

A 'place-based approach': integration and partnership working at the local level

131. In this chapter, we describe how a shared sense of place and purpose among local people, frontline workers and service leaders and the strong working relationships between local services that had formed before COVID-19 enabled local areas to:

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135 Q 146. See also Q 72 (Caroline Bernard).

136 Ministry of Housing, Communities and Local Government (MHCLG), 'Communities Secretary's statement on coronavirus (COVID-19): 18 April 2020' (18 April 2020): https://www.gov.uk/government/speeches/communities-secretary-robert-jenrick-on-covid-19-response-18-april-2020 [accessed 7 November 2020] and HC Deb. 3 June 2020, col 51WS

137 Ministry of Housing, Communities and Local Government (MHCLG), '£105 million to keep rough sleepers safe and off the streets during coronavirus pandemic' (24 June 2020): https://www.gov.uk/government/news/105-million-to-keep-rough-sleepers-safe-and-off-thestreets-during-coronavirus-pandemic [accessed 7 November 2020]

138 Q 146

- integrate services to meet the unique needs of communities in their area;
- use local knowledge and insight about local needs to improve the delivery of services;
- activate the skills and capacity of the local voluntary sector and community groups.

132. The overly centralised response to COVID-19 hampered service delivery. But many local areas were able successfully to meet the needs of their communities during the pandemic by adopting a 'place-based approach'.

Box 4: What is a 'place-based approach'?

A 'place-based approach' enables collaboration among local services, statutory and non-statutory, to meet an area's unique needs.

Services work together to use the best available local resources and assets, such as:

- the skills and capacity of local voluntary and community organisations;
- local knowledge and insight;
- a shared sense of place and purpose among local people, frontline workers and service leaders;
- good working relationships between public services at the local level, based on a culture of trust;

By working collaboratively with the people who live and work in an area, public services can better understand the local perspective. They can deliver integrated services where they are needed, irrespective of any departmental or sectoral silos at the national level.

Source: Iriss, 'Place-based-working' (28 July 2015): https://www.iriss.org.uk/resources/irisson/place-based-working [accessed 7 November 2020] and What Works Scotland, 'Place-based working' : http://whatworksscotland.ac.uk/topics/place-based-approaches/ [accessed 7 November 2020]

133. Nick Davies of the IfG told us that "any future programme of public service reform needs to recognise the interdependences between different services" and that many of the "wicked issues"[139] facing Government required "seamlessly knitting together or coordinating the support provided by different arms of the state". He argued that this was "inevitably much easier to do locally by taking a 'place-based approach' in response to local need".[140]

134. Despite the constraints on collaboration caused by national departmental and sectoral silos, many local areas rapidly integrated their public services during the pandemic. Sarah Pickup of the LGA said: "What the crisis has shown is that, when empowered to do so, local areas can collaborate to deliver change quickly and efficiently."[141]

139 A "wicked problem" in policy-making refers to a problem that is difficult to solve because its effects are not easy to define; it affects various stakeholders differently; it has many and varied causes; there is no single, clear solution; and many different arms of government are involved in tackling it. See Australian Government and Australian Public Service Commission, *Tackling wicked problems: a public policy perspective* (2017): http://www.enablingchange.com.au/wickedproblems.pdf [accessed 7 November 2020]

140 Q 9

141 Q 21

135. We heard that advances in service integration during the first lockdown often occurred in local areas where strong partnership working pre-dated the pandemic. Chris Naylor of the King's Fund told us: "The crisis has accelerated … integrated working in many parts of the country. [But] it is very variable in different places."[142] He said that the most impressive innovation had occurred "in parts of the country where they have invested a lot of time in working in a place-based way, building relationships across different agencies".[143]

136. The LGA described how Leicester, Leicestershire and Rutland councils had accelerated the integration of health and social care and responded quickly to COVID-19.[144] Due to their "history of strong working relationships", these authorities were able to "establish a care home cell at the start of the pandemic to ensure a joined-up and coordinated approach [with] the Clinical Commissioning Group (CCG) and the local Community Health Trust".[145]

137. NHS Providers highlighted the role played by Integrated Care Systems (ICS) in overcoming the barriers to integration of health and social care that we highlighted in Chapter 5. ICSs bring together local NHS organisations, councils and other local stakeholders to manage resources and improve the health and care of a local population. NHS Providers said that these bodies acted as convenors in "facilitating planning across the local health and care system … supporting trusts and other providers in their delivery roles". For example, the Buckinghamshire ICS Workforce Group was set up "to support care providers and facilitate staffing levels. The group coordinated support from the Buckinghamshire Health Trust, which shared their key staffing agencies, thereby providing care homes with access to a wider cohort of staff during the first wave of the virus."[146]

138. Witnesses said that central Government could build on these successes, and encourage stronger partnership working on the ground by granting increased autonomy to local service providers. The LGA called for a review of the NHS Long-Term Plan. It proposed that the Plan should emphasise the need for "a locally led approach [and] partnership, and place-based leadership".[147]

139. **The pandemic has demonstrated the need for local authorities, health care, social care and other service providers to operate as integrated components of local systems. Given the hurdles to public service delivery that COVID-19 has revealed, service providers should give careful consideration to which services are best coordinated at national level, and which services should be coordinated at local level.**

140. **The Government should set out in the white papers on English devolution and social care how it will ensure that local areas have the means and autonomy to develop a placed-based approach to delivering public services. This should be the default approach to reform of public services, rather than the current tendency to drive change from the centre.**

142 Q 69
143 *Ibid.*
144 Written evidence from the Local Government Association (LGA) (PSR0063)
145 *Ibid.*
146 *Ibid.*
147 *Ibid.*

141. **The Government should set out in the white paper on English devolution how the tension between the NHS as a national service provider and the aims of the Government's devolution agenda—which seeks to give more autonomy to local areas—may be reconciled. It should explain how the NHS will work with local authorities to ensure that the strategy for service integration laid out in the NHS Long-Term Plan aligns with place-based plans for integration in local areas.**

Working with local voluntary sector and community groups

142. Fundamental to the success of a 'place-based approach' to delivering services during the first lockdown was the ability of service providers to draw on the knowledge, skills and capacity of local voluntary organisations and community groups. There was a surge in civic action in many communities across the UK. We heard how millions of citizens supported the most vulnerable in their communities by volunteering with the NHS, charities or community groups.

143. A significant number of mutual aid groups were formed in response to the pandemic. There are now over 4,000; many are informal groups of volunteers who use social media to organise.[148] Nottinghamshire County Council created a new community hub to link these groups with vulnerable people. More than 600 volunteers contacted mutual aid groups to deliver food, collect and deliver medicines, look after pets, provide advice on health and help people with their transport needs.[149]

144. We learnt how community groups and volunteers formed a bridge between service providers and 'hard-to-reach' individuals.[150] Camden Council wrote: "The energy and commitment shown by our citizens in taking action and developing mutual aid groups within neighbourhoods has been inspiring." One mutual aid group, the Hampstead Volunteer Corps, worked with Camden Council to identify where food distribution centres were most needed.[151] Camden's experience was not unique—95 per cent of council CEOs reported that community groups had made a significant contribution to their COVID-19 response.[152]

145. Ian Jones, Chief Executive of Volunteer Cornwall, an organisation which supports Cornwall's 4,500 charities to recruit, develop and manage volunteers, told us how working with the voluntary sector enabled better integration between health and social care provision:

> "In early March … we started to [recruit] volunteers … 4,000 volunteers signed up in Cornwall to support people. We work with 280 COVID mutual aid groups … We quickly set up something called community coordination centres; an integrated service between health and care … When a referral came in from health or care, we could quickly evaluate and see whether it was a clinical need where we could give some

148 Written evidence from Dr Chris Cocking, Principal Lecturer, School of Health Sciences, University of Brighton (PSR0033)
149 Written evidence from County Council Network (PSR0016)
150 Written evidence from National Council for Voluntary Organisations(NCVO) (PSR0052)
151 Written evidence from London Borough of Camden Council (PSR0082)
152 Written evidence from National Council for Voluntary Organisations(NCVO) (PSR0052)

volunteer added value, or something that the community could do with volunteering so that it did not have to be escalated to clinical need."[153]

146. **Community groups and volunteers have played an invaluable role during the COVID-19 pandemic in forming a bridge between public services and 'hard-to-reach' individuals. There are now over 4,000 COVID-19 mutual aid groups supporting vulnerable people across the country. When commissioning public services in future, commissioners should recognise the valuable experience of service delivery gained by the third sector during the pandemic.**

147. **Areas where local authorities had built strong links with community organisations before the pandemic were able to harness the surge in civic action. Local charities and established voluntary and community organisations were better placed than centralised national bodies and charities to coordinate volunteers.**

Holding local areas to account

148. While witnesses welcomed the acceleration of a place-based approach to delivering services, we heard that a stronger system of local accountability was now required. Methods to assess whether local public service systems were meeting people's needs also needed to improve.[154]

149. Witnesses warned that targets set by central Government, including joint targets agreed across Government departments, would not be sufficient. They pointed to delayed transfer of care targets—which aim to reduce the number of patients who are clinically ready for discharge, but who cannot leave hospital because the necessary social care provision is not in place—as an example of a joint NHS and social care target set by central Government that did little to improve wellbeing outcomes for a local area. Sarah Pickup of the LGA warned: "Top-down targets can have perverse implications, like the delayed discharge target that has been around for ever … it diverted resources away from keeping people out of hospital and supporting people in the community."[155]

150. Saffron Cordery of NHS Providers called for top-down targets to be replaced by "locally drawn targets that a local system agrees" with central Government "that it is going to achieve". These shared targets should focus on outcomes, such as the health of the local population rather than limited performance targets, such as delayed transfer of care targets.[156]

151. Kate Terroni of the CQC referenced her organisation's local system review process, which looks at how well local health and social care services work together to care for people aged 65 and older in their area.[157] She explained that the CQC currently holds only individual providers to account, but that in the future the CQC may place greater emphasis on how well an individual provider works with other public services in its local area to "to ensure that people get joined-up care".[158]

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153 Q 56. See also Q 58.
154 Q 22; Q 23 (Sarah Pickup, Saffron Cordery and Kate Terroni)
155 Q 22
156 *Ibid.*
157 Care Quality Commission (CQC), 'Our reviews of local health and care systems' (22 March 2019): https://www.cqc.org.uk/local-systems-review [accessed 7 November 2020]
158 Q 22

152. Sarah Pickup advocated peer review as an effective approach to developing accountability. She said that the LGA had operated "a sector-led improvement approach":

> "The LGA operates with councils to run peer reviews … we have been working with NHS Confederation, NHS Providers and others to put in place peer reviews across health and care systems, and to take a cross-sector approach looking at outcomes and what we need to do together … Advice from your peers and other places that have achieved learning from good practice is what will help to deliver an integrated approach."[159]

153. **The Government should set out in the white paper on English devolution how it will empower local NHS providers, councils, and other local public service providers to draw up agreed measurable outcomes for their area. It should delineate how regulators will work with local areas to agree such outcomes and hold individual service providers accountable for partnership working. The outcomes should reflect the specific needs and priorities of local areas.**

159 Q 23

CHAPTER 8: A NEW APPROACH TO DATA-SHARING

154. Kirklees Council, a local authority in Yorkshire, described how organisations at the centre had approached data-sharing during the pandemic:

> "Data-sharing from organisations such as PHE (Public Health England) and DHSC has been wholly inadequate … the lack of data on testing … has left local areas with no mechanism for monitoring the number of confirmed cases of COVID-19 … Local arrangements that have been put in place to try and address the gaps in national data-sharing have required lengthy manual data cleansing processes."[160]

155. In this chapter we describe how existing relationships between local services enabled some local areas to plug these gaps. We heard how local leaders were able to collect data on their local communities and share this knowledge with services working on the frontline.

Data-sharing failures at the national level

156. COVID-19 has highlighted inadequate data-sharing between national and local services. Jessica Studdert of the NLGN said: "At an early stage in the pandemic local authorities did not receive information from the NHS about shielded groups, even though they were responsible for delivering food and essential supplies to them."[161]

157. Care England set out how, unlike in the NHS, the absence in social care of a systematic data collection system overseen by a central body had impeded efforts to track infection rates and coordinate a response. "Greater national data transparency at an earlier stage would have allowed providers to make better-informed decisions around contingency planning" and could have avoided "unnecessary deaths", it suggested. [162]

158. **COVID-19 has shown that the Government and other service providers need to rethink their approach to data-sharing. There has been too much reluctance from the centre to share data with organisations at the local level which are responsible for public services, hindering the efficient delivery of quality, person-centred services.**

159. **We recommend that the Government and national public services review their systems for sharing data with local services. Unless they have access to the information that they need, public services will be unable to meet the challenges posed by winter 2020/21 and the second England-wide lockdown.**

Innovative data-sharing at the local level: a 'place-based' approach

160. In contrast to the reluctance of national organisations to share data with their regional and local counterparts, we heard that many local efforts to overcome data-sharing barriers were successful, particularly in areas with a history of close partnership working. Anna Round of IPPR North had witnessed "some really good examples of data-sharing at the local level" which were key to ensuring that services understood and met local needs during the

160 Written evidence from Kirklees Council (PSR0010). See also Q 80 .
161 Q 10
162 Written evidence from Care England (PSR0004)

first lockdown.[163] Vicki Sellick, Executive Director of Programmes at Nesta, an innovation foundation, told us that Nesta had "seen some brilliant data-sharing examples", particularly in local areas which had "already established [data-sharing partnerships] and had set themselves up well".[164]

161. In London, councils shared data from across the capital on children who relied on free school meals, allowing services to provide additional support during the first lockdown.[165] Hackney Council used "unique property reference numbers" to compare datasets and service records in order to build a "single picture" of vulnerability in the borough. This included information on people's names, addresses and what made them vulnerable.[166]

162. We also heard how the Greater Manchester Combined Authority had made innovative use of data during the pandemic. For example, 10 councils in the GMCA area created a digital dashboard where care homes reported issues such as COVID-19 outbreaks and shortages in PPE. The dashboard enabled other local health and social care providers to offer support.[167]

163. Eamonn Boylan of the GMCA said:

> "We have been talking for years about how significant a step forward it would be for to us to have a single digital patient record that all clinicians across Greater Manchester could access … we did it within six weeks of the pandemic lockdown because it just had to happen; it was so necessary."[168]

164. The NLGN said: "There are opportunities for places, particularly cities and city regions, to adopt new data standards and invest in common approaches and tools for information governance." It added that "national public services should trust and utilise the capacity within local systems much better and share data from the outset."[169]

165. **Local areas should have the means and autonomy to maintain the data-sharing innovations developed during the COVID-19 pandemic. The Government should set out in the white paper on English devolution how it will support local areas and city regions to adopt new data standards, and how it will invest in common approaches and tools for information governance.**

The case for a new approach to data-sharing

166. Despite the impressive innovation seen in some parts of the country, we heard that many local leaders did not understand regulatory guidance on data-sharing. This lack of understanding had inhibited co-operation in some local areas.

167. During the pandemic the CCO had "encountered confusion amongst local areas" about what information they could share on vulnerable children, "with most local areas carrying on as before in terms of information-sharing and

163 Q 13
164 *Ibid.*
165 Written evidence from New Local Government Network (NLGN) (PSR0039)
166 Written evidence from New Local Government Network (NLGN) (PSR0039) and London Borough of Hackney (PSR0098)
167 Q 13 and written evidence from NLGN (PSR0039)
168 Q 36
169 Written evidence from NLGN (PSR0039)

cooperation, or 'muddling through'", but reporting that they were "unsure of the legal basis". The Office therefore called for new Government guidance on data-sharing powers and duties.[170]

168. **We are concerned that agencies do not share the data that they need to support vulnerable children and to determine which children need their help. The Government should issue new guidance on data-sharing powers and duties to protect vulnerable children, and, if necessary, introduce legislation to ensure that such data is shared.**

Towards a new consensus on data

169. Inadequate data-sharing can have deleterious effects on the quality of public services. When people use multiple services, providers may be unable to share the data that they need to ensure that delivery is tailored to individuals. Partly this lack of integration derives from cultural reluctance and risk aversion to sharing personal data;[171] partly it results from systemic barriers such as data protection regulations; and partly from silos between different agencies. Kirklees Council called for a "revised approach" which would "enable new data flows to be established quickly while still being compliant with GDPR (the General Data Protection Regulation)".[172]

170. However, the widespread roll-out of digital public services seen during the pandemic relied heavily on personal data. Professor Nick Pearce of the University of Bath noted that "the biopolitics of the COVID-19 pandemic" had not yet been widely discussed. He contrasted this lack of discussion with Asian democracies, where the debate on the balance between data protection and the provision of services was "far more developed".[173] We heard that in Taiwan (Republic of China), the 2003 severe acute respiratory syndrome (SARS) epidemic had encouraged officials to build consensus around the use of digital technologies.[174] Audrey Tang, Taiwanese Minister without Portfolio, explained how during COVID-19, Taiwan had built on this consensual approach: "We … ask people to rate and rank acceptable measures of using digital technologies to counter the coronavirus … and act only on the one that has broad consensus."[175]

171. The Information Commissioner, Elizabeth Denham CBE, told us that COVID-19 represented "an opportunity to get the public more on side with data-sharing".[176] She said that while cultural issues in the UK might have inhibited data-sharing during the pandemic, the current data protection legislation was flexible enough to "allow the sharing of data for the public good and in the public interest, as long as it is shared because it is necessary, transparent and proportionate". She added: "I do not understand where the fear [to share data] is coming from."[177]

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170 Written evidence from the Children's Commissioner's Office (CC0) (PSR0106)
171 Written evidence from New Local Government Network (NLGN) (PSR0039)
172 Written evidence from Kirklees Council (PSR0010). For information on the GDPR, see Information Commissioner's Office (ICO), *Guide to the General Data Protection Regulation (GDPR):* https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/ [accessed 20 October 2020].
173 Q 6
174 Q 119
175 Q 121
176 Q 111. See also Q 106 (Professor Sir Ian Diamond).
177 QQ 105–07

172. Despite the Information Commissioner's claims, the data-sharing failures that we have seen suggest that public service leaders do not fully understand the existing regulations and are not sufficiently confident in their ability to share data for the public good. Elizabeth Denham pointed to a forthcoming statutory code on data sharing—which will explain the data-sharing ramifications of upcoming changes to data protection legislation—as an opportunity to strengthen existing guidance for public services.[178]

173. **While some local areas were able to innovate and share data in new ways during the pandemic, many public service leaders lack the confidence and understanding of existing data protection legislation to share information about individual service users with system partners. Such reluctance can limit the ability of public services to keep people safe, particularly during national crises.**

174. **The Government, while recognising the need to protect personal data, should work with the Information Commissioner to build on the innovation in data-sharing seen in some local areas and to better understand the structural, legal and cultural impediments to data-sharing during the pandemic. Once the forthcoming statutory code on data-sharing is published, the Government and Information Commissioner should release updated guidance on how any such impediments should be addressed.**

175. **The use of data was a critical factor in determining citizens' experience of public services during the pandemic, and particularly for vulnerable people. The role of data in the delivery of public services will grow in prominence in the months and years ahead, as new digital technologies and Artificial Intelligence (AI) become more readily available to public service providers. A future inquiry may investigate data-sharing in public services more closely.**

178 Q 108 and Information Commissioner's Office, 'ICO consultation on the draft data-sharing code of practice' (9 September 2020): https://ico.org.uk/about-the-ico/ico-and-stakeholder-consultations/ico-consultation-on-the-draft-data-sharing-code-of-practice/ [accessed 30 October 2020]

CHAPTER 9: COMMISSIONING REFORM—UNLOCKING THE POTENTIAL OF CHARITIES AND THE PRIVATE SECTOR

> "I would never have viewed myself as vulnerable, but two hours after the announcement was made [to lock down] on that Monday evening I got a text saying [that I had to shield] and I really had a big shock. That hit me really hard because I am active, I do a lot of things, and suddenly I was not able to do anything at all … I began to panic. I live alone, I am single, so it was very hard. It hit me really hard within the first 24, 48 hours, realising, 'This is it. I am on my own.'
>
> "However, with Age UK Berkshire and our local council I was not alone, because not many days passed before I started getting phone calls to ask, 'Are you all right? Do you need anything? Do you need a food parcel?' The first time I got a food parcel on my doorstep I just cried. I thought, 'Someone has remembered me. I am not just a number, I am a real person' … Somebody called me each week or a couple of times a week just to find out how I was, because they knew I was struggling."

176. Tamsin Phipps told us that because her local Age UK stepped in to work with her local council to support her, she "survived lockdown".[179]

177. Many charities and businesses adapted quickly to the challenges of COVID-19, working alongside councils and other public bodies to deliver services to people like Tamsin. They were able to develop innovations in service delivery because the Government relaxed the regulatory framework governing the relationship between public bodies and other organisations. In this chapter we consider how future public service commissioning processes might take into account the important role played by charities and businesses and the need for sustainable funding settlements for third-sector organisations delivering public services.

Innovation in the charity and private sectors

178. Witnesses told us about the significant pressures that COVID-19 had placed on charities. Since the beginning of the outbreak, charities have faced both a surge in demand for their services and a significant drop in their revenue.[180] Many organisations reported that their fundraising income had reduced substantially; the first national lockdown and subsequent restrictions curbed the operation of charity shops, street collections and fundraising events and led to reduced donations by the public.[181]

179. However, we also heard about the many innovations that charities developed in response to the pandemic. The Rainbow Trust Children's Charity specialises in providing support to families across the country with children who have life-threatening or life-limiting illnesses. When outpatient and routine appointments were cancelled, the charity relieved some of the pressure on the NHS by providing hospital transport and supplying medicines to families in self-isolation. The Lead Nurse for Neonatal Palliative Care in

179 Q 136. See also Q 79.
180 Q 52
181 Written evidence from Marie Curie (PSR0092), Forget-me-not Hospice (PSR0002), Families First St Andrews (PSR0006), Maternal Mental Health Alliance (PSR0037), Scope (PSR0091) and Q 79

London, Alex Mancini, reported that the "flexibility" of the charity had been "invaluable" in supporting families and clinical teams.[182]

180. The private sector helped public services extend their reach during the first lockdown. In April 2020, at the height of the pandemic, the technology company Advanced helped health professionals who were in self-isolation to continue to take calls from NHS 111—a free-to-call non-emergency helpline that offers medical advice—at a time when the service was struggling to cope with rising demand. Advanced also built the 119 line, which allowed GPs to teleconference with patients so that they could continue to access primary care.[183]

New models of procurement: working with charities and businesses

181. Commissioning is the process which regulates how public bodies such as local authorities or Clinical Commissioning Groups (CCGs) procure services from public service providers, including charities and businesses.

182. On 20 March 2020 the Cabinet Office issued guidance for public service commissioners. The guidance allowed commissioners to procure services based on how they would benefit a community. Previously, the guidance had emphasised value for money.[184] Commissioners could now focus on social value rather than competitive tendering, meaning that local authorities could draw on the voluntary and community sectors and the surge in volunteers. Many witnesses welcomed how the guidance had relaxed key performance indicators (KPIs)—quantifiable measurements used to gauge an organisation's performance—which permitted grants to be made without strict conditions attached, and enabled less onerous procurement processes.[185] According to the Lloyds Bank Foundation, an independent charitable trust, and Josh Hardie of the CBI, this greater flexibility enabled businesses and charities to adapt their services to address local needs.[186]

183. The National Council for Voluntary Organisations and Kathy Evans, Chief Executive of Children England, told us that the new guidance had empowered commissioning bodies to try new ways of collaborating with the voluntary sector.[187] Andrew McCartan, Commissioned Services Manager at Wirral Council, said: "Traditionally, we've been a very KPI-, performance-driven organisation. During the crisis, we've seen organisations do things well without this level of process and a greater degree of trust and collaboration."[188] A disability charity in Cornwall described how its targets had been altered to create greater social value: "We are working with our partners on a Council commissioned 'Inclusion Matters' contract and have changed elements of it to enable us to respond with helping people with shopping, collecting prescriptions."[189]

182 Written evidence from Children England (PSR0013)
183 Q 51
184 Cabinet Office, 'Procurement Policy Note 02/20 : supplier relief due to coronavirus (COVID-19)' (20 March 2020): https://www.gov.uk/government/publications/procurement-policy-note-0220-supplier-relief-due-to-covid-19 [accessed 9 November 2020]
185 Written evidence from Lloyds Bank Foundation (PSR0011), Locality (PSR0074) and Children England (PSR0013)
186 Q 51 and written evidence from Lloyds Bank Foundation (PSR0011)
187 Written evidence from National Council for Voluntary Organisations(NCVO) (PSR0052) and Q 52
188 Written evidence from Lloyds Bank Foundation (PSR0011)
189 Written evidence from Lloyds Bank Foundation (PSR0011)

184. Many witnesses called for the Cabinet Office guidance to extend beyond the pandemic in order to maintain this flexibility.[190] Children England warned the Government not to "return to previous commissioning and contracting practice" and instead use the experience of COVID-19 to develop closer partnerships between commissioners and the third sector.[191] Paul Streets, Chief Executive of Lloyds Bank Foundation, argued that guidance should distinguish between heavily regulated statutory services, where there was "an absolute need for a regulated service that sets standards that give a degree of consistency and protection to people", such as adult social care, and non-statutory services, such as those for homeless people, where services should have more freedom to innovate to meet local needs.[192] The NCVO contended that to "support engagement of the voluntary sector and to enable it to play its full role in the delivery of services in the aftermath of the pandemic, sustainable grant funding" was "essential".[193]

185. Josh Hardie stated that the ways to build a "collaborative and social value approach" to partnership working between businesses and public services, as opposed to focusing on what could be delivered at the "lowest cost", had been set out in *The outsourcing playbook*,[194] Cabinet Office commissioning guidance published in 2019. Since then, the pandemic had helped to drive "progress" in partnership working on the ground. Mr Hardie argued that it was now important to "identify and value the changes we made and really push them through to the other side, because it would be a huge wasted opportunity if we did not".[195] The Shaw Trust, a charity that helps people with complex needs improve their skills and find employment, highlighted the forthcoming procurement green paper as an opportunity for the Government to formalise lessons learnt from COVID-19.[196]

186. **The Cabinet Office showed admirable flexibility during the pandemic in issuing new guidance to commissioners which put greater emphasis on the social value that commissioning can create and gave greater autonomy to frontline service providers.**

187. **The Cabinet Office should now update *The outsourcing playbook* to reflect the new ways in which businesses and charities delivered services during the pandemic, and provide commissioners with best-practice guidance to encourage joint working with the private and third sector. Any new guidance for commissioners must retain the existing focus on social value, partnership working and sustainable grant funding.**

188. **Once updated, *The outsourcing playbook* should be incorporated into the forthcoming green paper on procurement. Its guidance should apply across the public sector to ensure that public service commissioners prioritise social value when contracting services from charities and businesses.**

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190 Written evidence from Locality (PSR0074)
191 Written evidence from Children England (PSR0013)
192 Q 54
193 Written evidence from National Council for Voluntary Organisations (NCVO) (PSR0052)
194 Government Commercial Function and Cabinet Office, 'The outsourcing playbook' (20 February 2019): https://www.gov.uk/government/publications/the-outsourcing-playbook [accessed 9 November 2020]
195 Q 52
196 Written evidence from The Shaw Trust (PSR0101). The Government was due to publish the green paper in 2020: Institute for Government (IfG), 'Procurement after Brexit' (30 March 2020): https://www.instituteforgovernment.org.uk/explainers/procurement-after-brexit [accessed 9 November 2020].

CHAPTER 10: DIGITAL TECHNOLOGY AND INNOVATION IN FRONTLINE PUBLIC SERVICES

> "Social workers have had to adapt and completely overhaul how they engage with children and families. We have seen some great examples of how digital technology has improved social care, which I believe should stay for the future. We have heard the same from social workers as well; we are hearing that creative methods on WhatsApp, Skype, Zoom, Microsoft Teams have allowed connections with certain children that were not there before.
>
> "We have social workers reporting that attendance from professionals has increased, so they are having a better professional conversation with families. Often that is centred on health, education or the police. People are now in a virtual room and can contribute."[197]

189. Ryan Wise and other witnesses said that digital technology had enabled more efficient service delivery and improved users' access to services—particularly for those, such as vulnerable children, who are often considered 'hard to reach'. Technology has given frontline public service workers more autonomy to innovate to meet people's needs.

190. But digital technologies also bring risks. Ryan Wise warned:

> "There are extreme creative benefits from going digital that we should keep, but we should also not forget that those relationships, those sensory moments with people—that sense of feeling, touching, being in the moment—tell us a whole lot about what is going on."[198]

191. This chapter considers how public services benefited from digital innovation during the pandemic, and looks at some of the potential drawbacks of providing services online.

Better access and engagement

192. The pandemic precipitated a rapid introduction of digital technology in primary care. The 2019 NHS Long-Term Plan set an aspiration for all general practices to offer patients remote digital consultations by 2024.[199] In February 2020, 80 per cent of GP appointments happened face-to-face and just 14 per cent by telephone. In May 2020, two months into the pandemic, 99 per cent of practices had activated remote consultation platforms.[200] The Nuffield Trust suggested that this had been achieved by devolving decisions to the frontline. One GP told the think tank that they felt a "freedom to innovate that I'd never before experienced". Nuffield Trust added that NHS leadership "played a supportive role by issuing guidance and fast-tracking assurance processes".[201]

193. The Royal College of Midwives reported that technology had enabled its members to reach women in remote and rural locations. These women

197 Q 151
198 *Ibid.*
199 NHS, 'Online version of the NHS long term plan' Chapter 4 : https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/4-digitally-enabled-primary-and-outpatient-care-will-go-mainstream-across-the-nhs/ [accessed 9 November 2020]
200 Written evidence from the Nuffield Trust (PSR0041)
201 Written evidence from the Nuffield Trust (PSR0041). See also Q 28.

had benefited from "virtual triage", which had "reduced the number of unnecessary visits to hospital". NHS trusts had rolled out "blood pressure monitors and software for women to record their blood pressure and sugar levels at home, with a clinician checking results remotely".[202]

194. Changing Lives, a charity working with vulnerable adults, explained that the way that its staff interacted with service users had "changed radically as a result of COVID-19" with many addiction recovery services, such as group therapy and outreach, now offered online. Technology gave service users more ways to engage with addiction services, leading to more engagement during the first lockdown. Changing Lives reported a "reduction in relapse and, in some services, fewer drug-related deaths" as a result.[203]

195. Digital technology gave frontline workers in drug and alcohol treatment services greater freedom to make decisions.[204] Changing Lives stated that this approach would previously have been hampered by restrictions written into its contracts with commissioning authorities, which prescribed specific ways of delivering services.[205] Nathan Dick of Revolving Doors described how this "reduction in red tape" had given frontline workers more scope to innovate and build trust with users.[206]

196. However, Richard Sloggett of Policy Exchange cautioned that the "real acceleration [in] the use of digital [technologies]" at the front line of service delivery would need to be secured "on a longer-term, more sustainable basis". It was important to address the "real gap in the expertise and ability of the public sector on digital". He concluded that "all public bodies" needed to "look at training and education" and "the way people are recruited".[207]

Maintaining face-to-face services

197. There will be greater demand for digital services in future. However, relying too heavily on technology could exacerbate inequalities experienced by those who cannot access digital services. There is a link between deprivation and lack of access to digital technologies. The Children's Commissioner told us: "About 700,000 children do not have access to an iPad or a piece of tech, and about 60,000 of them do not have broadband."[208]

198. We heard that face-to-face services should not be reduced if this risked diminishing the quality of public services, or if it put people in danger. Changing Lives wrote that some of its services, such as those for homeless people, would continue to be offered face-to-face. It added that for some people, "home may not be a safe place to access support—for example, people who are experiencing domestic abuse or exploitation. Therefore, we would expect to offer a range of digital and face-to-face services in future."[209]

199. Healthwatch argued that it was important to evaluate how the digitisation of GP services had affected patients' outcomes, regardless of any advances in

202 Written evidence from the Royal College of Midwives (RCM) (PSR0051)
203 Written evidence from Changing Lives (PSR0042)
204 Written evidence from Collective Voice (PSR0050)
205 Written evidence from Changing Lives (PSR0042)
206 Q 71 and written evidence from Changing Lives (PSR0042)
207 Q 6
208 Q 32
209 Written evidence from Changing Lives (PSR0042)

efficiency.[210] The Nuffield Trust advocated users' involvement in the design of digital services:

> "Digital technology works best when it embraces user-centred design. Evidence shows that poorly designed and implemented systems can create opportunities for errors, and can result in frustrated healthcare professionals and patients."[211]

200. **There is a clear requirement for central Government and local services to evaluate the performance of services that moved online during the first lockdown, ensuring that public services maintain face-to-face services wherever they are needed. They should work closely with service users in conducting this evaluation, because users are best placed to advise on which services should be delivered online, by telephone, or in person.**

201. **Central Government and local services should build on the advances made during the pandemic by prioritising funding for public sector digital services. The Government should put a particular focus on improving the digital skills of the public service workforce, and improving digital access and skills for those parts of the population that are at risk of digital exclusion.**

210 Written evidence from Healthwatch England (PSR0115)
211 Written evidence from the Nuffield Trust (PSR0041)

CHAPTER 11: "FROM LOCKDOWN TO LOCK-IN"—HOW DO PUBLIC SERVICES LEARN?

202. Our inquiry uncovered many fundamental weaknesses in the delivery of public services. It also highlighted many innovations that public service providers will wish to sustain once the pandemic is over. Embedding this change was a central concern of service users. Agatha Anywio told us:

> "I pray that a lot of the help that older people had during the lockdown continues. I pray that those who receive it continue to receive it, because if they do not it will lead to mental problems and for some of them it will be unbearable if nobody contacts them. Even just a phone call [from a volunteer] once a week: that makes a lot of difference for people like me."[212]

203. On 15 July 2020, the Prime Minister announced a future "independent inquiry" to "learn the lessons of the pandemic".[213] We explored the approaches that public services might take in assessing their response to COVID-19. Our inquiry identified three phases of evaluation:

- firstly, a rapid evaluation of what went well and what went badly;
- secondly, an assessment of innovations during the first lockdown to embed positive changes;
- thirdly, a long-term evaluation of the fundamental weaknesses revealed by COVID-19 to inform future reform of public services.

Rapid evaluation

204. Rapid evaluation can assess how well public services responded to the onset of the pandemic. Nick Davies of the IfG suggested that such an evaluation would enable the Government to prioritise resource allocation for ongoing waves of the virus and make public services resilient during the winter of 2020/21. Lieutenant-General Douglas Chalmers DSO OBE, Deputy Chief of the Defence Staff (Military Strategy and Operations), Ministry of Defence (MoD), recommended that public services learn from the MoD's wide-ranging Mission Exploitation Symposium process, which was "used across the forces in Afghanistan and Iraq", and involved participants from a number of Government departments.[214]

205. Early assessments of the pandemic response indicate that national services such as the NHS were able to draw on pre-existing centralised decision-making structures to manage the initial stages of COVID-19 relatively successfully. But public services that were not part of these structures—such as social care providers—were overlooked by those planning the response.[215]

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212 Q 151

213 HC Deb.15 July 2020, col 1514

214 Nick Davies Q 9; Q 96. The Mission Exploitation Symposium was organised by the Army's Lessons Exploitation Centre from 2010 onwards. It gave an opportunity for brigades to reflect on their experiences in the field before sharing their learning with the rest of the army. Each symposium was attended by between 500 and 1000 participants, including representatives from the MoD, other Government departments, non-governmental organisations, liaison officers from allied forces, and a cross-section of personnel from across the army. Tom Dyson, *Organisational learning and the modern army*: a new model for lessons-learned processes, 1st edition (London: Routledge, 2019), pp.85–6

215 Nick Davies Q 9. See also Q 36 (David Williams).

206. Minister without Portfolio Audrey Tang told us how public services in Taiwan (Republic of China) had learnt from the 2003 SARS epidemic that they needed to improve their decision-making structures:

> "When SARS came the Taipei municipality issued reverse directions from the health bureau. [Current Taiwanese] Vice-President Chien-jen was the director of the health ministry at the time, and I think he learned the lessons. [Now] … anyone, be it a local level or a central level … automatically becomes part of the … command chain, the infrastructure. It has a very clear line of report. The municipalities are definitely in an implementing role instead of possibly issuing countering policies. That was a big problem back in 2003 and we have legal, design and regulatory remedies for that."[216]

Embedding changes

207. Richard Sloggett of Policy Exchange recommended that the Government undertake an "evaluation of the services that have changed, build the evidence and lock that change … in the short term, evaluation of what has worked and what has not is definitely a good way to start to move from lockdown to lock-in."[217] Lieutenant-General Douglas Chalmers suggested that the Government use the digital platforms that had been introduced during the pandemic to facilitate consultation with stakeholders at all levels of public service delivery and ensure that a variety of voices are heard.[218] Tracy Daszkiewicz, who oversaw the public health response to the 2018 Salisbury Novichok poisonings, stressed the importance of talking to people involved in responding to a crisis, to put any findings into a local context.

> "The Novichok incident … set us up very well for our early response to COVID. As the horizon-scanning was going on … we could start those conversations with colleagues very early and start to put those systems in place, ensuring we had that dialogue across that local, regional and national interface … That helped us to plan. Sharing that dialogue across the layers of the system means that you can plan effectively … that is what we were able to do very quickly as we were coming on board with COVID in the early part of this year."[219]

208. We heard that if such assessments were not carried out relatively quickly, innovations that developed during a crisis could be lost. As Josh Hardie of the CBI warned, "the gravitational pull of habits" should not be underestimated.[220] Changing Lives were concerned that innovations in addiction treatment would be overturned: "Statutory services are already keen to return to 'what was', despite improved engagement [by service users], reduction in relapse and, in some services, fewer drug-related deaths."[221]

Recognising long-term weaknesses

209. Lord O'Donnell GCB, Cabinet Secretary 2005–11, told us that governments tended to assume that the next crisis would be identical to the last: "You could do … things really well a second time. The problem is that you are

216 Q 124
217 Q 6
218 Q 96
219 Q 97
220 Q 51
221 Written evidence from Changing Lives (PSR0042)

coming up against a bunch of firsts." While it was important to "learn the lessons from the past", it was necessary to look at underlying weaknesses to ensure that the state was "flexible" and "resilient" to the various problems that it could face in the future. Lord O'Donnell explained:

> "You can learn from the past, but … what we learned from [previous] health crises was about stockpiling antivirals, PPE and stuff like that, which we did for a while … It was incomplete, in the sense that there were other things that you might say were probably more important that we were not looking at, such as how you generate good data when there is none … and the need to spend money on prevention rather than cure."[222]

210. **In recent months, the Prime Minister and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office have argued that the pandemic offers a chance for fundamental public service reform. Furthermore, the Prime Minister has promised an independent inquiry to learn lessons from COVID-19.**

211. **Because the Government did not give oral evidence to the inquiry, and its offer to send written evidence arrived too late, we were unable to discuss how it intends to learn lessons from the pandemic in the forthcoming public inquiry and the approach that it will take to public service reform. We therefore call on the Government to carry out:**

    (1) **a rapid evaluation of what worked well and what worked badly in public service delivery during the initial stages of the COVID-19 pandemic, to ensure that services quickly learn lessons. The Government should carry out this evaluation within the next six months;**

    (2) **an assessment of the changes seen in public service delivery during the first lockdown, to embed the innovations that worked well. To ensure that positive changes are not lost, the Government should publish its findings within a year;**

    (3) **a long-term evaluation of the fundamental weaknesses in public services that have been revealed by the pandemic, to inform a major project of public service transformation.**

212. **We suggest that this report offers a starting point for any evaluation of how public services adapted to the pandemic, and the implications of COVID-19 for the future transformation of public service delivery. In order to lock in the remarkable innovations adopted by service providers since the beginning of the pandemic, we have set out eight key principles for public service reform. These principles should now underpin the Government's approach to redesigning the UK's public services for the twenty-first century.**

222 Q 101

CHAPTER 12: THE PANDEMIC RESPONSE IN THE DEVOLVED JURISDICTIONS

213. We took evidence from witnesses with experience of public services in Scotland, Wales and Northern Ireland to inform our understanding of how COVID-19 affected public service delivery in England. Our key findings are in the boxes below.

Box 5: COVID-19 and social care in the devolved jurisdictions

Health and social care integration in the devolved administrations before COVID-19

In Scotland, more than half of the total NHS and adult social care budget is now delegated to an Integration Joint Board (IJB) for each area. IJBs are made up of representatives from the local authority, the local NHS board, and service user and third-sector organisations. They are led by a 'neutral' Chief Officer, who ensures that the commissioning strategy of the IJB does not prioritise the NHS agenda or social care agenda and takes an integrated approach. They are accountable to the members of the IJB, and the local NHS Board and council.[223]

A July 2018 King's Fund report on the Chief Officer's role found that IJBs provided an "unprecedented scope to work collaboratively to shift resources to community-based services and to develop new models of care as a shared, cross-system endeavour".[224] However the report found that NHS boards were still the dominant partner in local systems.

In 2018, the Welsh Government published 'A Healthier Wales: our plan for health and social care'.[225] This plan was supported by a "transformation fund" to support the development of collaborative pilot projects in health and social care, led by multi-agency regional partnership boards. By January 2019, £89 million had been allocated for proposals across Wales.

However, there has been a lack of substantial recurrent funding. In July 2019 the Wales Audit Office published a report on the Integrated Care Fund, an initiative also designed to support integrated working and new models involving health, social care and the third sector. The report found little evidence of successful projects being mainstreamed into core budgets or improving service outcomes.[226]

223 Scottish Parliament, *Health and social care integration: spending and performance update* (26 June 2019): https://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/SB_19_44.pdf [accessed 7 November 2020]

224 The King's Fund, 'Learning by doing: integrating health and care in Scotland' (3 July 2018): https://www.kingsfund.org.uk/blog/2018/07/integrating-health-and-care-scotland [accessed 9 November 2020]

225 Welsh Government, 'A healthier Wales: long-term plan for health and social care' (1 October 2019): https://gov.wales/healthier-wales-long-term-plan-health-and-social-care [accessed 9 November 2020]

226 Wales Audit Office, *Integrated Care Fund* (2019): https://www.audit.wales/sites/default/files/integrated-care-fund-report-eng_11.pdf [accessed 9 November 2020]

Uniquely within the United Kingdom, Northern Ireland has had a structurally integrated system of health and social care since 1973. Social care is integrated with health care under five health and social care trusts. They manage their own budget, which is allocated by the Northern Ireland Executive through the Northern Ireland Department of Health. Provision of continuing health care is organised directly by the health and social care trust, and therefore does not represent an additional source of revenue.

However, a July 2019 Nuffield Trust study found that structural integration had not translated into equality between health and care: "Despite the notional integration of health and social care, there are signs that the latter remains overlooked" with "little sign so far of the intended shift of care and resources into care outside hospital."[227]

What went well during the pandemic

The Nuffield Trust outlined how the Scottish Government's pandemic response had put health and social care on a more equal footing. The Scottish Government "explicitly recognised the crucial role of social care as early as 24 March" and committed to "shared leadership" across health and care.[228]

Anna Fowlie, Chief Executive of the Scottish Council of Voluntary Organisations (SCVO), elaborated:

"We have had a statutory process of integration of health and social care in place since 2016. Integrated joint bodies were set up and run jointly by the NHS boards and local authorities, and they oversee the running of the health and social care partnerships. Therefore, the mechanisms were there, and the right people were around the table at the start of this and already had established relationships. Like any partnerships, some will work better than others, but the mechanism is established.

"There is also joint leadership in the form of the Cabinet Secretary for health and social care and the Convention of Scottish Local Authorities, the local government association in Scotland, and its spokesperson for health and social care.

"One of the real successes we have seen is that a few years ago the Scottish Government committed to paying the Scottish living wage to all front-line workers in social care."[229]

The Nuffield Trust wrote that in Northern Ireland, "perhaps aided by its integrated systems", staff were "redeployed" from the NHS into social care. The Northern Ireland Executive is planning to "embed a new permanent framework for nursing and medical input into care homes".[230]

227 Nuffield Trust, 'Change or Collapse: lessons from the drive to reform health and social care in Northern Ireland' (10 July 2019): https://www.nuffieldtrust.org.uk/research/change-or-collapse-lessons-from-the-drive-to-reform-health-and-social-care-in-northern-ireland [accessed 10 November 2020]

228 Nuffield Trust, 'What steps are currently being taken to reform social care' (18 March 2020): https://www.nuffieldtrust.org.uk/news-item/what-steps-are-currently-being-taken-to-reform-social-care [accessed 10 November 2020]

229 Q 92

230 Written evidence from the Nuffield Trust (PSR0041)

Dr Victoria Winckler, Director of the Bevan Foundation, a Wales-based think tank, described a similar level of integration:

"The different arrangements in Wales for the delivery in particular of healthcare and the relationships already established between healthcare providers and social care providers have probably eased the approach to the pandemic. … In any situation, integration of shared values, protocols and procedures helps."[231]

What went less well during the pandemic

Professor Nick Pearce of the University of Bath presented a less clear picture:

"In Scotland, where there has been a longer-term tradition of a funding settlement for health and social care and more integration, there has been a much higher number of deaths proportionately in its care homes than in England and Wales."[232]

Anna Fowlie of the SCVO noted:

"Not … everything has been perfect. We have had … problems … in care homes and with PPE … I think the social care sector would say—I am sure the Scottish Government would disagree—that it has definitely come second to the NHS, understandably because acute services were the thing at the beginning, but it has brought into sharp relief again that it is not quite as integrated as we like to think.

"There is very much a protective attitude towards the health service because it belongs to government, which I can understand, and the plethora of different providers … makes it really hard to engage with social care."[233]

Dr Anthony Soares, Director of the Centre for Cross Border Studies, a think tank in Northern Ireland, told us that while the Northern Irish health and social care system's "approach to the COVID-19 crisis" had been "absolutely astounding", and that it had been "extremely successful in dealing with [the pandemic] in general terms", there had been "some challenges, with pressures being placed on the social care provision coming out of the healthcare system". For example, "there have been certain difficulties in ensuring that those moving from the hospital to social care setting have been tested, or their COVID-19 status established".

He pointed to some fundamental deficiencies:

"The whole health and social care services are generally integrated in Northern Ireland in their delivery organisations, but the provision of social care is often shaped by different legislation in comparison with healthcare, and there is a lot more diversity in the providers of social care, with both the private and voluntary sectors being involved." [234]

Victoria Winckler reported that in Wales there had been "issues in the transfer of patients, testing and so on… it is not quite so different from that experienced elsewhere … I would not like to pretend that everything was perfect".[235]

231 Q 92
232 Q 5
233 Q 92
234 Q 92
235 *Ibid.*

Box 6: Local government and the devolved administrations

The Bevan Foundation described how at the beginning of the pandemic, while the Welsh Government had "considered the option" of giving food vouchers to children's parents and carers, "a growing number of local authorities" had chosen to offer "cash payments to families in lieu of meals":

"We understand that 17 out of 22 authorities now make cash payments. The Welsh Government subsequently announced that the local authorities would continue to receive funding towards the cost of free school meals during the school summer holidays."[236]

David Isaac CBE, Chair of the Equalities and Human Rights Commission (EHRC), called on the UK Government to emulate this approach:

"In relation to education, there is a lot that could be done. For example, in Wales free school meals over the summer were paid in cash. That has a huge impact on families' ability to feed themselves. For me, that is a very quick win and something that could be applied throughout the UK."[237]

Nick Davies of the IfG drew a similar comparison:

"It might have been better … to give more responsibility, if there was more capability and capacity, at a local level to make … decisions. In Scotland, Wales and Northern Ireland, for example, there has been a much greater role for local authorities in decisions on free school meals, and they have also had the ability to provide cash to families rather than doing it through voucher schemes."[238]

236 Written evidence from the Bevan Foundation (PSR0100)
237 Q 64
238 Q 4

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Introduction

1. We suggest that the Government and other organisations prioritise the following principles for public service reform:

   - the Government and public service providers should recognise the vital role of preventative services in reducing the deep and ongoing inequalities that have been exacerbated by COVID-19;
   - central Government and national service providers must radically improve the way that they communicate and cooperate with local-level service providers if they are to deliver effective public services. They should analyse where services are best delivered from the centre, where local-level service providers are better placed, and where visible accountability sits. The Government should acknowledge that local providers are equal partners in the delivery of services;
   - charities, community groups, volunteers and the private sector must be recognised as key public service providers, and given appropriate support to deliver services effectively;
   - the resilience of public services to the challenges posed by the COVID-19 pandemic and ongoing demographic changes will require a fundamentally different, vastly more flexible approach to the sharing of data;
   - the integration of services to meet the diverse needs of individuals and the communities in which they live is best achieved by public service providers working together at the local level, and should be supported by joined-up working across Government departments at the national level;
   - local services and frontline workers must be given the resources and autonomy to innovate and improve the delivery of public services, while mechanisms to ensure the accountability of local service providers should be improved;
   - advances in digital technology should be used to increase access to public services, particularly for hard-to-reach groups, but should be applied intelligently. Online services should never replace face-to-face services if to do so would disadvantage the service user;
   - users must be involved in the design and delivery of public services. (Paragraph 8)

2. The Government's decision not to give oral evidence to the Committee is disappointing. Our aim in this report is not to apportion blame for past failings but to make constructive suggestions for future reform. The Government has stressed the importance of reforming public services after the pandemic; we hope that this report will assist it in this task. (Paragraph 13)

Insufficient support for prevention and early intervention

3. Preventable long-term diseases disproportionately affect the UK's poorest communities. People who are obese, who smoke, who are diabetic and who

live in unhealthy social, economic and physical environments are at higher risk of dying from COVID-19. (Paragraph 36)

4. An approach to public health that focused on preventing health inequalities over the long term would pay dividends by increasing the resilience of communities and reducing pressures on the NHS when a crisis occurs. If such an approach had been adopted before the pandemic, it would have reduced the number of deaths resulting from COVID-19. (Paragraph 37)

5. The Government's commitment in its 2019 general election manifesto to extend healthy life expectancy by five years by 2035—and to narrow the gap between the richest and poorest—is welcome. It should now publish its strategy to achieve this manifesto commitment and its response to the green paper *Advancing our health: prevention in the 2020s*. Both documents should set out how central Government will work in active partnership with individuals, communities, local government, the NHS, businesses and charities to design and deliver preventative services to improve the health of the poorest communities. (Paragraph 38)

6. The Government should confirm as soon as possible how preventative services will be delivered, either through the new National Institute for Health Protection or other agencies. It should also confirm how the National Institute for Health Protection's relationship with and accountability to the Department for Health and Social Care will differ from that of its predecessor, Public Health England. (Paragraph 39)

7. We recommend that the Home Office and Ministry of Justice draw up joint guidance on how the police, the prison system and National Probation Service should work with homelessness, mental health and addiction services to support people whose complex needs may have deteriorated during the pandemic. It should also outline the level of resource that the police and justice system should invest in preventative services (Paragraph 44)

8. There is a serious risk that disadvantaged children will fall further behind as a result of school closures during the pandemic. The Government should set out how it will support early intervention in education services to close the attainment gap, reduce exclusions and ensure that disadvantaged children's education will not suffer adverse long-term effects from the first lockdown. The Government should consult with Ofsted and the Children's Commissioner on how to hold schools to account and measure progress made in supporting disadvantaged children to catch up. (Paragraph 50)

9. Successive governments have failed to invest sufficiently in a preventative approach to health, education, justice and other public services. Investing in future potential can be difficult for governments due to a political cycle that prioritises immediate returns over long-term benefits to future generations; cost over social value; and the measurement of increased outputs over improved outcomes. (Paragraph 51)

10. The Government should recognise that investing in prevention and early intervention can reduce the pressures placed on the NHS and the justice system, and that supporting children to avoid poor life outcomes brings financial savings and economic benefits. A future inquiry might investigate further a preventative approach to public services. (Paragraph 52)

Inequality of access to high-quality public services

11. Before COVID-19, vulnerable children were falling through the gaps between public service providers, "invisible" to social services, the NHS and the education system. Many more have become "invisible" during the pandemic since losing contact with public services. (Paragraph 61)

12. The Government should urgently develop a cross-agency strategy which would support vulnerable children in, or at risk of, crisis and ensure that public services do not lose touch with children during future crises such as the COVID-19 pandemic. As part of this strategy, the Troubled Families Programme and community services that facilitate multi-agency support for families such as children's centres and family hubs should be extended. Schools should have Child and Adolescent Mental Health Services professionals, police liaison officers and youth workers who can collaborate to address vulnerable children's needs. (Paragraph 66)

13. The Government should study New Zealand's "joint ventures" to understand better how central Government can encourage cross-agency collaboration on complex social problems. (Paragraph 67)

14. COVID-19 should be a wake-up call for the Government that the designers and providers of public services have paid insufficient attention to the specific needs of minority groups. The Public Sector Equality Duty has had limited success; Black, Asian and Minority Ethnic and Gypsy, Roma and Traveller groups experience significant inequalities of access. These inequalities have worsened since the beginning of the pandemic. (Paragraph 75)

15. The Government should introduce a race equality strategy that would apply across public services and address inequalities of access for Black, Asian and Minority Ethnic and Gypsy, Roma and Traveller people. Such a strategy should include joint targets, shared by all relevant service providers and supported by voluntary sector organisations working directly with these groups, to tackle persistent inequalities in health and educational outcomes. The strategy should investigate the links between such inequalities. (Paragraph 76)

16. Service providers should respond to race equality targets by developing clear implementation plans to meet them. The Government should set out the role of regulators in holding public services accountable for these implementation plans and targets. (Paragraph 77)

'Co-production' and user voice

17. The pandemic has shown that designing public services without consulting the people who use them embeds fundamental weaknesses such as inequalities of access. Users often have a better understanding of the outcomes that they would expect to see from public services, and involving user voice in service design increases the resilience of those services . (Paragraph 84)

18. Local authorities and central Government should set out how they will support homelessness, mental health and addiction service providers to involve people with 'lived experience'—and the voluntary organisations that advocate on their behalf—in the design and delivery of services. (Paragraph 85)

19. 'Co-production' can embed service delivery innovations of the kind that have developed since the pandemic began, and in a cost-effective manner. In its response to this report the Government should confirm how it will encourage 'co-production' in the commissioning of public services, and how it will measure the levels of involvement in service design by groups of service users such as disabled people and those from BAME backgrounds. (Paragraph 86)

The fragility of adult social care

20. The COVID-19 pandemic has accentuated the systemic frailties in the care sector, with the tragic consequence of a large number of deaths in care homes and domiciliary care settings. Reform is now more urgent than ever. (Paragraph 101)

21. In recent years much has been written about the lack of integration between health and social care and the need to provide adequate funding for social care. The problem of fragmentation of services is understood, but no priority has been given to creating coordinated services on the ground. (Paragraph 102)

22. Closer integration and equality between health and social care will require Government action in three key areas. The fragility the adult social care should be addressed by providing the sector with adequate funding; the Government should give social care equal visibility and priority to health care; and the two sectors should integrate data collection and share data more effectively. (Paragraph 103)

23. The Government should commit at the earliest opportunity to an interim sustainable funding settlement for adult social care. The Government has delayed the publication of its white paper on the long-term funding, integration and reform of the sector. This should be published as a matter of urgency. (Paragraph 104)

24. We are concerned that the Government's own pandemic planning had identified that social care would need significant support during the outbreak of a disease like COVID-19, yet social care was the poor relation to the NHS when it came to funding. In reviewing its pandemic planning processes the Government should explain how it will ensure that the social care sector receives adequate funding, resources and support while COVID-19 continues, and in any future pandemic. (Paragraph 105)

Over-centralised delivery of public services

25. COVID-19 has demonstrated that certain key public service functions are best delivered locally. These include the pandemic response of public health systems, the recruitment of volunteers and contact-tracing. To increase the resilience of public services in any future health crises, the Government must give more decision-making responsibility to its partners at the local level. (Paragraph 117)

26. It is clear that the underfunding of local services in recent years left them ill-equipped to deal with the resource pressures of the COVID-19 pandemic. For too long Government has prioritised services delivered from the centre, when many of the services that people use every day are organised at local level. The pandemic offers an opportunity to rethink how central Government funds and supports local services. (Paragraph 127)

Empowering local public services and communities

27. The pandemic has demonstrated the need for local authorities, health care, social care and other service providers to operate as integrated components of local systems. Given the hurdles to public service delivery that COVID-19 has revealed, service providers should give careful consideration to which services are best coordinated at national level, and which services should be coordinated at local level. (Paragraph 139)

28. The Government should set out in the white papers on English devolution and social care how it will ensure that local areas have the means and autonomy to develop a placed-based approach to delivering public services. This should be the default approach to reform of public services, rather than the current tendency to drive change from the centre. (Paragraph 140)

29. The Government should set out in the white paper on English devolution how the tension between the NHS as a national service provider and the aims of the Government's devolution agenda—which seeks to give more autonomy to local areas—may be reconciled. It should explain how the NHS will work with local authorities to ensure that the strategy for service integration laid out in the NHS Long-Term Plan aligns with place-based plans for integration in local areas. (Paragraph 141)

30. Community groups and volunteers have played an invaluable role during the COVID-19 pandemic in forming a bridge between public services and 'hard-to-reach' individuals. There are now over 4,000 COVID-19 mutual aid groups supporting vulnerable people across the country. When commissioning public services in future, commissioners should recognise the valuable experience of service delivery gained by the third sector during the pandemic. (Paragraph 146)

31. Areas where local authorities had built strong links with community organisations before the pandemic were able to harness the surge in civic action. Local charities and established voluntary and community organisations were better placed than centralised national bodies and charities to coordinate volunteers. (Paragraph 147)

32. The Government should set out in the white paper on English devolution how it will empower local NHS providers, councils, and other local public service providers to draw up agreed measurable outcomes for their area. It should delineate how regulators will work with local areas to agree such outcomes and hold individual service providers accountable for partnership working. The outcomes should reflect the specific needs and priorities of local areas. (Paragraph 153)

A new approach to data-sharing

33. COVID-19 has shown that the Government and other service providers need to rethink their approach to data-sharing. There has been too much reluctance from the centre to share data with organisations at the local level which are responsible for public services, hindering the efficient delivery of quality, person-centred services. (Paragraph 158)

34. We recommend that the Government and national public services review their systems for sharing data with local services. Unless they have access to the information that they need, public services will be unable to meet the

challenges posed by winter 2020/21 and the second England-wide lockdown. (Paragraph 159)

35. Local areas should have the means and autonomy to maintain the data-sharing innovations developed during the COVID-19 pandemic. The Government should set out in the white paper on English devolution how it will support local areas and city regions to adopt new data standards, and how it will invest in common approaches and tools for information governance. (Paragraph 165)

36. We are concerned that agencies do not share the data that they need to support vulnerable children and to determine which children need their help. The Government should issue new guidance on data-sharing powers and duties to protect vulnerable children, and, if necessary, introduce legislation to ensure that such data is shared. (Paragraph 168)

37. While some local areas were able to innovate and share data in new ways during the pandemic, many public service leaders lack the confidence and understanding of existing data protection legislation to share information about individual service users with system partners. Such reluctance can limit the ability of public services to keep people safe, particularly during national crises. (Paragraph 173)

38. The Government, while recognising the need to protect personal data, should work with the Information Commissioner to build on the innovation in data-sharing seen in some local areas and to better understand the structural, legal and cultural impediments to data-sharing during the pandemic. Once the forthcoming statutory code on data-sharing is published, the Government and Information Commissioner should release updated guidance on how any such impediments should be addressed. (Paragraph 174)

39. The use of data was a critical factor in determining citizens' experience of public services during the pandemic, and particularly for vulnerable people. The role of data in the delivery of public services will grow in prominence in the months and years ahead, as new digital technologies and Artificial Intelligence (AI) become more readily available to public service providers. A future inquiry may investigate data-sharing in public services more closely. (Paragraph 175)

Commissioning reform—unlocking the potential of charities and the private sector

40. The Cabinet Office showed admirable flexibility during the pandemic in issuing new guidance to commissioners which put greater emphasis on the social value that commissioning can create and gave greater autonomy to frontline service providers. (Paragraph 186)

41. The Cabinet Office should now update *The outsourcing playbook* to reflect the new ways in which businesses and charities delivered services during the pandemic, and provide commissioners with best-practice guidance to encourage joint working with the private and third sector. Any new guidance for commissioners must retain the existing focus on social value, partnership working and sustainable grant funding. (Paragraph 187)

42. Once updated, *The outsourcing playbook* should be incorporated into the forthcoming green paper on procurement. Its guidance should apply across the public sector to ensure that public service commissioners prioritise

social value when contracting services from charities and businesses. (Paragraph 188)

Digital technology and innovation in frontline public services

43. There is a clear requirement for central Government and local services to evaluate the performance of services that moved online during the first lockdown, ensuring that public services maintain face-to-face services wherever they are needed. They should work closely with service users in conducting this evaluation, because users are best placed to advise on which services should be delivered online, by telephone, or in person. (Paragraph 200)

44. Central Government and local services should build on the advances made during the pandemic by prioritising funding for public sector digital services. The Government should put a particular focus on improving the digital skills of the public service workforce, and improving digital access and skills for those parts of the population that are at risk of digital exclusion. (Paragraph 201)

"From lockdown to lock-in"—how do public services learn?

45. In recent months, the Prime Minister and the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office have argued that the pandemic offers a chance for fundamental public service reform. Furthermore, the Prime Minister has promised an independent inquiry to learn lessons from COVID-19. (Paragraph 210)

46. Because the Government did not give oral evidence to the inquiry, and its offer to send written evidence arrived too late, we were unable to discuss how it intends to learn lessons from the pandemic in the forthcoming public inquiry and the approach that it will take to public service reform. We therefore call on the Government to carry out:

    (1) a rapid evaluation of what worked well and what worked badly in public service delivery during the initial stages of the COVID-19 pandemic, to ensure that services quickly learn lessons. The Government should carry out this evaluation within the next six months;

    (2) an assessment of the changes seen in public service delivery during the first lockdown, to embed the innovations that worked well. To ensure that positive changes are not lost, the Government should publish its findings within a year;

    (3) a long-term evaluation of the fundamental weaknesses in public services that have been revealed by the pandemic, to inform a major project of public service transformation. (Paragraph 211)

47. We suggest that this report offers a starting point for any evaluation of how public services adapted to the pandemic, and the implications of COVID-19 for the future transformation of public service delivery. In order to lock in the remarkable innovations adopted by service providers since the beginning of the pandemic, we have set out eight key principles for public service reform. These principles should now underpin the Government's approach to redesigning the UK's public services for the twenty-first century. (Paragraph 212)

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

The Members of the Public Services Committee at the time of this report were:

Baroness Armstrong of Hill Top (Chair)
Lord Bichard
Lord Bourne of Aberystwyth
Lord Davies of Gower
Lord Filkin
Lord Hogan-Howe
Lord Hunt of Kings Heath
Baroness Pinnock
Baroness Pitkeithley
Baroness Tyler of Enfield
Baroness Wyld
Lord Young of Cookham

Declarations of interests

Baroness Armstrong of Hill Top
Member, Strategic Group, Fulfilling Lives, Newcastle and Gateshead

Lord Bichard
Chairman, National Audit Office
Member of the Commission for Smarter Government

Lord Bourne of Aberystwyth
Governor and Deputy Chair of International Students' House
President of Remembering Srebrenica
Owner of freehold property in Hampshire which is let out
Barrister
Author of legal textbooks

Lord Davies of Gower
No relevant interests were declared

Lord Filkin
Vice-Chair of the APPG on Longevity
Strategic Advisory Group

Lord Hogan-Howe
Non-executive Director of the Cabinet Office

Lord Hunt of Kings Heath
Council Member, General Medical Council
President of GSI
Self-employed consultant on NHS and wider health issues
Trading as Philip Hunt Consultancy

Baroness Pinnock
Vice President of local branch of Local Government Association (LGA)
Local Councillor, Kirklees Council

Baroness Pitkeathley
President of the National Council of Voluntary Organisations (NCVO)
Vice-Chair, Cumberland Lodge

Baroness Tyler of Enfield

Non-executive director, Social Work England

Former Chair, Making every Adult Matter (MEAM)

Baroness Wyld

Non-executive board member, Ofsted

Non-executive Director, Department for Digital, Culture, Media and Sport (DCMS)

Member of recovery committee, Ofqual

Trustee, The Urology Foundation (until 31 October 2020)

Lord Young of Cookham

No relevant interests were declared

A full list of Members' interests can be found in the Register of Lords' interests: https://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests/

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at https://committees.parliament.uk/committee/430/public-services-committee/publications/ and available for inspection at the Parliamentary Archives (020 7219 3074)

Evidence received by the Committee is listed below in chronological order of oral evidence session, and then in alphabetical order. Those witnesses marked with ** gave both oral evidence and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

Oral evidence in chronological order

**	Nick Davies, Programme Director, Institute for Government (IfG)	QQ 1–9
*	Nick Pearce, Director, Institute for Policy Research, University of Bath	QQ 1–9
**	Richard Sloggett, Senior Fellow and Health and Social Care Lead, Policy Exchange	QQ 1–9
*	Anna Round, Senior Research Fellow, IPPR North	QQ 10–18
*	Vicki Sellick, Executive Director, Nesta	QQ 10–18
**	Jessica Studdert, Deputy Director, New Local Government Network (NLGN)	QQ 10–18
*	Kate Terroni, Chief Inspector of Adult Social Care, Care Quality Commission (CQC)	QQ 19–26
*	Sarah Pickup, Deputy Chief Executive, Local Government Association (LGA)	QQ 19–26
**	Saffron Cordery, Deputy Chief Executive, NHS Providers	QQ 19–26
*	Anne Longfield OBE, Children's Commissioner for England and Wales	QQ 27–34
*	Claire Murdoch, National Director for Mental Health Services, NHS England and Chief Executive Officer, Central and North West London NHS Foundation Trust	QQ 27–34
*	Amanda Spielman, Chief Inspector, Ofsted	QQ 27-34
*	Dr Jeanelle de Gruchy, President, Association of Directors of Public Health (ADPH)	QQ 35–42
**	David Williams, Chair, County Council Network	QQ 35–42
*	Eamonn Boylan, Chief Executive, Greater Manchester Combined Authority	QQ 35–42
*	James Zuccollo, Director for School Workforce, Education Policy Institute	QQ43–50
*	Professor Dame Donna Kinnair, Chief Executive and General Secretary, Royal College of Nursing (RCN)	QQ43–50

*	Mary Robertson, Public Services Lead, Trades Union Congress (TUC)	QQ 43–50
**	Kathy Evans, Chief Executive, Children England	QQ 51–55
*	Josh Hardie, Deputy Director General, Confederation of British Industry (CBI)	QQ 51–55
**	Paul Streets, Chief Executive, Lloyds Bank Foundation for England and Wales	QQ 51–55
*	Lauren O'Donoghue, Branch Secretary, Sheffield, Association of Community Organisations for Reform Now (ACORN UK)	QQ 56–59
*	David Knott, Director, Office for Civil Society	QQ 56–59
*	Ian Jones, Chief Executive, Volunteer Cornwall	QQ 56–59
*	Rosie Lewis, Deputy Director and Violence Against Women and Girls Services Manager, The Angelou Centre	QQ 60–65
*	David Isaac CBE, Chair, Equality and Human Rights Commission	QQ 60-65
**	Sarah Mann, Director, Friends, Families and Travellers	QQ 60–65
**	James Bullion, President, Association of Directors of Adult Social Services	QQ 66–69
*	Professor Sir Michael Marmot, Director, UCL Institute of Health Equity	QQ 66–69
*	Chris Naylor, Senior Fellow, King's Fund	QQ 66–69
*	Caroline Bernard, Head of Policy and Communications, Homeless Link	QQ 70–74
*	Rick Muir, Director, Police Foundation	QQ 70–74
**	Nathan Dick, Head of Policy, Revolving Doors Agency	QQ 70–74
*	Caroline Abrahams, Charity Director, Age UK	QQ 75–83
*	Neil Heslop, Chief Executive, Leonard Cheshire	QQ 75–83
**	Nigel Edwards, Chief Executive, Nuffield Trust	QQ 75–83
*	Paul Johnson, Director, Institute for Fiscal Studies (IFS)	QQ 84–89
*	Professor Tony Travers, Professor in Practice, LSE Department of Government, London School of Economics (LSE) and Director of LSE London	QQ 84–89
*	Sarah Arnold, Senior Economist, New Economics Foundation	QQ 84–89
**	Dr Victoria Winckler, Director, Bevan Foundation	QQ 90–95
*	Anthony Soares, Director, Centre for Cross Border Studies	QQ 90–95

**	Anna Fowlie, Chief Executive, Scottish Council for Voluntary Organisations (SCVO)	QQ 90–95
*	Lord O'Donnell GCB, Cabinet Secretary 2005–2011	QQ 96–103
*	Lieutenant General Douglas Chalmers DSO OBE, Deputy Chief of the Defence Staff (Military Strategy and Operations), Ministry of Defence	QQ 96–103
*	Tracy Daszkiewicz, Deputy Director of Population Health and Wellbeing, Public Health England	QQ 96–103
*	Professor Sir Ian Diamond, National Statistician, Head of the Government Statistical Service and Chief Executive of the UK Statistics Authority	QQ 104–111
*	Elizabeth Denham CBE, Information Commissioner	QQ 104–111
*	Steve Wood, Deputy Commissioner–Regulatory Strategy, Information Commissioner's Office	QQ 104–111
*	Simon Madden, Acting Director of Policy and Strategy, NHSx	QQ104–111
**	Audrey Tang, Minister without Portfolio and Digital Minister, Taiwan (Republic of China)	QQ 112–124
*	Todd Krieble, Deputy Chief Executive, New Zealand Institute for Economic Research	QQ 112–124
*	Professor Claire Alexander, Associate Director, Centre on Dynamics of Ethnicity	QQ 125–135
*	Lord Woolley of Woodford, Founder and Director, Operation Black Vote	QQ 125–135
*	Agatha Anywio	QQ 136–141
*	Tamsin Phipps	QQ 136-141
*	Debra Baxter	QQ 142–145
*	Patricia Stewart	QQ 142–145
*	Dawn Knight	QQ 142–145
*	Shay Flaherty	QQ 146-149
*	Jackie Topping	QQ 146–149
*	Michaela Berry	QQ 150–155
*	Ryan Wise	QQ 150–155
**	Katie Rose, Centre for Public Impact	QQ 150–155
*	Rudolf Henke, German Bundestag Health Committee COVID-19 lead	QQ 156–161
*	John Kampfner	QQ 156–161

Alphabetical list of all witnesses

**	Caroline Abrahams, Charity Director, Age UK (QQ 75–83)	
	Action on Smoking and Health (ASH)	PSR0065
	Age UK	PSR0028
	Air Ambulance Kent Surrey Sussex	PSR0078
*	Professor Claire Alexander, Associate Director, Centre on Dynamics of Ethnicity, University of Manchester (QQ 125–135)	
	All-Party Parliamentary Group for Axial Spondyloarthritis	PSR0080
	Alzheimer's Society	PSR0044
	The Angelou Centre	PSR0088
	Anthony Nolan	PSR0015
	Agatha Anywio (QQ 136–141)	
*	Sarah Arnold, Senior Economist, New Economics Foundation (QQ 84–89)	
	Association of Community Organisations for Reform Now (ACORN UK)	PSR0094
	Association of Directors of Adult Social Services (ADASS)	PSR0089
	Association of Directors of Public Health (ADPH)	PSR0069
	Asthma UK and British Lung Foundation	PSR0027
	Dr Arun Baksi, Our NHS, Our Concern, Doctors Association UK, British Association of Physicians of Indian Origin (BAPIO), Doctors for the NHS	PSR0008
	Battersea Cats and Dogs Home (Battersea)	PSR0038
*	Debra Baxter (QQ 142–145)	
	Caroline Bernard, Head of Policy and Communications, Homeless Link (QQ 70–74)	
	Dr Roberta Bernardi, Lecturer in Management, University of Bristol	PSR0062
	Michaela Berry (QQ 150–155)	
	Dr Valerie Bevan	PSR0048
*	Eamonn Boylan, Chief Executive, Greater Manchester Combined Authority (GMCA) (QQ 35–42)	
	British Medical Association (BMA)	PSR0071
*	James Bullion, President, Association of Directors of Adult Social Services (ADASS) (QQ 66–69)	
	Camurus	PSR0073

	Cancer 52	PSR0060
	Care Quality Commission (CQC)	PSR0086
	Catch 22	PSR0036
	Centre for Cross Border Studies	PSR0093
	Centre for Mental Health	PSR0043
	Centre for Public Impact	PSR0026
*	Lieutenant General Douglas Chalmers DSO OBE, Deputy Chief of the Defence Staff (Military Strategy and Operations), Ministry of Defence (QQ 96–103)	
	Changing Lives	PSR0042
	Children's Commissioner's Office (CCO)	PSR0106
	City of London Corporation	PSR0103
	Clinks	PSR0053
	Dr Chris Cocking, Principal Lecturer, School of Health Sciences, University of Brighton	PSR0033
	Collective Voice	PSR0050
	Community Leisure UK, UKactive	PSR0023
	Community Transport Association	PSR0095
	Confederation of British Industry (CBI)	PSR0085
*	Saffron Cordery, Deputy Chief Executive, NHS Providers (QQ 19–26)	
	County Councils' Network	PSR0016
	Tracy Daszkiewicz, Deputy Director of Population Health and Wellbeing, Public Health England (QQ 96–103)	
	Nick Davies, Programme Director, Institute for Government (IfG) (QQ 1–9)	
*	Dr Jeanelle de Gruchy, President, Association of Directors of Public Health (ADPH) (QQ 35–42)	
	Dementia Focus Group	PSR0114
*	Elizabeth Denham CBE, Information Commissioner, Information Commissioner's Office (QQ 104–111)	
*	Professor Sir Ian Diamond, National Statistician, Head of the Government Statistical Service and Chief Executive of the UK Statistics Authority (QQ 104–111)	
**	Nathan Dick, Head of Policy, Revolving Doors Agency (QQ 70–74)	PSR0090 PSR0112
	Directory of Social Change	PSR0061
	Doctors for the NHS	PSR0070
	Doctors in Unite	PSR0019

	Early Intervention Foundation	PSR0020
*	Nigel Edwards, Chief Executive, Nuffield Trust (QQ 75–83)	
	Dr Angelo Ercia	PSR0003
	Equality and Human Rights Commission (EHRC)	PSR0107
	Evangelical Alliance UK	PSR0066
*	Kathy Evans, Chief Executive, Children England (QQ 51–55)	PSR0013
	Families First, St Andrews	PSR0006
	Shay Flaherty (QQ 146–149)	
**	Anna Fowlie, Chief Executive, Scottish Council for Voluntary Organisations (SCVO) (QQ 90–95)	
	Friends, Families and Travellers, National Federation of Gypsy Liaison Groups	PSR0079
	Fulfilling Lives Newcastle Gateshead	PSR0045
	Good Things Foundation	PSR0075
	Greater Manchester Combined Authority (GMCA)	PSR0017
	Professor Martin Green, Chief Executive, Care England	PSR0004
*	Josh Hardie, Deputy Director, Confederation of British Industry (CBI) (QQ 51–55)	
	Healthwatch England	PSR0115
	Healthwatch Sandwell	PSR0116 PSR0117
*	Rudolf Henke, German Bundestag Health Committee COVID-19 lead (QQ 156–161)	
	Hereford Vennture	PSR0031
	Neil Heslop, Chief Executive, Leonard Cheshire (QQ 75–83)	
	Institute for Volunteering Research	PSR0014
*	David Isaac CBE, Chair, Equality and Human Rights Commission (EHRC) (QQ 60–65)	
*	Paul Johnson, Director, Institute for Fiscal Studies (IFS) (QQ 84–89)	
*	Ian Jones, Chief Executive, Volunteer Cornwall (QQ 56–59)	
*	Rosie Lewis, Deputy Director and Violence Against Women and Girls Services Manager, The Angelou Centre (QQ 60–65)	
*	John Kampfner (QQ 156–161)	

*	Professor Dame Donna Kinnair, Chief Executive and General Secretary, Royal College of Nursing (RCN) (QQ 43–50)	
	Kirklees Council	PSR0010
*	Dawn Knight (QQ 142–145)	
*	David Knott, Director, Office for Civil Society (QQ 56–59)	
*	Todd Krieble, Deputy Chief Executive, New Zealand Institute for Economic Research (QQ 112–124)	
	Lloyds Bank Foundation for England and Wales	PSR0011
	Local Government Association (LGA)	PSR0063
	Locality	PSR0074
	London Borough of Camden	PSR0082
	London Borough of Hackney	PSR0098
*	Anne Longfield OBE, Children's Commissioner for England and Wales (QQ 27–34)	
*	Simon Madden, Acting Director of Policy and Strategy, NHSx (QQ 104–111)	
	Making Every Adult Matter (MEAM)	PSR0087
*	Sarah Mann, Chief Executive, Friends, Families and Travellers (QQ 60–65)	
	Marie Curie	PSR0092
*	Professor Sir Michael Marmot, Director, UCL Institute of Health Equity (QQ 66–69)	
	Maternal Mental Health Alliance (MMMA)	PSR0037
	Mencap	PSR0081
	Mental Health Foundation	PSR0058
	MHA (Methodist Homes)	PSR0059
*	Claire Murdoch, National Director for Mental Health Services, NHS England and Chief Executive Officer, Central and North West London NHS Foundation Trust	
	Muslim Council of Britain	PSR0108
	Mydex CIC	PSR0058
	National Council for Voluntary Organisations (NCVO)	PSR0052
	National Institute for Health Research (NIHR) Health Protection Research Unit in Emerging and Zoonotic Infections, University of Liverpool; Institute of Infection and Global Health, University of Oxford; Nuffield Department of Primary Care Health Sciences	PSR0102
	NASUWT	PSR0022

	The National Lottery Community Fund	PSR0072
*	Chris Naylor, Senior Fellow, The King's Fund (QQ 66–69)	
	New Local Government Network (NLGN)	PSR0039
	New Philanthropy Capital (NPC)	PSR0068
	NHS England and NHS Improvement	PSR0111
	NHS Providers	PS00005
	Nuffield Trust	PSR0041
*	Lord O'Donnell GCB, Cabinet Secretary, 2005–2011 (QQ 96–103)	
*	Lauren O'Donoghue, Branch Secretary, Sheffield, Association of Community Organisations for Reform Now (ACORN UK) (QQ 56–59)	
	Siobhan O'Dwyer, Senior Lecturer in Ageing and Family Care, University of Exeter	PSR0118
	Our NHS Our Concern	PSR0035 PSR0046
	Our NHS Our Concern, British Association of Doctors of Indian Origin, Doctors Association UK	PSR0049
	Our NHS Our Concern, Doctors Association, British Association of Doctors of Indian Origin, Doctors for the NHS	PSR0032
	Nick Pearce, Director, Institute for Policy Research, University of Bath (QQ 1–9)	
*	Tamsin Phipps (QQ 136–141)	
*	Sarah Pickup, Deputy Chief Executive, Local Government Association (LGA) (QQ 19–26)	
	PPL	PSR0110
	Public and Commercial Services Union (PCS)	PSR0067
	Public Services, Department of Social Policy, Faculty of Business and Society, University of South Wales	PSR0099
	The Richmond Group of Charities	PSR0029
*	Mary Robertson, Public Services Lead, Trades Union Congress (TUC) (QQ 43–50)	
**	Katie Rose, Centre for Public Impact (QQ 150–155)	PSR0113
*	Anna Round, Senior Research Fellow, IPPR North (QQ 10–18)	
	Royal College of Midwives	PSR0051
	Royal College of Surgeons of Edinburgh	PSR0104
	Scope	PSR0091
*	Vicki Sellick, Executive Director, Nesta (QQ 10–18)	

	Shared Lives Plus	PSR0018
	Shaw Trust	PSR0101
*	Richard Sloggett, Senior Fellow and Health and Social Care Lead, Policy Exchange (QQ 1–9)	
*	Anthony Soares, Director, Centre for Cross Border Studies (QQ 90–95)	
	Social Business International Ltd, E3M partners and members	PSR0024
	Amanda Spielman, Chief Inspector, Ofsted (QQ 27–34)	
	St Elizabeth Hospice	PSR0076
	St John Ambulance	PSR0030
*	Patricia Stewart (QQ 142–145)	
	Stone King LLP	PSR0034
*	Paul Streets, Chief Executive, Lloyds Bank Foundation for England and Wales (QQ 51–55)	
*	Jessica Studdert, Deputy Director, Government Network (NLGN) (QQ 10–18)	
	TACT Fostering	PSR0012
*	Audrey Tang, Minister without Portfolio, Taiwan (Republic of China) (QQ 112–124)	
*	Kate Terroni, Chief Inspector of Adult Social Care, Care Quality Commission (CQC) (QQ 19–26)	
	Luen Thompson, Chief Executive Officer, Forget-Me-Not Children's Hospice	PSR0002
	Together for Short Lives	PSR0105
*	Jackie Topping (QQ 146–149)	
*	Professor Tony Travers, Professor in Practice, LSE Department of Government, London School of Economics (LSE) and Director of LSE London (QQ 75–83)	
	Volunteer Centre, Kensington and Chelsea	PSR0084
	Lee Whitehead, Chief Executive, Smart Social	PSR0001
*	David Williams, Chair, County Council Network (QQ 35–42)	
**	Dr Victoria Winckler, Director, Bevan Foundation (QQ 90–95)	PSR0100
*	Ryan Wise (QQ 150–155)	
	Women's Resource Centre	PSR0047 PSR0054 PSR0055

* Steve Wood, Deputy Commissioner—Regulatory Strategy, Information Commissioner's Office (QQ 104–111)
* The Lord Woolley of Woodford, Founder and Director, Operation Black Vote (QQ 125–135)

Zebra Technologies Europe Limited PSR0083

* James Zuccollo, Director for School Workforce, Education Policy Institute (QQ 43–50)

APPENDIX 3: CALL FOR EVIDENCE

Public services: lessons from coronavirus

Public Services Committee

The House of Lords Select Committee on Public Services was established on 13 February 2020 to scrutinise issues that cut across different public services, to complement the Departmental focus of committee scrutiny in the House of Commons.

The Public Services Committee will focus its work on the transformation of public services, to ensure that they are meeting the needs of individuals and communities in the twenty-first century

The Committee will consider public services in the broadest possible sense—we will explore community-level initiatives and the role of the private, voluntary and charitable sectors in the delivery of public services.

Shortly after the establishment of the Committee, public services were presented with one of the gravest challenges of recent history—the outbreak of COVID-19. In our first inquiry, the Committee will examine what the experience of coronavirus can tell us about the future role, priorities and shape of public services. This short review of lessons for public services will inform later, broader work on public service reform.

The remit of the Public Services Committee will largely be limited to scrutiny of public service delivery in England. In Northern Ireland, Scotland and Wales, responsibility for public services generally rests with the devolved administrations. However, the Committee hopes to learn from public service best practice in the devolved jurisdictions, both to draw comparisons and apply lessons learnt.

COVID-19: an opportunity for public service reform?

The coronavirus crisis already represents the biggest shock to the UK's economy and society since the Second World War. The loss of life and the disruption to communities across the country have been devasting, while the public health emergency and the resulting economic downturn have placed unprecedented pressures on our public services.

The months and years ahead—with demand for services likely to rise in the context of a significantly diminished economy—will present new challenges and difficult choices for services. The coronavirus outbreak requires a fundamental rethink of how public services respond to the needs of the communities that they serve.

The pandemic has already encouraged radical thinking in some areas of public policy. In recent weeks, we have seen the establishment of numerous community initiatives to support people during lockdown. These schemes have involved collaboration among community groups; the voluntary sector; the private sector; NHS and social care providers; the police; and local authorities and other services, to ensure that the needs of local communities are met.

However, although the pandemic has demonstrated what is possible, questions remain about whether more could have been done to prevent harm, whether the transformation seen in some service areas will remain once the crisis is over, and whether best practice will be shared with services that struggled during lockdown.

This inquiry will focus on four key areas: the integration of services; inequalities in access and outcome; the relationship between local and national services; and the role of business and the third sector—charities, volunteers and community groups—during coronavirus.

The questions set out below are intended to provide a framework for those who wish to offer their views. You need not answer all the questions, just those that are relevant.

The Committee is seeking input on the following questions:

General

1. What have been the main areas of public service success and failure during the COVID-19 outbreak?

2. How have public attitudes to public services changed as a result of the COVID-19 outbreak?

Resource, efficiency and workforce

3. Did resource problems or capacity issues limit the ability of public services to respond to the crisis? Are there lessons to be learnt from the pandemic on how resources can be better allocated and public service resilience improved?

4. Did workforce pressures preceding the crisis, such as difficulties in the recruitment or retention of workers, limit the ability of public services to meet people's needs during the lockdown? How effectively, if at all, have these issues been addressed during the COVID-19 outbreak? Do public services require a new approach to staff wellbeing?

5. Why have some public services been able to achieve goals within a much shorter timeframe than typically would have been expected before the COVID-19 outbreak—for example, the increase in NHS capacity? What lessons can be learnt?

Technology, data and innovation

6. Has the delivery of public services changed as a result of coronavirus? For example, have any services adopted new methods of meeting people's needs in response to the outbreak? What lessons can be learnt from innovation during coronavirus?

7. How effectively have different public services shared data during the outbreak?

8. Did public services have the digital skills and technology necessary to respond to the crisis? Can you provide examples of services that were able to innovate with digital technology during lockdown? How can these changes be integrated in the future?

Inequalities

9. Have public services been effective in identifying and meeting the needs of vulnerable groups during the COVID-19 outbreak? For example, were services able to identify vulnerable children during lockdown to ensure that they were attending school or receiving support from statutory services? How have adults with complex needs been supported?

10. Were groups with protected characteristics (for example BAME groups and the Gypsy, Roma and Traveller community), or people living in areas of deprivation, less able to access the services that they needed during lockdown? Have inequalities worsened as a result of the lockdown? If so, what new pressures will this place on public services?

11. Are there lessons to be learnt for reducing inequalities from the new approaches adopted by services during the COVID-19 outbreak?

Integration of services

12. A criticism often levelled at service delivery is that public services operate in silos—collaboration is said to be disincentivised by narrow targets from central Government departments, distinct funding and commissioning systems, and service-specific regulatory intervention. Would you agree, and if so, did such a framework limit the ability of public services to respond to people's needs during the COVID-19 outbreak?

13. Were some local areas, where services were well integrated before the crisis, better able to respond to the outbreak than areas where integration was less developed? Can you provide examples?

14. Are there any examples of services collaborating in new and effective ways as a result of COVID-19? Are there lessons to be learnt for central Government and national regulators in supporting the integration of services?

15. What does the experience of public services during the outbreak tell us about services' ability to collaborate to provide "person-centred care"?

The relationship between central Government and local government, and national and local services

16. How well did central and local government, and national and local services, work together to coordinate public services during the outbreak? For example, how effectively have national and local agencies shared data?

17. How effectively were public services coordinated across the borders of the devolved administrations? Did people living close to the border experience difficulties in accessing services?

18. Can you provide any examples of how public services worked effectively with a local community to meet the unique needs of the people in the area (i.e. taking a "place-based approach" to delivering services) during the COVID-19 outbreak?

19. Would local communities benefit from public services focusing on prevention, as opposed to prioritising harm mitigation? Were some local areas able to reduce harm during coronavirus by having prevention-focused public health strategies in place, for example on obesity, substance abuse or mental health?

Role of the private sector, charities, volunteers and community groups

20. What lessons might be learnt about the role of charities, volunteers and the community sector from the crisis? Can you provide examples of public services collaborating in new ways with the voluntary sector during lockdown? How could the sectors be better integrated into local systems going forward?

21. How effectively has the Government worked with the private sector to ensure services have continued to operate during the COVID-19 outbreak?