PROTECTING CHILDREN AT A DISTANCE: SUMMARY OF FINDINGS FROM STAGE 1

A multi-agency investigation of child safeguarding and protection responses consequent upon COVID-19 lock-down/social distancing measures

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Executive Summary

This Executive Summary presents key findings from the first stage of a study designed in response to widespread concerns about the operation of child safeguarding and protection arrangements consequent upon the Covid-19 lockdown and social distancing measures. In light of the challenges to intra- and interagency communication and the impact on joint working of actions taken by individual agencies, the study focuses on safeguarding and protection practice, practitioner working and the multiagency response to the COVID-19 Pandemic.

Study

The study was granted ethical approval by the King's College London Research Ethics Committee [LRS-19/20-19420] and deemed a service evaluation by participating NHS organisations. It is funded by the *King's Together: Multi & Interdisciplinary Research Scheme* and the *Economic & Social Research Council Impact Acceleration Accounts Social Science Impact Fund.*

Stage I comprised 67 semi-structured hour-long interviews undertaken between June and September 2020 with safeguarding leaders in London from Safeguarding Partnerships, and children's social care, health, police, law, education and mental health services (see Appendix 1). Most participants were identified through their professional role and contacted directly, with initial contacts forwarding to a nominee where appropriate. Overall, the participants provide contributions covering 24 London boroughs, although many covered more than one borough or worked across boroughs, particularly where they worked in an acute trust, as a solicitor, or as a police officer.

Stage II comprises a national survey of the same professional groups, which will focus on the evolving concerns and response to the COVID-19 pandemic following the full reopening of schools in September 2020, in order to share emerging good practice and make recommendations on strengthening and 'future proofing' the safeguarding system in England.

This report presents an overview of the key findings and recommendations at pages 2-6, followed by a more detailed summary and questions for further consideration from page 7. The full length report will be available early in 2021.

Summary of Key Findings

1. The impact of the response to Covid-19 on the safeguarding continuum

- **School closures:** All participants raised significant concerns related to the closure of schools during the first lockdown and the challenges of ensuring eligible children continued to attend school. Most of the boroughs with which we had contact described having undertaken much work to increase the numbers attending, mostly with only modest success. Where children deemed to be vulnerable remained at home, 'keeping in touch' strategies were implemented, such as regular, generally weekly, calls to families, amounting to a 'huge increase' in contacts with known vulnerable children.
- **Early help/prevention and support work:** Most early help services shifted to online provision, with some concerns that signposting to services and resources left the initiative with parents to contact practitioners, which meant that parents were not benefitting from proactive offers of support from practitioners which helps to ensure higher levels of take up. Participants pointed to rising levels of early help needs consequent upon the exacerbation of poverty and familial stress because of the pandemic, which conflicted with the tendency to prioritise statutory services and pre-existing cuts to early help budgets. Boroughs took a range of different approaches in relation to children's centres. A range of innovations were introduced to support families that might be struggling with caring for their children and to maintain engagement.
- **Disclosure and referrals:** Considerable thought had been given to creating opportunities for children to disclose maltreatment and/or share concerns arising from their experiences, both through keeping in touch and in preparation for return to school. A number of participants stressed that mental health impacts might not be seen straight away and might present in many different ways that could be missed. An important point to note is that interviewees from most boroughs said that referrals that were received over the summer were more likely to be particularly high risk and/or complex and more likely therefore to lead to assessment, child protection investigation and social care intervention. Concern was raised that full assessment was not possible from a doorstep visit.
- **Assessment and follow-up*:*** For many professionals face-to-face visits and meetings were temporally suspended and most services moved online, even statutory child protection visits and assessments. Most practitioners across all sectors reported that it was harder to make things happen for children during the pandemic, noting, for example, difficulties in getting hold of the right people to make or confirm arrangements, accessing appropriate services and the complexity involved in ensuring that arrangements were safe. There were indications that the lack of services available to at risk children and young people impacted risk planning and risk management strategies, with a lot less opportunity for surveillance and monitoring.

- **Child protection planning and case conferences:** Case conferences and practice relating to child protection plans differed by borough. There was generally a hybrid approach to conferences, meetings and hearings, and parents were included face-to-face if judged necessary or beneficial. Children were likely to remain on a plan for longer than would normally be expected, because of difficulties in undertaking assessment and monitoring and less confidence in the outcome of assessments where all contact was remote. At the time of the interviews many participants were not yet completely clear on what was the best way forward, and how children and families had really experienced online/hybrid case conferences.
- **Court proceedings*:*** Once court proceedings have been initiated, advocates' meetings and pre-hearing meetings were reported as much more efficient and well attended. However, lawyers referred to universal legal concern around engagement and delivery of justice in remote hearings. Delays in court proceedings, which can have a huge emotional impact on children and families, were reported. Concerns about adequate monitoring of risk and reduced scope for alternative plans such as kinship placements may have affected the outcomes of some hearings.
- **Looked after children and care leavers:** A surprising area of considerable success for some local authorities was a reduction in placement moves. However, a pre-existing shortage of placements was significantly exacerbated. One area sourced extra residential care in anticipation of an increased need for places, which was useful in supporting placement stability. Children in care had to cope with many issues. Contact was of particular concern for separated babies. Greater engagement with many young people was reported by social workers as many (but not all) were more comfortable communicating remotely.

2. Multi-agency working

- **Decision-making:** Many participants across a range of areas and agencies described an initial vacuum of decision-making, resulting in a sense that 'everything stopped'. Strategic decisions were experienced by many participants as imposed on a 'top-down' basis, driven by a priority to protect the health and safety of service users and staff. A failure to involve all key stakeholders in decisions about services could lead to inadequate consideration of potential risks and long-term implications for safeguarding.
- **Multi-agency working:** Although multi-agency arrangements tended to be a focus only after agencies had managed their own immediate business, the general consensus was that thereafter interagency working was a significant focus of attention. A particularly valuable exercise appeared to be joint planning ('coordinated eyes') for monitoring of all children deemed to be highly vulnerable. A concern for the future arose from the withdrawal of many collocated roles.
- **Operation of Safeguarding Partnerships:** The pandemic was felt to have accelerated the process of embedding the new arrangements and encouraging closer working between the partners. Framing of the partnership in national guidance was problematic in light of the key role played by schools during lockdown. Interviewees lamented that Safeguarding Partnerships had no influence over some key decisions

affecting safeguarding in their areas. Suggestions for the future included compilation of reports on the impact of Covid-19 on their communities across partners, to plan for any further needs and risks that arise; mapping out groups that may be most vulnerable; and supporting knowledge exchange to discuss the implications of remote and online working.

3. Professional practice

- **Risk and vulnerability:** Revised risk assessment of cases known to services took place in almost all agencies. Discussions took place both uni-professionally and in a number of boroughs on an interagency basis. Where RAG Rating was undertaken at Safeguarding Partnership level, the exercise was complex but regarded as valuable, while concerns were expressed that the absence of a single shared list of vulnerable children between agencies led to problems of not knowing who was monitoring or supporting the most vulnerable children.
- **Redeployment:** Healthcare services throughout England structured their provision to respond to the influx of adult Covid-19 patients, resulting in widespread redeployment of health professionals including health visitors and other practitioners working with children. Safeguarding GPs were often absorbed into increased practice workload. Strategic health Safeguarding leads (Designated Nurses and Doctors), as well as Named Doctors, Named Nurses, Safeguarding Advisors (including for general, midwifery and mental health nursing) and Looked After Children (LAC) Nurses, were often described as being redeployed. It was found to have a negative impact on supervision, communication, workload, and oversight and training, and felt to indicate inadequate regard for safeguarding. Notably, different decisions have been made about redeployment during the second lockdown period, suggesting that some evaluation of this is under way.
- **Communication and engagement with children and families:** Direct access to children and families was significantly reduced for all safeguarding professionals and agencies. Many remained critical of the blanket rapid removal of face-to-face contact with children and families and the reluctance of some agencies and professionals to reintegrate some face-to-face provision. There were many concerns about picking up safeguarding issues and non-verbal cues remotely and ascertaining whether others were in the room with children or parents. Building trust and rapport and ensuring the child's voice is heard is harder remotely and concerns were expressed that families could feel unsupported at a distance. Digital exclusion was highlighted as a prominent challenge. Yet many reported improved communication with some families and young people. Online engagement was considered particularly successful for maintaining relationships and 'checking-in' with children and families. Assessing risk and managing risk was thought to be more problematic at a distance and online.
- **Workforce capacity and wellbeing:** Participants from all professional groups talked about exhaustion from dealing with backlogs, covering gaps in the workforce and not taking leave. There was also a recognition of the impact of Covid-19 on staff health, mental health, family life, financial stability and caring responsibilities, and the unavoidable impact of this on professional lives. Gaps in the usual informal support

were felt keenly. Participants nonetheless described many peer support initiatives, both structured and intentionally set up and organically developing. A need for further mental health training and support for social work staff, including for bereavement, was identified.

- **Training and upskilling:** Training predominantly stopped initially. Capacity to move immediately to online training varied significantly across organisations and agencies. Many practical and technological challenges were encountered, and some felt that online training was ill-designed for safeguarding training, which usually drew on more dynamic and discussion-based methods. Participants identified a range of urgent training needs in addition to upskilling to make the most of technological tools. Gaps were noted in uptake of child safeguarding training relating to some adult services and the impact of deployment of safeguarding leads in health who normally run safeguarding training.
- **Guidance and regulation:** Initial government guidance was widely regarded as reactive and too slow. It was considered to have improved over time, however, and some commented that it was proportionate, although the pace of change of guidance and inadequate time to implement it were problematic for some, particularly in education. Some concerns were expressed that the perceived status of the guidance inhibited local adaptations. Specialist guidance from professional representative bodies or local networks seemed to be most positively received.

4. Changing patterns in safeguarding concerns

- **Unseen children*:*** Our study revealed unanimous concern about children and parents no longer being seen routinely by universal health services, schools and other services, from maternity care through to the transition into adulthood. There was concern about economic deprivation and increased inequalities in the population that would impact on children's lives and safety. It was anticipated (and evidenced by some) that 'new' children have become vulnerable through this pandemic. Participants highlighted the challenges in, and a corresponding lack of effective initiatives for, identifying children at risk not already known to professionals, often describing this as their biggest and most concerning challenge. At least one area educated 'lockdown' volunteers to pick up families under stress, and some advertised access routes to advice about housing, poverty, unemployment and wellbeing.
- **Babies:** Our participants described insufficient face-to-face assessment and some inadequate support for new mothers, although this shifted over time in some areas. Of benefit was some increase in disclosures relating to domestic abuse when the partner could not be present at midwifery appointments.
- **Domestic abuse*:*** A London-wide initiative to combat domestic abuse was led by the Metropolitan Police. Agencies reported ensuring that all colleagues were briefed on risk factors and signposting to services such as temporary refuges, independent domestic violence advocacy and interventions by adult mental health teams. Advice was provided on remote interviewing to elicit disclosure. Some adult mental health services identified the highest risk violence victims and perpetrators on their caseload and put additional psychological support in place for both.

- **Mental Health:** Increasingly complex presentations of adults with mental health difficulties in child protection cases were noted by several participants. Child and adolescent mental health concerns related to the increased complexity of some safeguarding referrals. Community, online and helpline provision was established where not previously evident.
- **Youth violence and youth justice***:* Participants related apparent changes in patterns of youth violence and criminal activity, with an initial reduction in missing children and referrals relating to child sexual exploitation and criminal exploitation, including gang-related activity and County Lines. The police continued community work, including with gangs, and reported concerns that younger children may have started to be involved in child criminal exploitation. Young people in the youth justice system experienced delays in decisions, resulting in some cases in longer detention in custody. Access to young people in the secure estate was highly restricted during lockdown, leading to significant concerns about their wellbeing.
- **Children with disabilities and neurodevelopmental conditions:** Pressure increased on the families of some children with disabilities where institutions closed, leading to concerns about carers' mental health. Some play areas and outdoor spaces were offered for booking by families with special needs children and other support included virtual coffee mornings. This relied on the availability of 'Covid-safe' spaces and significant encouragement or reassurance by professionals to access these spaces. There was concern about increased waiting times for assessments and support.

Summary of overarching recommendations

1- Cross-government recognition of the multi-faceted long-term harm to children's wellbeing and future prospects that is the likely legacy of the pandemic must underpin a coordinated response.
2- Planning for future crises should adopt a balanced approach to conflicting risks, informed by established best practice in safeguarding and consultation on justifications for deviation from established practice norms.
3- The exacerbation of inequalities in the pandemic and the revelation of their effects on vulnerable populations presents an opportunity to reimagine and revitalize early help and preventative work, building on supportive relationships with families forged through the crisis.
4- Consultation should be initiated within and across disciplines and agencies to establish guidance on the use of digital communication to improve efficiency without cost to safety.

Key Findings

1. The impact of the response to Covid-19 on the safeguarding continuum

1.1 School closures

Stage 1 of our research took place between the partial reopening of schools on 1st June 2020 and the full return to school for the new academic year in September 2020. **All participants raised significant concerns related to the closure of schools during the first lockdown and the challenges of ensuring eligible children continued to attend school.** The definition of 'vulnerability' for the purposes of school attendance was interpreted differently in different areas. Children considered vulnerable who were eligible to attend but did not do so tended to be disengaged or poor attenders already and it was difficult to distinguish opportunistic evasion of scrutiny from genuine concern about risk of infection. **Most of the boroughs with which we had contact described having undertaken much work to increase the numbers attending, mostly with only modest success.** A range of reasons for vulnerable children not attending school were reported by professionals, including a sense of stigma among parents; foster carers taking the opportunity to spend time with the children in their care and get to know them better; health worries on the part of headteachers, particularly of special schools; strong union activity discouraging any in person contact between teachers and students; and media messaging that reinforced the importance of staying home. Concerns were expressed that reluctance by parents to send their children to school may continue in the autumn and translate into increased levels of home schooling. Current government statistics on school attendance since September 2020 are difficult to interpret in the light of the second lockdown in November 2020 but show attendance at primary schools at 90 per cent and at secondary schools at 81 per cent on 3rd December, with 9-11 per cent of pupils estimated as not attending for Covid-19 related reasons (Gov.UK, 2020). In our study, practitioners were described as not always comfortable in promoting the message that all socially vulnerable children should continue to go to school during the first lockdown, citing lack of clarity over how safe schools were in relation to Covid infections and ethical dilemmas for practitioners who had decided not to take up key worker spaces for their own children because of concerns about their safety but were being asked to encourage others to send their children to school. Participants expressed mixed views as to whether attendance requirements should have been stronger or possibly even mandatory.

Where children deemed to be vulnerable remained at home, 'keeping in touch' strategies were implemented, such as regular, generally weekly, calls to families, amounting to a 'huge increase' in contacts with known vulnerable children. Participants reported that, in general, positive relations were built with families and it was widely believed these arrangements were instrumental in enabling families to regard services as supportive rather than punitive. A minority of boroughs used police officers to follow up on families who did not respond to contacts, but this was felt by others to be heavy handed.

1.2 Early help/prevention and support work

Identified concerns regarding prevention and support work included: reductions in many support services such as parenting programmes, targeted youth work and mother and baby

clubs; the lack of short breaks and respite care for families with SEND children; and the welfare of shielded children. **Most early help services shifted to online provision, with some concerns that signposting to services and resources left the initiative with parents to contact practitioners which meant that parents were not benefitting from proactive offers of support from practitioners which help to ensure higher levels of take up.** Information about the availability, nature and mode of services needed to be regularly updated, and it was often felt that this information was not always accessible or updated frequently enough. **Participants pointed to rising levels of early help needs consequent upon the exacerbation of poverty and familial stress because of the pandemic, which conflicted with the tendency to prioritise statutory services and pre-existing cuts to early help budgets.** In one area, however, the threshold for early help access was lowered to allow intervention where families did not respond to professional contact.

Boroughs took a range of different approaches in relation to children's centres, with some continuing face to face, some closing all facilities and others offering a reduced service, for example by limiting access to younger children and their parents only. In one, the service remained open for weighing babies and provision of advice to parents who were struggling, and another kept one centre open as a one-stop shop for domestic abuse support work and midwifery. **A range of innovations were introduced to support families that might be struggling with caring for their children and to maintain engagement**, including a free online TV channel, which was expected to be continued and grown beyond the pandemic; virtual 'stay and play' sessions; online learning resources; and even virtual teaching of skills such as massage. Tweets were used to attract new families. One authority made resources from their children's centres, such as puppets, available for loan, with educational guidance on their use and that of everyday objects from the home. In general, the decreased face-to-face offer was a concern and only one participant described a strengthening of links between children's centres and children's social care to explore potential risks.

1.3 Disclosure and referrals

Considerable thought had been given to creating opportunities for children to disclose maltreatment and/or share concerns arising from their experiences, both through keeping in touch and in preparation for return to school. One headteacher issued every child with log in details for a child-friendly wellbeing report programme and encouraged daily reporting, although uptake declined over time. Other schools actively educated children on how to disclose concerns and those using google classroom were able to track students' access and engagement through it and to monitor children's demeanour during remote lessons. Many schools were preparing for support to students on return to school, including: staggered starts to allow more time to speak with young people about their experiences; written and video resources to support return to education and increasing access to counselling services; a trauma informed approach or 'recovery curriculum'; as well as welfare officer and educational psychology time and input into resources. However, there were differences in approach, with one school taking the view that providing a return to normality was the most important role for schools rather than providing a specific recovery curriculum. **A number of participants stressed that mental health impacts might not be seen straight away and might present in many different ways that could be missed.**

Referrals to Children's Social Care generally followed the national pattern of initial falls (of up to 40% in one borough) followed by recovery as schools started to open more widely in June. One area noted pre-birth concerns did not change but referrals of babies decreased. **An important point to note is that interviewees from most boroughs said that referrals that were received over the summer were more likely to be particularly high risk and/or complex and more likely therefore to lead to assessment, child protection investigation and social care intervention**, a similar observation to that of Baginsky and Manthorpe (2020). Jenny Coles, President of the Association of Directors of Children's Services, also referred to increased cases of children with urgent complex needs in a statement on 19th November.

One authority reported higher numbers of Police Protection and another a significant rise in re-referrals, although it was unclear if the pandemic was implicated in the latter. Local Authorities did not consider that thresholds were applied differently, but **concern was raised that full assessment was not possible from a doorstep visit.** There was also consideration that some professionals might have been desensitised to risk by hearing numerous stories of the stress affecting children (for example at school).

1.4 Assessment and follow-up

For many professionals face-to-face visits and meetings were temporally suspended and most services moved online, even statutory child protection visits and assessments. Participants described considerable thought about what best practice was in terms of accepting children for child protection medicals, and also regarding the need for face-to-face assessments of risk and need. In many cases, for child protection medicals, an initial history with the child took place remotely to reduce the amount of in person contact, before needing to put on protective equipment to see the child or young person face-to-face. Overall, however, **most practitioners across all sectors reported that it was harder to make things happen for children during the pandemic, noting, for example, difficulties in getting hold of the right people to make or confirm arrangements, accessing appropriate services and the complexity involved in ensuring that arrangements were safe.** Local authorities gradually returned to face-to-face practice at different rates. **There were indications that the lack of services available to at risk children and young people impacted risk planning and risk management strategies, with a lot less opportunity for surveillance and monitoring.**

1.5 Child protection planning and case conferences

Case conferences and practice relating to child protection plans differed by borough. In a number of authorities, initial case conferences were suspended and cases were put on a provisional or holding child protection plan as a precautionary measure. In general participants described a more risk averse approach than is usually the case. **Children were likely to remain on a plan for longer than would normally be expected, because of difficulties in undertaking assessment and monitoring and less confidence in the outcome of assessments where all contact was remote.** There was concern that assessments of parenting capacity and of children might be less reliable remotely. In one area there was a large number of applications for care proceedings where local authorities were concerned about the safety of children whose welfare they were not confident had been monitored adequately due to the pandemic.

There was generally a hybrid approach to conferences, meetings and hearings, and parents were included face-to-face if judged necessary or beneficial. This led to concern that parents had sometimes found this stressful if their supporting social worker was on the end of a phone in the meeting. Conversely, when parents were taking part remotely, there was concern about who else could be in the room. However, a key benefit was identified in more efficient use of time and higher attendance rates by professionals (also a finding of Baginsky and Manthorpe, 2020). **At the time of the interviews many participants were not yet completely clear on what was the best way forward, and how children and families had really experienced online/hybrid case conferences.**

1.6 Court proceedings

Once court proceedings have been initiated, advocates' meetings and pre-hearing meetings were reported as much more efficient and well attended, and some judges were felt to have become adept at chairing remote hearings, the remote context allowing greater control over advocate interventions. Remote hearings were regarded as particularly useful for short hearings such as case management and directions or contact disputes, where there was no need to assess the evidence, and it was felt they have long-term potential to free court space for contested hearings and save court time. However, some family courts stopped hearings completely for some time and participants reported very long delays and backlogs in court business. HMCTS (2020) published an overview of the recovery for civil and family courts and tribunals in November 2020, which describes efforts to improve remote practice through standardisation, additional administrative support and training.

While processes improved over time, **lawyers referred to universal legal concern around engagement and delivery of justice in remote hearings.** Parents with learning difficulties were reported to be at significant disadvantage under the new arrangements, particularly as remote hearings were tiring and required sustained concentration. Participants reported that courts and local authorities often appeared to assume that people had access to the technology needed to attend court hearings and other meetings, and some clients were significantly disadvantaged by not having access to technology for video meetings/hearings, which are already stressful, complex and sensitive processes. **Delays in court proceedings, which can have a huge emotional impact on children and families**, were reported as being accompanied by reduced contact with social workers and decreased face-to-face support. A number of lawyers considered that the crisis had resulted in increased litigation responses for some children in need and that **concerns about adequate monitoring of risk and reduced scope for alternative plans, such as kinship placements may have affected the outcomes of some hearings.** The Family Justice Observatory initial consultation similarly reported concerns about fairness and empathy in remote hearings in family law courts (Nuffield Family Justice Observatory (NFJO, 2020). In its follow up survey most professionals considered that fairness had been achieved, yet 88 per cent of parents and relatives expressed concerns about the way their case was dealt with (Ryan et al., 2020). The President of the Family Division has stressed that telephone connections should not be used for parents except as a last resort (McFarlane, 2020).

1.7 Looked after children and care leavers

Looked after numbers appeared stable despite reported increased court hearings, but were anticipated to rise in the autumn. Fewer looked after children than expected went to school; it was speculated that this might relate to carers' concerns such as shielding, as well as young people's wishes. **A surprising area of considerable success for some local authorities was a reduction in placement moves,** in part reflecting fewer children missing from care and reduced stress in placements where children were not required to attend school. **However, a pre-existing shortage of placements was significantly exacerbated**, particularly for mother and baby units and residential units, with problems arising from older, vulnerable carers and, in some cases, children being infected or possibly infected. A variety of responses were recounted, including re-recruiting retired foster carers; increasing the number of children placed with individual carers; extending the age range for which carers were approved to foster; enhancing the fee for emergency placements; and relaxing matching criteria. High risk, low volume accommodation posed a particular challenge in London in the context of pre-existing gaps in provision. One area depended on adult facilities to house a young person, and in another, staff themselves housed two young people in an emergency. **One area sourced extra residential care in anticipation of an increased need for places, which was useful in supporting placement stability.** It was also felt that cross borough collaboration in relation to out of area placements increased.

Children in care had to cope with many issues including decreased face to face contact with their birth families, as well as the death of a carer or a family member. **Contact was of particular concern for separated babies.** Face-to-face contact was ordered by some courts, for example, in parks, creating considerable challenges for local authorities. Communication in distant placements between birth parents and their children was better than usual by virtue of virtual contact; **greater engagement with many young people was reported by social workers as many (but not all) were more comfortable communicating remotely**. Considerable innovation was reported in supporting children in care and care leavers, such as online activities, food parcels and peer support.

Questions for further consideration for the safeguarding continuum

i. What is the best approach to the definition of 'vulnerable' children to ensure that all students of concern are offered the opportunity to attend school should schools close to the public again?
ii. What are the most effective strategies to improve the school attendance of children identified as 'vulnerable' during times of crisis?
iii. Should regulations around home-schooling be tightened in the aftermath of the pandemic?
iv. The pandemic has significantly increased the need for early help services while tending to reinforce a shift to statutory services in response to families in acute crisis. How can preventative and early help services be strengthened to support families in time of national crisis and keep pressure off statutory services?
v. How can innovations such as the repurposing of children's centres to support vital service delivery during periods of crisis be promoted and evaluated?

vi. What is the most appropriate role for online service delivery and remote communication in the context of safeguarding and child protection work?
vii. How do we measure and interpret changes in levels, severity and complexity of referral, including referral and re-referral to early help services, children's social care and for child protection medical examinations?
viii. What measures are required in the short, medium and long-term to support any significant surge in child protection cases?
ix. How can the mental health of children and young people in and out of school best be supported?
x. What can be learnt from differences in approaches to case management and the use of child protection plans where assessment is impeded by social distancing measures?
xi. What can be learnt from different approaches to building and maintaining relationships with vulnerable parents and supporting them remotely during proceedings and in the aftermath of an adverse decision?

2. Multi-agency working

2.1 Decision-making

Many participants across a range of areas and agencies described an initial vacuum of decision-making, resulting in a sense that 'everything stopped'. Agencies 'hunkered down' to address the immediate impact of lockdown on their own agency before inter-agency collaboration was re-established. Decisions were made by professionals on a case-by-case basis through discussion in the initial absence of general guidance. One Designated Nurse described joint working as 'reactive' and pointed to the need for far greater integration of health and social care services planning at a strategic as well as an operational level. **Strategic decisions were experienced by many participants as imposed on a 'top-down' basis, driven by a priority to protect the health and safety of service users and staff.** While some participants felt that a central command and control mode worked well in the circumstances, others felt that **a failure to involve all key stakeholders in decisions about services could lead to inadequate consideration of potential risks and long-term implications for safeguarding.**

2.2 Multi-agency working

Although multi-agency arrangements tended to be a focus only after agencies had managed their own immediate business, the general consensus was that thereafter interagency working was a significant focus of attention. A sense that 'Covid brought everyone together' was conveyed by many interviewees. A number of participants drew attention in particular to a strengthening of relationships between schools and local authorities. **A particularly valuable exercise appeared to be joint planning ('coordinated eyes') for monitoring of all children deemed to be highly vulnerable** and in some areas this included mental health leads. **A concern for the future arose from the withdrawal of many collocated roles,** either as a result of redeployment or from the shift to remote working. However, strengthened multi-agency working was thought to be more likely to be evident at strategic level and was thought not always to be experienced by front-line professionals.

2.3 Operation of Safeguarding Partnerships

There is little available information as yet about how the new partnership arrangements are working but it appears from our study that there is a wide variation in the extent of changes made locally in response to the new requirements. **The pandemic was felt to have accelerated the process of embedding the new arrangements and encouraging closer working between the partners.** However, while some participants felt that a smaller executive body was beneficial to decision-making, some expressed that social care sometimes acted unilaterally, and others felt that the **framing of the partnership in national guidance was problematic in light of the key role played by schools during lockdown**, and some areas had already included school representation on their executive board. A few similar comments were made about representation by mental health. There was also commentary as to the need for greater involvement by the partnership in operational matters and the significance of the new independent scrutineer role in that regard. In the London context, where health services were described as fragmented, the complexity of the structure of health provision and the importance of health providers' engagement in the Safeguarding Partnership was

also highlighted**. Interviewees lamented that Safeguarding Partnerships had no influence over some key decisions affecting safeguarding in their areas**, such as: the NHS England guidance to redeploy safeguarding professionals (named and designated); organisational decisions to redeploy health visitors and school nurses; and local authorities' decisions to close children's centres. Decisions made unilaterally by different acute trusts, for example in terms of when midwifery services would stop visiting, or who would be redeployed, indicated an initial gap in organisational thinking relating to safeguarding that could have been ameliorated by a more active engagement of provider leads within a safeguarding board, and by working closely with the designated leads in the partnership.

Across London, Safeguarding Partnership participants indicated that significant thought was being given to potential scenarios that might arise and ensuring that resources are available as required. **Suggestions for the future included compilation of reports on the impact of Covid-19 on their communities across partners, to plan for any further needs and risks that arise; mapping out groups that may be most vulnerable; and supporting knowledge exchange to discuss the implications of remote and online working.**

Questions for further consideration for multi-agency working

i. What common patterns in gaps or weaknesses in multi-agency working during the pandemic can be identified and targeted in order to 'future proof' the system?
ii. How can Safeguarding Partnerships build on activities developed during the pandemic to further promote and support multi-agency communication and collaboration?
iii. What is the appropriate role of Safeguarding Partnerships in identifying and responding to new patterns of risk across and between agencies?
iv. Safeguarding Partnerships can play a valuable role in understanding and mitigation of the impact of measures in one agency on other agencies: how can membership and structures at local level take this into account, particularly in relation to education, mental health and health providers?
v. What should be the role of Safeguarding Partnerships in establishing the strategic local area response in advance of future crises and how can the tripartite format be used to lever engagement to prioritise safeguarding from the 3 agencies?

3. Professional practice

3.1 Risk and vulnerability

Revised risk assessment of cases known to services took place in almost all agencies. RAG (red-amber-green) rating of risk was carried out by social care in accordance with guidance from the Principal Social Worker (Buzzi and Megele, 2020). In some cases, all children known to services in the preceding two years were reassessed and some areas included early help cases. Adult mental health services identified the highest risk Domestic Violence and Abuse (DVA) victims and perpetrators on their caseload and put additional psychological support in place for both. **Discussions took place both uni-professionally and in a number of boroughs on an interagency basis,** including social care, education, police and health, either through existing meetings or 'new' meetings, platforms or groups that were specifically convened in response to COVID-19, and also tracked community risk. When other agencies such as CAMHS were involved, this took some time to get off the ground, but these arrangements proliferated as social care and the multiagency team realised the benefits of robust information-sharing, particularly with some increasing complexity of cases. In order to address issues relating to information sharing as a result of likely changes in the level of risk pertaining to individual cases, one area extended the work of the Multi Agency Strategic Hub (MASH) in order to discuss the needs of vulnerable children not under statutory services but where there were concerns. **Where RAG Rating was undertaken at Safeguarding Partnership level, the exercise was complex but regarded as valuable, while concerns were expressed that the absence of a single shared list of vulnerable children between agencies led to problems of not knowing who was monitoring or supporting the most vulnerable children.**

3.2 Redeployment

Healthcare services throughout England structured their provision to respond to the influx of adult Covid-19 patients, resulting in widespread redeployment of health professionals (Adams, 2020; Conti and Dow, 2020; Evans, 2020, Institute of Health Visiting (IHV), 2020). In our study, participants reported significant redeployment of Health Visitors, School Nurses, Community Paediatricians, Acute Paediatricians, Child and Adolescent Mental Health Practitioners, Mental Health Nurses, Midwives and other health providers, usually to acute adult health care roles, and some triage settings. **Strategic health Safeguarding leads (Designated Nurses and Doctors), as well as Named Doctors, Named Nurses, Adult and Child Safeguarding Advisors (including general, midwifery, community and mental health nursing) and Looked After Children (LAC) Nurses, were often described as being redeployed**. **Safeguarding GPs were often absorbed into increased practice workload.** Although the decision was made in two boroughs by the Designated professionals themselves, in most boroughs, redeployment of the safeguarding leadership (including Designated Nurses) was directed from above. **It was found to have a negative impact on supervision, communication, workload, and oversight and training and felt to indicate inadequate regard for safeguarding.** Other agencies also arranged redeployment of staff, for example from early help into statutory services in CSC. Police reported no redeployment for safeguarding officers but some movement of other officers to cover anticipated changes in patterns of need, for example relating to domestic abuse. Patterns of redeployment, changes to practice and reversion of roles were different in every area and merit evaluation to inform

better advance planning in the future. **Notably, different decisions have been made about redeployment during the second lockdown period, suggesting that some of this evaluation is under way.**

3.3 Communication and engagement with children and families

A child-centred systems approach recognises the importance of seeing children alone and within their family setting in order to understand the child's perspective and experiences as well as family relationships and dynamics. Direct engagement with children and families also allows practitioners to build constructive, trusting and positive reciprocal relationships (Munro, 2011; Nicolas, 2015; Sidebotham et al., 2016; HM Government, 2018). Established ways of working to promote these practices were instantly overthrown under lockdown, generating concern about the lack of 'eyes on children'.

Direct access to children and families was significantly reduced for all safeguarding professionals and agencies with the exception of the police and practice nurses that had been advised to continue immunisation programmes. Some services resumed some in-person provision, particularly from when the lockdown restrictions eased from June 2020, but much continued at a distance and is now anticipated to remain this way until at least Spring 2021. While participants recognised that agencies were faced with unprecedented social distancing restrictions and concerns about the spread of the virus from person to person, **many remained critical of the blanket rapid removal of face-to-face contact with children and families and the reluctance of some agencies and professionals to reintegrate some face-to-face provision. There were many concerns about picking up safeguarding issues and non-verbal cues remotely and ascertaining whether others were in the room with children or parents** (see also Baginsky & Manthorpe, 2020; Ferguson et al., 2020; Talbot, 2020). There was also the concern that the pandemic could be used as an excuse not to engage directly with professionals. Of particular concern was the drawing back by health visiting from face-to-face contact with mothers of newborn babies. It is encouraging that current guidance expects social workers to make face-to-face visits to families wherever possible, following assessment of risk in each case (Department for Education, 2020).

Online conferences and meetings are tiring, and were not always felt to be in a family's best interest. **Building trust and rapport and ensuring the child's voice is heard is harder remotely and concerns were expressed that families could feel unsupported at a distance** (particularly in the context of court proceedings) or struggle with technology. **Digital exclusion was highlighted as a prominent challenge,** with many children and families unable to access reliable internet and suitable devices. Those with additional communication or learning needs were also felt to be often disadvantaged by online communication. However, participants also pointed to increased frequency of contacts and proactive communication with young people by social workers, teachers and CAMHS. **Many reported improved communication with some families and young people** where communication was found to be less stigmatising and more supportive in the context of the pandemic (see also Ferguson et al., 2020) and for those who engaged better remotely, including some young people in care. **Online engagement was felt to be particularly successful for maintaining relationships and 'checking-in' with children and families.** Some online direct services such as online counselling was also often described as possible and helpful for children and families, while building new relationships,

assessing risk and managing risk was thought to be more problematic at a distance and online.

3.4 Workforce capacity and wellbeing

For many, particularly young professionals in social care and the police previously undertaking lengthy commutes, the challenges presented by a dramatically increased workload coupled with parenting or family responsibilities were felt to be offset to a considerable degree by the advantages of home working arrangements. There was less sick leave than anticipated and actual staffing levels remained high in all agencies, although some concurrently described high levels of stress and anxiety (for example, staff returning to school or where the team had experienced sickness and/or bereavement). Recruitment and resourcing for new staff was a priority, particularly in social care, where recruitment and staff retention are expected to remain an ongoing challenge.

Participants from all professional groups talked about exhaustion from dealing with backlogs, covering gaps in the workforce and not taking leave. Delayed cases, poor remote administration arrangements, technical carriers and higher caseloads particularly contributed to excessive workloads among lawyers. Back-to-back online meetings were also extremely tiring for staff who at times felt under more scrutiny working at home (in one case being required to submit hourly work returns). **There was also a recognition of the impact of Covid-19 on staff health, mental health, family life, financial stability and caring responsibilities, and the unavoidable impact of this on professional lives.**

Gaps in the usual informal support were felt keenly, and supervision sessions were in general well attended although in some areas these decreased in number or stopped. A number of lawyers noted that the circumstances of the pandemic had resulted in some poor or unresponsive social work practice with a disconnect between social workers and their managers due to poor supervision and communication. **Participants nonetheless described many peer support initiatives, both structured and intentionally set up and organically developing.** Several participants reported that they could access online mental health support, others noted the importance of their managers talking with staff individually or in groups to support and build resilience, and a psychological hub for staff was described in one CAMHS. National networks such as the National Network for Designated Health Professionals (NNDHP) were described as being particularly helpful. **A need for further mental health training and support for social work staff, including for bereavement, was identified.**

3.5 Safeguarding related training

Training predominantly stopped initially, and not all agencies or organisations recovered a training programme during the first lockdown period of March–July. **Capacity to move immediately to online training varied significantly across organisations and agencies**. **Many practical and technological challenges were encountered, and some felt that online training was ill-designed for safeguarding training, which usually drew on more dynamic and discussion-based methods**. Here again professional bodies such as NNDHP and the Family Law Bar Association provided valuable input for upskilling in remote platforms and sharing good practice. **Participants identified a range of urgent training needs in addition to**

upskilling to make the most of technological tools, including: training on remote work with children and families; expanding the base for basic safeguarding training (e.g. to community Covid volunteers); ensuring frontline professionals such as police officers were alert to heightened safeguarding risks such as domestic abuse; training to support bereavement and provide psychological support to children and families; and training to identify and respond staff well-being concerns. **There were gaps in uptake of child safeguarding training relating to some adult services and an impact from redeployment of safeguarding leads in health who normally ran safeguarding training and supervision.**

3.6 Guidance and regulation

Initial government guidance was widely regarded as reactive and too slow, reflecting a wider concern that safeguarding was not a focus for the government at the outset of the pandemic and that the government was inadequately prepared. **It was considered to have improved over time, however, and some commented that it was proportionate, although the pace of change of guidance and inadequate time to implement it were problematic for some, particularly in education.** Health professionals perhaps expressed most dissatisfaction about guidance as it related to safeguarding, which was felt to have suffered as a result of the primary focus being on adults and the management of the acute infection within health settings. **Some concerns were expressed that the perceived status of the guidance inhibited local adaptations** and in particular some trusts used it to discourage face-to-face work in cases where practitioners considered it essential (such as new baby visits). The central Covid-19 advice to 'stay at home' conflicted with efforts to encourage children deemed to be vulnerable to attend school and guidance from courts and CAFCASS about visits to child clients was also experienced as contradictory and unhelpful. The discretion given to schools and social care in determining which children should be defined as vulnerable for the purposes of school attendance allowed for interpretation to suit schools' circumstances but was variously construed. This issue will become clearer with the publication of serious case reviews/learning reviews, but mixed views were expressed as to whether attendance requirements should have been stronger or possibly even mandatory. **Specialist guidance from professional representative bodies or local networks seemed to be most positively received**, including that from the Royal College of Paediatrics and Child Health and the President of the Family Division.

The government made provision for a range of relaxations to statutory regulations and timeframes during the initial months of the crisis. Most local authorities in our study appear to have considered that these were a useful tool in case of emergencies and particularly should staff capacity drop significantly. However, they reported employing them in only a limited way if necessary, primarily as a matter of principle, but they also cited concerns about judicial review. These appear to have been well-founded in light of the recent ruling of the Supreme Court that the relaxations pertaining to children in care were unlawful (R (on the application of Article 39) v Secretary of State for Education [2020]).

Questions for further consideration for professional practice

i. Practice during the pandemic has seen a new emphasis on different means of information sharing, such as shared risk assessments and greater development of shared secure IT platforms between agencies. Which of these means should be a focus to promote robust decision-making in future?
ii. Our findings indicate particular caution in the redeployment of safeguarding leads/experts and nursing staff supporting children and families: what should be the wider approach in relation to health and mental health staff with frontline children and families responsibilities and safeguarding leads across all agencies?
iii. What further guidance is needed to support assessment of which families need face-to-face meetings and support; how face-to-face contact should be operationalised; and how to ensure support and protection where contact continues remotely?
iv. How can supervision and peer support be reimagined in the light of a long-term shift to increased use of remote working practices?
v. Training needs to be available online for ready access in any crises. Our findings suggest that it should in addition to upskilling to ensure broad technological competence across the workforce, there needs expanding the practitioner base with required safeguarding training, and particular upskilling in the identification of domestic violence; and responding to trauma and psychological vulnerability. To what extent are these areas of concern shared across other areas of England and across agencies?

4. Changing patterns in safeguarding concerns

4.1 Unseen children

The implementation of lockdown measures and the negative implications of the pandemic (including financial distress, job loss, lack of social networks and peer-to-peer support) have been described as creating ideal conditions, or the 'perfect storm' for 'under the radar' child abuse and neglect to thrive and impact the lives of children previously unknown to CSC in addition to those already known to services (Adams, 2020, p.4; Romanou and Belton, 2020). **Our study revealed unanimous concern about children and parents no longer being seen routinely by universal health services, schools and other services, from maternity care through to the transition into adulthood.** Access to Emergency Departments (Lynn et al., 2020) and GPs reduced dramatically during lockdown, as well as to specialist health services such as CAMHS and Paediatric care, thereby reducing the opportunities for professionals to identify significant risks and needs, and to provide early help. **There was concern about economic deprivation and increased inequalities in the population that would impact on children's lives and safety. It was anticipated (and evidenced by some) that 'new' children have become vulnerable through this pandemic**, as levels of vulnerability are thought to have increased among all groups of children. Safeguarding those already known took priority, through the RAG rating exercise (above at 2.1). **Participants highlighted the challenges in, and a corresponding lack of effective initiatives for, identifying children at risk <u>not already known</u> to professionals, often describing this as their biggest and most concerning challenge.** Despite expectation by the police, in particular, that online abuse is likely to have risen (in line with the NSPCC's (2020) report of a 60 per cent increase in calls to their helpline reporting concerns about children experiencing online sexual abuse during lockdown), increased communication about online safety did not translate into increased reports according to our participants. **At least one area educated 'lock down' volunteers to pick up families under stress, and some advertised access routes to advice about housing, poverty, unemployment and wellbeing.** Domestic abuse initiatives are reported below.

4.2 Babies

Many thousands of babies were born during lockdown. Saunders & Hogg (2020) note that whilst some mothers describe positives of a partner being home, and less stress with fewer visitors, overall it was felt that babies and their parents experienced increased stress. **Our participants described insufficient face-to-face assessment and some inadequate support for new mothers, although this shifted over time in some areas** to more consistent handover to community teams, with increased face-to-face visits and weighing of babies in clinics. Maternity services identified increased safeguarding concerns in a number of areas, with post-natal depression and lack of support networks being frequently mentioned. **Of benefit was some increase in disclosures relating to domestic abuse when the partner could not be present.** Although not a universal contact, Practice Nurses were the professionals seeing most mothers and babies face-to-face, as they attended for routine immunisations.

4.3 Domestic abuse

Calls by adults to the NSPCC helpline concerned about the risk to children from domestic abuse increased by a third during lockdown (NSPCC, 2020a), while the London Metropolitan Police (the Met Police) received 11% more calls about domestic abuse during the first lockdown compared with the same period in 2019 (Ivandic & Kirchmaier, 2020). **A London-wide initiative to combat domestic abuse was led by the Met Police.** In addition to national helplines, participants described initiatives that included: continuation of Operation Encompass (police alerts to schools on incidents affecting children) during the summer holidays, which was observed to be effective at picking up children who had not come to attention previously; more frequent Multi-Agency Risk Assessment Conference (MARAC) meetings, with daily high harm review mechanisms to support swift referral into services; use of neighbourhood teams to raise awareness of domestic abuse and highlight available services; and police engagement with serial / high risk domestic violence perpetrators. **Agencies reported ensuring that all colleagues were briefed on risk factors and signposting to services such as temporary refuges, independent domestic violence advocacy and interventions by adult mental health teams. Advice was provided on remote interviewing to elicit disclosure.** However, not all services were asking about domestic abuse routinely. Some midwives saw more DA disclosure at booking appointments where women were seen alone as a result of Covid-19 social distancing restrictions. Some local authorities undertook early help work for lower risk Merlin referrals from police, supported by proactive monitoring including 'door-step' visits. Previously unknown families who came to attention were observed to be likely to include an aggressive, dominant male figure who would not normally spend so much time at home. Some adult mental health services identified the highest risk violence victims and perpetrators on their caseload and put additional psychological support in place for both. Legal aid amendments making it easier for parents to apply for legal aid for non-molestation injunctions against a violent partner were regarded as very valuable.

4.4 Mental Health

Social restrictions in response to pandemics, including Covid-19, are associated with increased mental distress and exacerbation of existing mental health conditions amongst young people (Gayer-Anderson et al., 2020). **Increasingly complex presentations of adults with mental health difficulties in child protection cases were noted by several participants and accord with population findings** (PHE, 2020). A number of adult mental health teams were only just appointing safeguarding leads and completing child safeguarding training. **Child and adolescent mental health concerns related to the increased complexity of some safeguarding referrals**, and particular concern for children out of school and child carers. The nature of service provision also changed significantly with children's wards and hospital schools closing, and restrictions on visitors. Difficulties were encountered in placing children attending Emergency Departments where the mental health threshold was not met, no appropriate social care placements were available, and families could not take the child back. **Community, online and helpline provision was established where not previously evident**, including through diversion of educational psychologists, institution of 24/7 crisis lines and video resources for schools, parents and children. Broader initiatives to support families' well-being over the summer months included making use of facilities that

had been closed to public use, such as adventure playgrounds or special schools' outdoor spaces.

4.5 Youth violence and youth justice

Criminal exploitation had become a priority focus before lockdown for many London authorities struggling to get to grips with gangs, knife crime and County Lines activity. **Participants related apparent changes in patterns of youth violence and criminal activity, with an initial reduction in missing children and referrals relating to child sexual exploitation and criminal exploitation, including gang-related activity and County Lines.** Early in the pandemic, an obvious lack of young people on the streets was often referred to. Some participants expressed optimism that lockdown had enabled some children who had been constantly missing to settle in foster care and that some victims of child sexual exploitation might be able to break the contacts and patterns of behaviour during lockdown. However, as lockdown eased, sexual offences against adults and children in public places began to rise and County Lines activity picked up again. Participants also described changed forms and patterns of exploitation and gang-related activity, often using online mechanisms. **The police continued community work, including with gangs, and reported concerns that younger children may have started to be involved in child criminal exploitation.**

Young people in the youth justice system experienced delays in decisions, resulting in some cases in longer detention in custody. Access to young people in the secure estate was highly restricted during lockdown, leading to significant concerns about their wellbeing.

4.6 Children with disabilities and neurodevelopmental conditions

Pressure increased on the families of some children with disabilities where institutions closed, leading to concerns about carers' mental health. Other institutions did not permit outside visitors, meaning that children and families were separated for significant periods of time. A few areas still offered short breaks, but many parents were resistant to children attending school or respite. **Some play areas and outdoor spaces were offered for booking by families with special needs children and other support included virtual coffee mornings. This relied on the availability of 'Covid-safe' spaces and significant encouragement or reassurance by professionals to access these spaces.**

Lockdown had an adverse impact on parenting children with neurodevelopmental conditions. Access to a significant number of services was lost to these children and families during the first lockdown, and some have not yet been re-established. Assessments were suspended and waiting lists have increased steadily, leaving carers without advice on behaviour management during lengthy confinements, in some cases alongside home working. Online assessment is being trialled for some conditions, including autism.

Questions for further consideration for changing patterns in safeguarding concerns

i. Babies have been identified as a population of particular concern under the conditions imposed as a result of the pandemic. What measures and/or guidance (such as for review, weighing, and view of sleeping arrangements) should be implemented to ensure high risk contexts to babies are picked up as early as possible?
ii. Given their role in immunisation, how can the role of practice nurses in safeguarding be supported and enhanced to ensure competence in identifying domestic abuse and risk?
iii. How can we ensure that all practitioners/professionals are competent to screen for domestic abuse routinely, including during online communication?
iv. Should expectant mothers be offered at least one routine appointment during pregnancy in the absence of their partner?
v. Should legal aid amendments making it easier for parents to apply for legal aid for non-molestation injunctions against a violent partner be continued?
vi. Changes in patterns and models of contextual harm have emerged in response to changing conditions under the pandemic. How can these be addressed in order to support young people to disengage from exploitation and/or abusive relationships?
vii. Should the use of statutory processes for safeguarding be strengthened where there is contextual harm and for young people in the youth justice system?
viii. How can the safety of children in care who have returned to their familial home be assured?
ix. How can contact with their families be assessed, facilitated and supported for children living away from home in the context of face-to-face restrictions?

Conclusions

The first stage of this study, reported here and carried out in the summer months of the COVID-19 pandemic, is unique in interviewing a breadth of different professional child safeguarding leaders from across London. This approach has enabled collation of the range of single agency and multi-professional responses from different boroughs, that aimed to prevent, address and alleviate harm to children in unprecedented circumstances. It is recognized that difficult decisions were made in emergency conditions and circumstances varied across localities and services. This report does not seek to needlessly criticize in any way and indeed should stand primarily as testament to the extraordinary commitment, resilience and creativity exhibited by members of all disciplines engaged in child safeguarding. **However, it is apparent that the speed at which lockdown was imposed exposed some inadequacies in contingency plans and poor resilience, despite the fact that no agencies reported significant reductions in overall staff capacity.**

Our participants expressed widespread concern that children were largely side-lined in the response to the pandemic, endorsing the report of the Children's Commissioner (2020). While government rhetoric in the summer stressed the reopening of schools in the autumn, the focus was on resuming education rather than responding to the needs of children emerging from lockdown. **Participants in our study pointed to the urgent need for the government to recognize the multi-faceted long-term harm to children that is the likely legacy of the pandemic, from reduced educational attainment and employment opportunities to increased mental ill-health and delayed disclosure of maltreatment.** Some felt that 'What would you have done normally?' should be a starting point for work with vulnerable children and families in recognition of the devastating effect of lockdown on children's safety and well-being.

The pandemic has both exposed and exacerbated inequalities, particularly digital poverty and gendered inequalities. An overarching government policy response is required that addresses preventative services and early help, including midwifery and health visiting, and that confronts the long-term implications for mental health services. Clear-sighted assessment of the right balance between infection control and safeguarding must inform policy and guidance at all levels and in all areas, including NHS England and legal processes, as well as clear and consistent public messaging. Consideration should be given – following appropriate consultation - to changes in social care legislation and guidance to make provision for digital visits and contact where appropriate and protect face-to-face provision where necessary.

In view of the numbers in each group, the study does not allow for detailed analysis of issues by profession but does allow for an informed view from the perspectives of all professional groups, to enable a picture of the complexity of the impact of the pandemic on safeguarding arrangements and the child protection system. **Stage II will allow for further investigation of emerging practice responses across England and understanding of the impact of the prolonged restrictions on the well-being and protection of children.** That phase will draw on the additional expertise of partner organisations and an expert reference group (listed below) to ensure the study is informed by a wide range of stakeholders.

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The next stage of this study will be carried out in collaboration with:
Partner organisations:
National Police Chief's Council, Vulnerability, Knowledge and Practice Programme (reporting through the cross-government Child Safeguarding Reform Delivery Board)
The Children's Society
The Association for Safeguarding Partners (TASP)
The Association of Child Protection Professionals (AoCPP)

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Appendix 1: Participant Sample Table - First Stage Interviews

Profession	Number interviewed	Detail
Children's Social Care	11	5 Directors of Children's Services 5 Assistant Directors 1 Conference Chair
Health	15	3 Designated Doctors 8 Designated Nurses 4 Named Doctors/nurses covering 9 boroughs & 3 acute trusts.
Mental Health	8	8 Mental Health Safeguarding Leads covering 14 boroughs
Police	8	6 Detective Superintendents 1 Detective Chief Inspector 1 Detective Inspector covering 19 boroughs.
Law	6	6 Children's panel lawyers
Education	10	5 Local Authority Directors of Education/Learning 1 Local Authority schools officer 4 Head Teachers with Safeguarding Partnership engagement covering 11 boroughs
Safeguarding Partnerships	9	8 Independent chairs/scrutineers 1 Safeguarding Partnership manager covering 10 boroughs

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