PROTECTING CHILDREN AT A DISTANCE

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

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List of Acronyms

CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CIN	Child in Need
CSC	Children's Social Care
CYP	Children and Young People
DCS	Director for Children's Services
DFE	Department for Education
DSL	Designated Safeguarding Lead
DVA	Domestic Violence and Abuse
EHCP	Education, Health and Care Plan
EHE	Elective Home Education
FLBA	Family Law Bar Association
IRO	Independent Reviewing Officer
LA	Local Authority
LAC	Looked After Children
LSCB	Local Safeguarding Children Board
MASH	Multi-Agency Strategic Hub
NHS	National Health Service
NNDHP	National Network for Designated Health Professionals
RAG	Red-Amber-Green (in relation to risk assessment rating)
SEND	Special Educational Needs and Disabilities
SP	Safeguarding Partnership
UASC	Unaccompanied Asylum-Seeking Children
UC	Universal Credit

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https://www.kcl.ac.uk/research/protecting-children-at-a-distance

Summary

1 – INTRODUCTION

This report presents key findings from 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 focused on safeguarding and protection practice, practitioner working and the multiagency response to the COVID-19 pandemic. Stage 1 comprised interviews with 67 safeguarding lead professionals in London: findings from these informed the construction and response options for the second stage survey. Stage 2 comprised a national survey of the same professional groups. Data was collected between 1st February and 8th March 2021 , at which time England was experiencing its third lockdown. The survey focused on the evolving concerns and response to the COVID-19 pandemic and lessons learnt from earlier lockdowns, in order to share emerging good practice and make recommendations on strengthening and 'future proofing' the safeguarding system in England. 417 responses from safeguarding leads from Health (155), Law (71), Education (56), Children's Social Care (52), Safeguarding Partnerships (34), Police (30) and Mental Health (19) were analysed. Some caution needs to be exercised in relation to the survey findings because of the balance of respondents both between and within groups and small numbers in parts of the survey where not all respondents were eligible to answer. This is taken into consideration in the report of the main findings from the survey stage summarised here.

Ethical approval for the study was granted by the King's College London Research Ethics Committee [LRS-19/20-19420]. Stage 1 was deemed a service evaluation by participating NHS organisations. The Health Research Agency (HRA) confirmed that NHS ethical approval was not needed for stage 2 on 13th January 2021. The study is funded by the *King's Together: Multi & Interdisciplinary Research Scheme* and the *Economic & Social Research Council Impact Acceleration Accounts Social Science Impact Fund.*

The summary report from stage 1 is available here:
https://www.kcl.ac.uk/ecs/assets/projects/protecting-children-at-a-distance-executive-summary-of-stage-1-findings.pdf

2 – MULTI-AGENCY WORKING

2-1 Interagency collaboration

Because the pandemic impacted at a time when many Safeguarding Partnerships were relatively new, we were interested in understanding how the new structures were affected and how Safeguarding Partnerships had managed their role under the pandemic. We took advantage of the opportunity to ask about how the shift from Local Safeguarding Children's

Boards (LSCBs) to Safeguarding Partnerships was perceived to have affected arrangements under the conditions imposed by the pandemic.

2.1 70% of respondents involved in the work of their local Safeguarding Partnership (n=293) agreed/agreed strongly that the shift to tripartite leadership had been achieved/maintained during the pandemic in their local area. Although some strongly worded qualitative comments suggest that the shift has not been a comfortable one in some areas, only 7.5% disagreed/disagreed strongly.

2.2 Nearly half of respondents (49%, n=279) were neutral as to whether the replacement of LSCBs with Safeguarding Partnerships improved inter-agency collaboration in their local area, seemingly in line with commentary around whether a new body was the right response to questions raised about the operation of LSCBs. But the remaining respondents were more than three times as likely to agree than disagree: 12% disagreed/strongly disagreed; and 39% agreed/strongly agreed. Police, Children's Social Care and Safeguarding Partnerships respondents were most likely to state that they agreed/strongly agreed.

2.3 56% of respondents (n=269) considered that the strength of working relationships amongst Safeguarding Partners and relevant agencies improved as a result of the adaptations introduced as a result of the pandemic (described in interviews as primarily more frequent regular meetings; proactive communication and sharing of data and information; a sense of a shared predicament; and less bureaucratic obstruction).

a. Education respondents were most likely to disagree (39%).
b. 67% (n=116) of respondents reported increased scrutiny of data and trends at Safeguarding Partnership level, with only four of the 72 respondents who commented on retention opposing retention.

2.4 Broader joint/collaborative working between individual agencies seems to have held up well overall, with agencies more likely to report improvement than deterioration in their joint working with other specific agencies, although with a more positive picture strategically than operationally, as we might expect.

a. Most agencies were most likely to report improvements rather than deterioration in joint working with Education, suggesting other professionals have found schools to have responded well to the challenges of the pandemic.
b. Consistently however, schools are less positive than other agencies about joint working with other agencies in their local area and many appear to feel excluded from information and not consulted adequately.
c. There was a particular mismatch between Education (schools) and Children's Social Care in that Children's Social Care tended to report that joint working with schools was more likely to have improved than deteriorated over the pandemic, but schools were much more likely to report deterioration of joint working with Children's Social Care than improvement.

2.5 There was strong support for some form of representation of some relevant agencies (schools, CAMHS, health providers and housing) on the Executive Boards of Safeguarding

Partnerships (notwithstanding the statutory accountability), likely reflecting concerns expressed in interviews around potential loss of the wider partnership with the shift to Safeguarding Partnerships and as to whether operational input was strong enough.

a. There was even stronger support for greater involvement of those agencies in the wider work of Safeguarding Partnerships – over 90% in all cases.
b. The responses suggest considerable strength of feeling about the importance of schools' engagement in local arrangements in particular, with 94% of 304 respondents agreeing that Education providers should be represented on the executive board and 98% supporting greater involvement in the wider work of Safeguarding Partnerships by Education providers.
c. We thought that the strength of feeling that we gleaned from the interviews as to the absence of the representation of health providers might be a problem particular to London where the health estate is particularly fragmented, but the survey results suggest it is a nationwide issue. The question arises as to what the implications might be of the transition to Integrated Care Systems under the Health and Social Care White Paper *Integrating Care.*

2.6 Although over half of respondents (n=253) reported single agency reassessments of risk (RAG rating), just under 20% reported a single shared assessment coordinated by the Safeguarding Partnership and the remainder reported some inter-agency collaboration.

a. Generally, the exercise was regarded as effective, and a joint agency approach appears to be perceived as more effective than single agency (close to significance: (asymptomatic significance (2-sided) .055).
b. Qualitative comments highlight concerns around children not known to services.

2.7 Significant proportions of respondents reported a range of adaptations described by our interview participants to support information sharing:

a. 33% (n=111) stated that the remit of the MASH or equivalent was widened to encompass consideration of more groups of children.
b. 70% (n=135) reported increased sharing of data and trends within local authority areas and increased scrutiny on data and trends at Safeguarding Partnership level.
c. 47% (n=101) described increased sharing of data/trends between local authority areas.
d. Those who introduced such changes were asked if they would retain them, and over 80% of the (smaller number) responding stated that they would.

2.8 There was strong support (98%, no agency under 94%) for introduction of a system to enable all agencies to share pre-agreed information relating to safeguarding children (n=280).

2.9 We asked how well the voice of the child could continue to be heard at strategic and individual level during the adaptations introduced during the pandemic. More respondents considered that the voice of the child was less readily heard than felt that it was more readily heard, but this was less pronounced at strategic level (47% less readily and 20% more readily) than individual level (59% less readily and 16% more readily). At individual level, Children's Social Care respondents were most optimistic by some way (30% less readily heard and 35% more readily heard). At strategic level,

Education was least optimistic by a pronounced margin (68% less readily heard compared with 3% more readily heard).

1. Ongoing evaluation as to the effectiveness of Safeguarding Partnerships in coordinating local areas' safeguarding children services and providing strategic leadership. In particular, consideration as to how best to ensure that all relevant agencies, including schools, health providers, and mental health providers, are fully engaged in the work of Safeguarding Partnerships in the light of the critical role played by schools during periods of lockdown and the forthcoming Integrated Care legislation.
2. Arrangements for multi-agency collaboration and cooperation for the protection of children become of heightened importance during periods of lockdown: robust safeguarding contingency plans should be prepared in advance of any future crises with full input from Safeguarding Partnerships, including in relation to redeployment of any staff with safeguarding responsibilities.
3. Consideration to building on some of the initiatives for joint risk assessments and enhanced scrutiny and/or sharing of data and trends to enhance risk management in the future. In particular, thought should be given to extension of the NHS Child Protection-Information Sharing Programme to a wider range of agencies.
4. Attention to processes and mechanisms through which hearing the voices of all children can be adequately assured in any future incidents in which universal services are closed, with attention to particular/special needs of children and families and barriers such as digital poverty.

2-2 Role of schools

2.10 87% of respondents (n=295) felt that attendance should be mandatory for all *primary school* vulnerable children in families with low clinical risk (health 92%).

2.11 85% of respondents (n=285) felt that attendance should be mandatory for all *secondary school* vulnerable children in families with low clinical risk (health 91%).

2.12 The most effective strategies to increase school attendance were thought to be:

a. encouragement from the Designated Safeguarding Lead or school staff known to the family (used by 97%, 83% thought effective to some extent/significantly).
b. using parental concerns about behaviour or schoolwork (use 91%, effective 68%).
c. encouragement from the family's social worker (use 87%, effective 64%).

2.13 78% (n=255) thought that the number of Elective Home Education students was rising significantly (42%) or slightly (36%) as a result of the pandemic.

2.14 80% (n=111) thought schools have taken on more responsibility for safeguarding as a result of the pandemic; over half who agreed felt that this enhanced role should be retained but to do so would require additional investment.

a. Schools were most likely to consider that it is not an appropriate role for schools or only appropriate in circumstances where most children are not attending school.

2.15 A wide range of strategies were employed to keep in touch with and support children and families where vulnerable children were not in school, including regular contact in termtime and (to a lesser extent) holidays; food parcels; IT provision; in-person/ doorstep visits; supply of books and games; follow-up of non-responsive families by Children's Social Care; and follow-up of non-responsive families by police liaison.

a. as suggested by interviewees, these appear to have been effective in improving relationships with families in many instances and these improvements have generally been sustained to date.

b. Police liaison was regarded as controversial by some interviewees but was used by 57% of survey respondents (n=72) and the same proportion intended to use again in future if required.

2.16 Varied and sometimes uncoordinated support for children's mental health and disclosure in/through schools was described. Learning from the pandemic may be of longer-term use as schools take on greater responsibility for work to support children's mental health.

Recommendations:

5. Concerted intervention by both education and safeguarding professionals to reengage 'vulnerable' children not attending school during the pandemic, to limit numbers of children who do not return to mainstream schooling.
6. Legislation to improve monitoring and regulation of Elective Home Education.
7. A review of the role of schools and school staff in safeguarding, including specialist provision within schools, staff training, and the appropriateness and burden of early help work, and monitoring and evaluation of recent investment in mental health support in schools.
8. Consideration of how to ensure that schools' knowledge of children and families is fully respected in multi-agency discussions and taken into consideration in individual safeguarding / child protection cases.

3 – PROFESSIONAL PRACTICE

3-1 Communication

One of the biggest impacts on professional practice has been the social distancing measures put in place to control the pandemic, which have significantly reduced the in-person contact between universal, early help and specialist safeguarding practitioners and children and families. The decisions made about how to engage with children and families through the pandemic have therefore been critical and shifting.

3.1 In the first lockdown 52% of respondents said that in-person work was generally reserved for cases that were assessed as high risk or where the risk was uncertain, with only 22% of respondents indicating they adopted a 'why not in-person'

approach. However, through subsequent lockdowns the 'why not in-person approach' was used more (rising to 39%) and reserving in-person contact for high risk or uncertain 'cases' reduced slightly to 35%.

a. Some differences were seen by agency in the overall approach to communication and engagement with children and families. The Police predominantly adopted a 'why not in-person approach' through both the first and subsequent lockdowns while Mental Health and Law predominantly adopted an approach which reserved in-person work to the high risk or unknown cases through both the first and subsequent lockdowns.

3.2 While the majority thought that use of these communication methods through the course of the pandemic (in-person, Video-link or Telephone) has been about right (73%; 77%; 76%), 26% of respondents said that they felt in-person communication should have been used more, and 21% of respondents said that they felt telephone communication should have been used less.

3.3 Overall, it appears that the initial caution regarding in-person communication seen in the first lockdown reduced in subsequent lockdowns with a move towards more in-person contact as much as possible within the restrictions.

3.4 Overwhelmingly respondents indicated that many children and families had difficulties in accessing all critical IT resources needed for effective online communication. Particular difficulties were identified for many professionals in accessing fast internet connection and in their ability to use technology (i.e. digital literacy).

3.5 There was consensus regarding the common concerns about remote communication we listed, with 97% concerned about not being able to use all senses to pick up non-verbal cues, 95% concerned about not knowing who else is in the room, 93% concerned about who remote communication excludes, 85% concerned about the risk of misunderstandings, 84% concerned about the impact on relationship building/rapport and 80% concerned about lack of warmth/felt support in communication.

3.6 There was less consensus on some of the benefits of remote communication, with large proportions of respondents (32%-53%) neither agreeing nor disagreeing with potential benefits (such as reducing feelings of stigma for parents/carers; easier to clarify roles; parents /carers feeling less intimidated; children feeling more able to contribute; avoids parents/carers being in the same room). The highest levels of agreement with these benefits were: 58% of respondents agreed that a benefit to remote communication was avoiding carers/parents having to be in the same room, and 44% agreed that children may feel more able to contribute. Conversely almost half of respondents (48%) did not agree that it was easier to ensure clarity of identity and roles of respondents online (and only 17% agreed with this).

3.7 Overall, there appears to be a high level of ambivalence regarding online communication, its use, its suitability for safeguarding work and its role in future safeguarding practice. There is clearly a high level of concern about access to online forms of communication, the impact of online communication on relationship building and

on skills needed for assessment. However, when respondents were asked about their experiences of specific statutory processes that had been held remotely (such as MASH; Strategy/section 47 meetings/discussions; Child protection case conferences; Core group meetings; Emergency Court Hearings; Case Management Hearings; Final Hearings and Looked After Children reviews) most respondents felt that these statutory processes and meetings were better attended and remote access was a more efficient use of time (the inevitable exception here being Remote Final hearings). Most respondents also did not agree that meetings and processes happening remotely were disliked by parents/carers and by children/young people (except for Final Hearings and Remote Core Group meetings). However, as the earlier questions related to IT access have shown, the majority of respondents believed that most of these remote statutory processes/meetings were difficult to access for some parents and carers, and also sometimes, although less so, for practitioners. Respondents saw the value and the challenges of remote communication, thus requiring a nuanced way forward rather than a blanket approach to its use, such as more frequent use for meetings between practitioners and check-ins with children and families, with in-person communication remaining an essential part of the safeguarding process.

3.8 This high level of ambivalence is also seen through a question we asked in relation to each of the remote statutory processes/meetings, which was whether the advantages of holding these processes/meetings remotely outweighed the disadvantages. While in most cases the majority of respondents felt that the advantages were NOT outweighed by the disadvantages, there was a significant minority (approx. 40%) who DID feel the disadvantages outweighed any advantages (with the exception of Final Hearings).

3.9 We asked respondents how these various statutory processes/meetings should be held in the future, and the majority indicated that they should allow for both in-person attendance and remote attendance at the same time. The exceptions were Final Hearings, which the majority of respondents felt should return to in-person attendance, and Case Management Hearings, which the majority felt should remain remote.

3.10 However, while a large proportion of respondents said that they would like many statutory processes/meetings to be held in a format allowing both online and in-person engagement at the same time, it is unclear exactly how many respondents have had experience of this mode of working. For example, the majority said that child protection case conferences had been held online across most of the time from March 2020 until early 2021. The use of a Hybrid approach for case conferences appears to be relatively limited (approximately 15-20%, although this increases a little between lockdowns).

3.11 While we asked about the experiences of remote communication and preferences of parents/carers and children/young people in the approaches used (i.e. in-person, Video-link, telephone etc) we have poorer responses rates for these questions. It is clear though that the preference of children and families did not usually shape which mode of engagement is used. This indicates the need for further research on the experiences

of children and families of remote communication, particularly when considering the use of hybrid models for the foreseeable future.

3.12 There were some differences seen in the experience and attitudes towards online communication with respondents from Education being consistently more likely than other agencies to indicate that they find remote communication problematic and they advocate more strongly for a return to in-person engagement.

Recommendations:

9. Continued investment in ensuring vulnerable children and families have access to online services, resources and information, as well as being able to engage through video-link with practitioners. Investment is needed not only in hardware and software, but also in increasing connectivity and equipping vulnerable children and families with IT information and IT support.
10. Continued investment to ensure that practitioners are fully able to engage with vulnerable children and families and carry out their safeguarding duties safely at a distance, with particular attention to increased connectivity for practitioners and increased digital literacy and IT support.
11. Clear evidence-based guidance for practitioners to identify when in-person engagement needs to happen and when digital contact is appropriate or preferable. Guidance needs to take into account both the experiences of practitioners and vulnerable children and families, with attention to the 'why not in-person approach' that has increasingly been used as the pandemic has progressed.
12. When digital communication is used as part of child protection practice, regular reviews of how this medium is being used must be enacted to reduce the risks associated with this form of communication for child protection purposes.
13. Investment in child-friendly and 'safe' technology to aid safeguarding work by all actors, such as the development of apps or social media sites that support protection work.
14. Investment in creating the possibility for more meetings between professionals, including those that involve vulnerable children and families, which enable people to attend online and in-person at the same time (a 'hybrid' approach). This includes making the necessary technology, space and technical knowledge widely available; taking into account the experiences of professionals and children and families; and the development of practice guidelines to enhance use of this hybrid approach.
15. Conversations with vulnerable children and families about their preferred method of communication need to occur as a routine aspect of practice.

3-2 Redeployment

3.13 In follow up to the interview data, which raised several concerns about the nature and impact of redeployment, predominantly of health professionals, on safeguarding, we asked respondents to what extent they agreed with the redeployment of specific professional groups. The strength of feeling regarding the appropriateness of the

redeployment of key universal and safeguarding health professions is clear from the data. Less than 10% of respondents disagreed with statements that various staff should not be redeployed, and at least 80% or more of the respondents agreed with the statements about various staff not being redeployed.

3.14 The only statement which had less support was in relation to whether the redeployment of universal health staff should have been agreed by Safeguarding Partnerships, whereas much more support is given to plans for redeployment of universal staff being made in conjunction with safeguarding leadership in that organisation and also that the redeployment of safeguarding lead staff should have been agreed by Safeguarding Partnerships. Overall, it is clear that respondents did not generally agree with the redeployment of universal and specialist health professionals that are key to child safeguarding (such as midwives/Health Visitors/Designated or Named professionals). It is also clear that more involvement in the decision-making around redeployment from safeguarding leads or Safeguarding Partnerships was wanted.

Recommendations:

16. Future decisions around redeployment of a. **health professionals with safeguarding responsibility** and b. **health professionals who are critical for the early identification of safeguarding concerns** (such as midwives and health visitors) should be undertaken in consultation with both safeguarding leadership within health and Safeguarding Partnerships.

3-4 Workforce capacity and wellbeing

3.15 Our data shows the huge impact of the pandemic on staff wellbeing across all seven agencies included, with the majority of respondents stating that practitioners with responsibility for safeguarding/child protection in their agency had faced increased caring responsibilities, reduced staff and practitioners in their team/organisations, increased workloads, loneliness, mental health concerns, and illness. Bereavement, poor conditions when working from home, and inadequate resources to do their job were also noted by a significant minority. Economic hardships and housing precarity appear to have affected safeguarding/child protection staff the least.

3.16 Some small increases in workloads, loneliness, staff mental health concerns, reduced practitioners, staff illness, bereavement, and economic hardship can be seen between the first lockdown and the third lockdown (in early 2021 when the survey was distributed). Some small decreases in increased caring responsibilities (probably because more school places were accessed for critical workers in the third lockdown), poor working from home environment, inadequate access to resources do their job and redeployment can be seen between the first lockdown and the third lockdown (in early 2021 when the survey was distributed).

3.17 It is not surprising then that over the course of the pandemic (i.e. since the end of March 2020 through to early March 2021, when the survey closed) 29% of respondents

said that the wellbeing of safeguarding professionals in their organisation had decreased significantly, 46% said that it had decreased slightly, 18% said that it had stayed the same, 7% said that it had improved slightly and 1% said that it had improved significantly overall. Education, Law and Safeguarding Partnerships were more likely to state that wellbeing had decreased significantly, and Mental Health were more likely to say that wellbeing had stayed the same.

3.18 Various strategies were employed to support different aspects of staff wellbeing, the majority of which were rated as quite or very effective, particularly regular individual supervision, regular contact with manager, ensuring opportunities for informal peer support and regular group supervision. The two strategies which did not seem to be as effective as the others were accessing mental health support/counselling and decreased length of online meetings to allows for breaks – although we do not have any further data to indicate whether the strategies were ineffective because they were difficult to employ or because they were ineffective even when employed well. Respondents indicated that a limited number of strategies were used to address increased safeguarding/child protection work, the top two strategies being increased scope and/or delivery of training and revised rotas.

Recommendations:

17. Recognition of the critical role that safeguarding practitioners from all agencies have played in keeping children and young people safe during the pandemic needs to happen at the highest levels in government.

18. Professional wellbeing must be prioritised in workforce planning decisions made over the coming year: critical areas of staff wellbeing that need urgent attention include the balance of work with increased caring responsibilities, increased workloads, loneliness, poor mental health, staff illness and bereavement.

19. Further investment in strategies to increase practitioner wellbeing, including regular individual supervision and contact with managers; regular opportunities created for informal peer support (including both in-person and online spaces); regular group supervision and discussion; and active management of leave.

3-5 Safeguarding related training

3.19 Four aspects of training were identified by over half of all respondents as in the top five training priorities for all relevant professionals as a result of the pandemic: Impact of the pandemic on the mental health of children; Remote safeguarding/protection of children; Child protection during a pandemic and Domestic violence.

3.20 Unsurprisingly, the pandemic has had a huge impact on how safeguarding training is delivered, with only 3% being delivered online before the pandemic, while respondents reported that 86% of safeguarding training was currently online in early 2021 (figure

3.23). Online only and mixed methods were anticipated for the foreseeable future. However, when asked how safeguarding training is best carried out, only 2% of respondents said that it was best carried out online, with the majority stating in a mixed mode (63%) and a significant minority (33%) stating in-person.

Recommendations:

20. Further investment in training programmes which combine in-person and online modes, or which allow both in-person and online engagement at the same time. Despite safeguarding training largely being carried out online throughout the pandemic, participants clearly indicated that safeguarding training is best carried out with all (or some) in-person elements and not all online. Immediate training priorities include the impact of the pandemic on the mental health of children; remote safeguarding protection of children; child protection during a pandemic; and domestic violence.

4 – SERVICE PROVISION

4-1 Complexity & severity of cases

4.1 Most respondents from all agencies considered that referrals had increased in both severity (84%, n=238) and complexity (88%, n=240) since the onset of the pandemic in line with some national data.

4.2 Most respondents including 16 of the 30 Children's Social Care respondents stated that children in their areas were on plans for longer during the first lockdown, reduced to 13/30 in subsequent lockdowns. Meaningful work was said to be difficult at a distance. Some areas used temporary plans in order not to disadvantage families.

Recommendations:

21. Recognise that services need to spend sufficient time on assessments, with dedicated time for analysis and professional supervision.
22. Multiagency discussion is crucial: services need to be configured in such a way as to ensure availability of appropriately trained staff for strategy and other case discussions, and that robust interagency pathways are in place.
23. Upskill the workforce in identifying and signposting when there are mental health difficulties as well as at-risk settings and behaviours.
24. Ensure that there is a 'think safeguarding' as well as a 'think family approach' to vulnerability and need.

4-2 Early help /early intervention

4.3 172/193 (89%) noted increased Early Help needs locally, and the perception of this was similar across the agencies. It is therefore a concern that 60/153 (39%) said that Early Help services were cut in favour of statutory services. This was only the case for 3/28 (10%) Children's Social Care respondents and 4/15 (27%) of Safeguarding Partnerships respondents, but particularly noted by Education 14/22 (64%).

4.4 A few respondents (15%) reported *lower* thresholds for Early Help (n=144) while a similar proportion reported *raised* thresholds for Early Help (n=133): any increased threshold would be of concern given the reported increased need for Early Help.

4.5 118/173 (68%) said that there was more onus on families to take the initiative to contact services for early help. This is particularly a concern given the vulnerability of families that may have language, learning or mental health difficulties and would find it harder to access services. In particular, Education and Health (80%, 95/119) reported that families needed to take more initiative to contact Early Help services, which may reflect the context of Health and Education having a more universal role, regular contact with families and a different understanding of need. Internet access and literacy would also be factors increasing inequalities as 184/196 (94%) said that provision had shifted online. Only 57/108 (53%) of respondents considered that online Early Help services were effective.

4.7 The majority of comments from survey respondents highlighted the importance of resourcing Early Help as well as early years and early intervention both during the pandemic and long-term.

4.8 All but 5% reported that children's centres were closed or partly closed physically in the first six months: 153/217 (70%) were closed, and 54/217 (25%) were partly closed. 67% of total respondents thought that this was an appropriate response to the pandemic.

4.9 56/129 (43%) said that children's centres were repurposed in some way, for example to include health visiting.

a. 74% of respondents thought that such repurposing was appropriate.

4.10 129/154 (89%) said that children's centres offered pre-existing functions remotely, either in full (67/154) or for part of the service (62/154).

a. Only 4/29 (14%) respondents from Children's Social Care said that there was no offer during the pandemic.

b. Only 37/151 (25%) of respondents thought that it was not appropriate to offer pre-existing functions remotely.

Recommendations:

25. Baseline Early Help resourcing needs to be strengthened.

26. Evaluate the effectiveness of online provision of Early Help; assess which groups did not access the services during the pandemic; and formulate take-away lessons from this for a broader reach in the future.

27. Ensure equity of access and detail how support will be offered and provided to families that do not have internet access or may have social/ learning vulnerabilities.
28. Enhance local information sharing strategies should further lockdown take place, such that information on health, early intervention, and protection are part of the routine local mail out in addition to local authority information.
29. Plan for future lockdown such that children's centres are accessible and safe.
30. Develop plans for COVID safe spaces for client meetings and family contacts in the longer term.

4-3 Mental health practice

4.11 Due to the widespread increase in concern about the mental health of children and young people, we asked all respondents about the impact of the changes to mental health services, and whether they felt this has increased any safeguarding risks. Respondents predominantly felt that all of the main changes to mental health services (moving services offered to children/young people online; moving adults from hospital to the community and moving children/young people from hospital to the community) increased some safeguarding risks to children/young people, although a significant minority of respondents (21%) felt that moving mental health services online for children/young people may have had some safeguarding benefits.

4.12 We also asked all respondents about the importance of action by mental health services and practitioners in protecting children/young people during the pandemic. All of the actions and interventions by mental health services and practitioners we listed were considered important (over 90% of respondents said that the action is important or very important), with particular emphasis being placed on keeping specialist services open and involving CAMHS early in planning support for looked after children.

Recommendations:

31. Recognition of the critical role that mental health services and practitioners play in safeguarding children and young people needs to happen at the highest levels in government.
32. Mental health including community interventions need to be adequately resourced: a proportion of government resources allocated to mental health services should be ringfenced for safeguarding leadership and supervision for both child/adolescent and adult mental health practitioners.
33. Future decisions about significant and widespread changes to mental health provision (such as moving to online services or moving from hospital to community care) should be undertaken in consultation with safeguarding leadership within Mental Health and Safeguarding Partnerships.

34. Increased child safeguarding training is needed for all adult mental health practitioners due to increased child safeguarding risks linked to higher levels of mental health problems.

4-4 Looked After Children

4.13 A number of strategies were used to increase placements with variable success:

a. Recruiting more foster carers: of Children's Social Care respondents, 15/19 had variable placement success with only 4/19 indicating that it was not a successful strategy.

b. Return retired carers: 14/23 Children's Social Care respondents did not use this strategy and of the 9 Children's Social Care that did try to recruit, 5/9 were unsuccessful in increasing placements.

c. Increasing numbers per carer: used by only 8/23 Children's Social Care respondents, and reported to be unsuccessful by only one respondent, indicating short term applicability.

d. Relaxed matching: 7/24 Children's Social Care attempted this, with some success for 6 of these.

e. Most of 38 respondents carried out strategies to educate and provide pandemic information for carers (16/19 Children's Social Care respondents, of which 7/19 found success and 9/19 partial success in supporting finding successful placements for children).

f. 18/34 had experience of extended age range of children placed with foster carers increasing placements in 15/18 with confidence in 6, and increased numbers placed in a further 9 with some concerns about the success of placements.

g. Enhancing the fee for emergency placements was only used by 3/23 (13%) of Children's Social Care respondents and with only limited success.

4.14 Commissioning extra residential placements was attempted by 14 /23 (61%) Children's Social Care, successfully in all but two, with some concern about the success of placements in 9/12.

4.15 Cross authority collaboration was said to be needed to secure low volume, high risk accommodation by 32/42 (76%) of respondents working with Looked After Children (11/17 (76%) from Children's Social Care).

4.16 The majority (59/87, 68%) felt that placement stability had stayed the same or improved during the pandemic, and 63/77 (82%) said that relationships with carers had improved or stayed the same (only 18% felt that relationships had worsened).

4.17 However, of significant concern is that 37/67 (55%) felt that relationships with parents had deteriorated during the pandemic (including 8/22 (36%) of Children's Social Care respondents).

4.18 Encouragingly, 90% of Education respondents felt that engagement with education had stayed the same or improved, although 36% of other respondents thought it had worsened.

4.19 Increased remote contact with Social Worker/Personal Adviser/ IRO was noted to be put in place by 26/27 (96%) of Children's Social Care respondents, and given the repeated lockdowns it is unsurprising that this has been maintained by 25/27 of them. 62/72 (86%) of total respondents noted that remote contact had increased.

4.20 24/26 (92%) of Children's Social Care respondents reported that their local authority introduced in-person contact with Looked After Children in alternative placements, and this was continued in 23 local authorities at the time of the survey and said to be ongoing by 42/66 (64%) of the total respondents.

4.21 Virtual activities for Looked After Children such as yoga or art were reported to have been set up by 18/22 of Children's Social Care and reported by a 34/54 (63%) of all respondents.

4.22 All 27 Children's Social Care respondents said that they had provided laptops for Looked After Children, with 26 continuing this provision at the time of the survey.

4.23 44/67 (66%) respondents provided food parcels for Looked After Children, and 42 reported that this was continuing at the time of responding to the survey, including 16/24 (67%) from Children's Social Care.

4.24 Online resources were provided for foster carers by 24/25 (96%) Children's Social Care and noted by 7/11 Education respondents, and 52/58 (90%) respondents overall.

4.25 31/52 (60%) total respondents including 15/22 (68%) Children's Social Care noted that their area introduced peer support, with the majority continuing peer support at the time of the survey (29/52 (56%) of the total). The outcomes of peer support will be useful to analyse in the future as something ongoing that may help young people, and in terms of the safety provisions around this.

4.26 There was particular concern raised for disabled children, unaccompanied minors, and LAC in detention, where overall 30/65(46%), 22/55(40%) and 28/50(56%) respectively felt that support was worse during the pandemic.

4.27 Care Leavers: respondents reported concerns over isolation (59/70 (84%), including 21/24 Children's Social Care); 33/75 (44%) felt that transition planning had been negatively affected, with delayed transition out of care noted by 19/24 (79%) Children's Social Care; and 27/70 (38%) of respondents felt that professional support had declined.

Recommendations:

35. Ensure that alternative and skilled provision is available should a children's home need to close.

36. Explore the impact of the pandemic on the carer experience, including trends in placement stability following rapid induction during COVID-19, develop strategies to strengthen support to current carers and review carer training and suitability.

37. Consider whether the increased severity and complexity of cases has translated into more complex placements to maintain and in this context assess the provision, as well as the training and support needs of social workers and carers.
38. Develop further contact centres that can also cater for separated mother and babies in a pandemic safe way as part of the planning requirement.

Protecting Children at a Distance

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

1. Introduction

This report presents findings from 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. All participants to both stages of the study were working under extreme pressure. We are exceptionally grateful for their time and expert insights. Many interviewees we spoke with during the first lockdown reported finding the opportunity for structured reflection valuable.

The study was granted ethical approval by the King's College London Research Ethics Committee [LRS-19/20-19420]. Stage 1 was deemed a service evaluation by participating NHS organisations. The Health Research Agency (HRA) confirmed that NHS ethical approval was not required for stage 2 on 13th January 2021. The study is funded by the *King's Together: Multi & Interdisciplinary Research Scheme* and the *Economic & Social Research Council Impact Acceleration Accounts Social Science Impact Fund.*

Methodology

The project was conceived as a modified Delphi study in two stages. The Delphi technique has been widely used in health and social care (Hackett et al., 2006). It was employed because it is particularly suited to areas where research is limited (Iqbal and Pipon-Young, 2009). Characteristics include consultation of experts through an iterative process designed to identify salient issues which are then put to the experts in later stages to seek areas of consensus or disagreement (Iqbal and Pipon-Young, 2009). The methodology supported the key aims of the study, namely to:

i) identify key concerns as to the impact of the pandemic on the operation of the child protection system and safeguarding practice and adaptations to professional practice in response;

ii) gather evidence and consolidate learning as to emerging best practice arising from those adaptations during the pandemic; and

iii) advise policy-makers as to key measures required to increase the resilience and capacity of the child protection and safeguarding system in the wake of the pandemic.

Stage 1 comprised 67 semi-structured hour-long interviews undertaken between June and September 2020 with safeguarding leaders in London from Safeguarding Partnerships, Children's Social Care, Health, Police, Law, Education and Mental Health services (see Table 1.1). Most participants were identified through their professional role and contacted directly, with initial contacts forwarding to a nominee where appropriate. Overall, the participants provided 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.

Table 1.1: Interview participants (Stage 1)

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

Interview findings informed the survey in Stage 2 and also add depth and context to the survey findings. In response to requests by professional groups, the survey stage was extended to England. The survey was set up on Qualtrics to ensure security of data and allow for the complexity of filtering that was required (to view a PDF of the survey please visit:

http://bit.ly/KCLSurvey). It was piloted by members of the Expert Reference Group, feedback tending to suggest that it was overlong but there were no areas that could obviously be cut. Length of time to complete the survey varied widely depending on respondents' roles and their contribution of qualitative comments. We are aware that many invested considerable time in the survey and that has resulted in over 1,000 extremely rich qualitative comments to supplement the quantitative data.

Leads in national, regional and professional organisations were contacted and asked to share the survey with colleagues in appropriate posts. The survey was live from 1st February – 8th March 2021. Information on the landing site reiterated that participation in the survey was completely voluntary and that completion implied consent to participate. There was also a caution that the platform saves responses as they are given, meaning that data cannot be withdrawn from the study once provided. Respondents could pause and save their responses to return to the survey later or skip questions they did not wish to answer or did not feel were applicable to them. Questions or groups of questions were also targeted at different groups of respondents. Consequently, there are different numbers of responses for different parts of the survey, with some tailing off towards the end. Completion was anonymous although the nature of the data captured (for example, we asked if respondents held a national-level role), and for some groups the limited number of eligible participants, meant that it might be possible to identify individuals from a number of items of data combined. We have responded to this in the way in which we have reported respondents' roles, particularly from the qualitative comments that were added. Analysis of the quantitative data was undertaken using IBM's SPSS analytical software with the assistance of Dr Chris Stride, an applied statistician at the University of Sheffield.

Survey Respondents

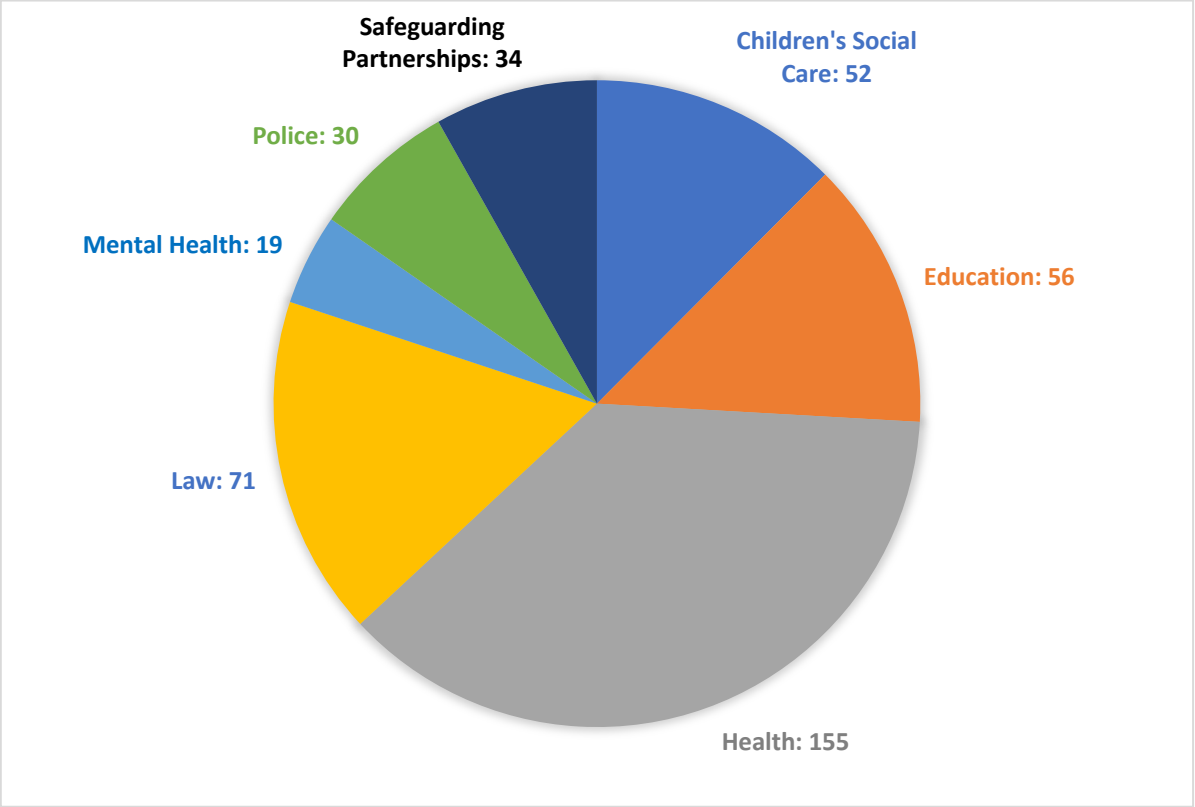
The total number of respondents recorded as registering on the platform was 563. 417 responses were included in the study. The exclusions mostly comprise individuals who did not complete the question as to their primary disciplinary affiliation, as that had implications for filtering and analysis. Where quotations are provided in this report, we have truncated the given description of respondents' professional role where necessary to preserve anonymity.

Responses by professional groups

Gathering the perspectives of the different disciplines involved in child safeguarding and protection is central to the aims and design of the study, but it is not of course possible to draw on equivalent roles in different disciplines. Our starting point was individuals most likely to represent their agency on local Safeguarding Partnerships, from Police, Clinical Commissioning Groups (CCGs) and Children's Social Care (CSC), to which we added Safeguarding Partnership independent scrutineers/chairs and/or business managers. Children's Social Care invitations were addressed to Directors of Children's Services (DCSs) with a request to forward to another member of staff if appropriate. Health professionals

included Clinical Commissioning Group strategic expert leads (Designated Doctors and Nurses), via their national network, as well as Named professionals for General Practice, Acute Trusts and Midwifery, via their national and London networks. Mental Health safeguarding leads were contacted via regional groups and contacts. Conscious of the discussion around representation of schools on Safeguarding Partnerships and of the role of schools in safeguarding arrangements during lockdown, we added school headteachers or Designated Safeguarding Leads, accessed through the National Association of Head Teachers. To glean a picture of the whole of the safeguarding/child protection process, we included both local authority and children's panel lawyers, the latter contacted through the Association of Lawyers for Children. Figure 1.1 shows the overall breakdown of responses by the seven professional groups.

Figure 1.1: Pie chart showing number of respondents from each professional group (n=417)

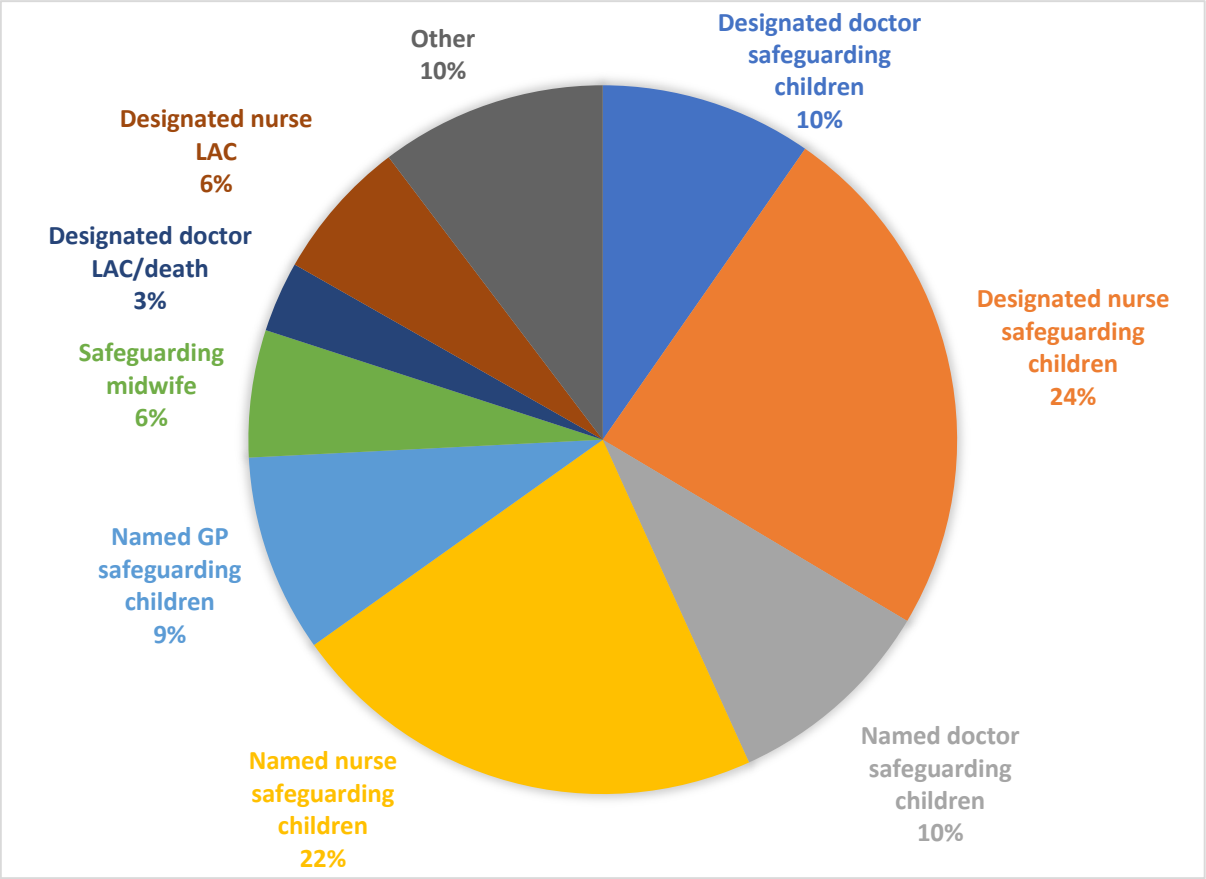


For some groups, there was a very limited pool of potential respondents. For example, Children's Social Care (CSC) and Safeguarding Partnership (SP) respondents are likely to be limited to one per local authority area, although it is possible that two individuals from the same Safeguarding Partnership completed the survey, as invitations were sent to business managers as well as scrutineers/chairs. Police representation tends to cover more than one local authority as there are only 43 police forces across England. The numbers responding from Police are therefore fairly small (30), but nonetheless there is representation from all regions except the North East. For Education there is a very different picture, with a much

larger potential pool, although many of those may not regard themselves as very involved in local safeguarding arrangements. The same applies in relation to Health respondents, who comprised 37% of the overall response but that proportion is made up of a number of different post-holders.

In some groups a number of different roles are represented within the respondent group. This is particularly pertinent in Law, where we have 71 respondents in total, of which 34 were local authority solicitors and the remainder predominantly children's panel lawyers. The picture is particularly complicated in Health, as shown in Figure 1.2 below. Health has a number of professional subgroups with safeguarding leadership as part of their role, including Named and Designated professionals. A third of our Health respondents had safeguarding designate roles, and at least half were nurses in leadership positions including midwifery.

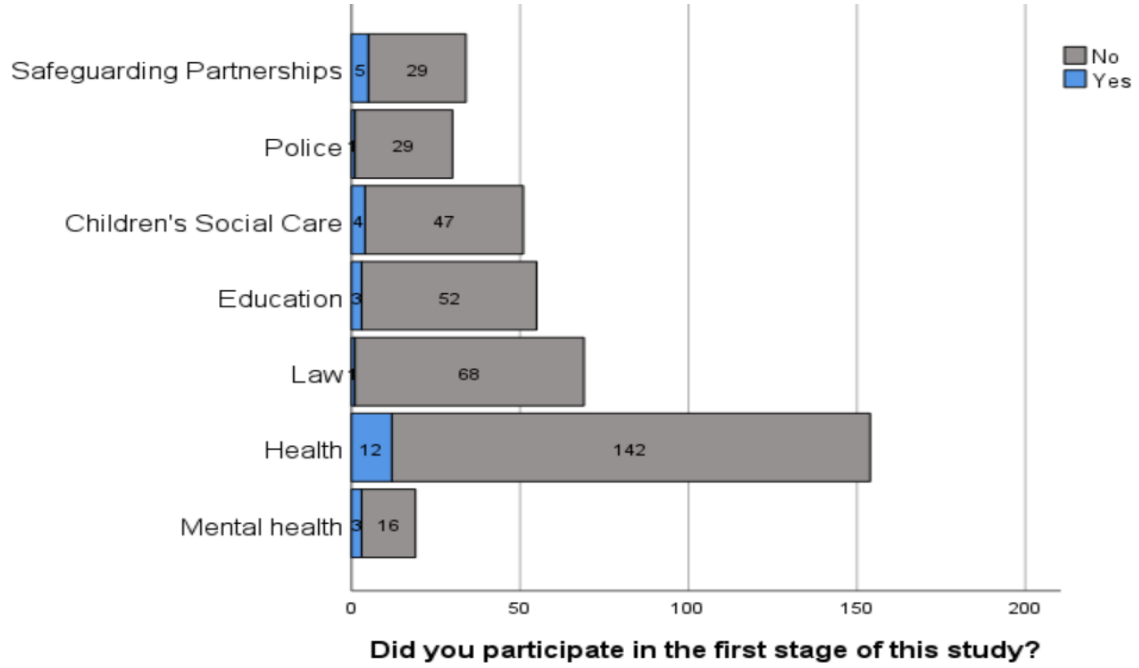
Figure 1.2: Role of Health professional respondents (n=155)



Participation in first stage of study

The majority of responses were from new participants, with just 29 respondents having taken part in the interviews, as show in Figure 1.3, representing a significant departure from a conventional Delphi approach.

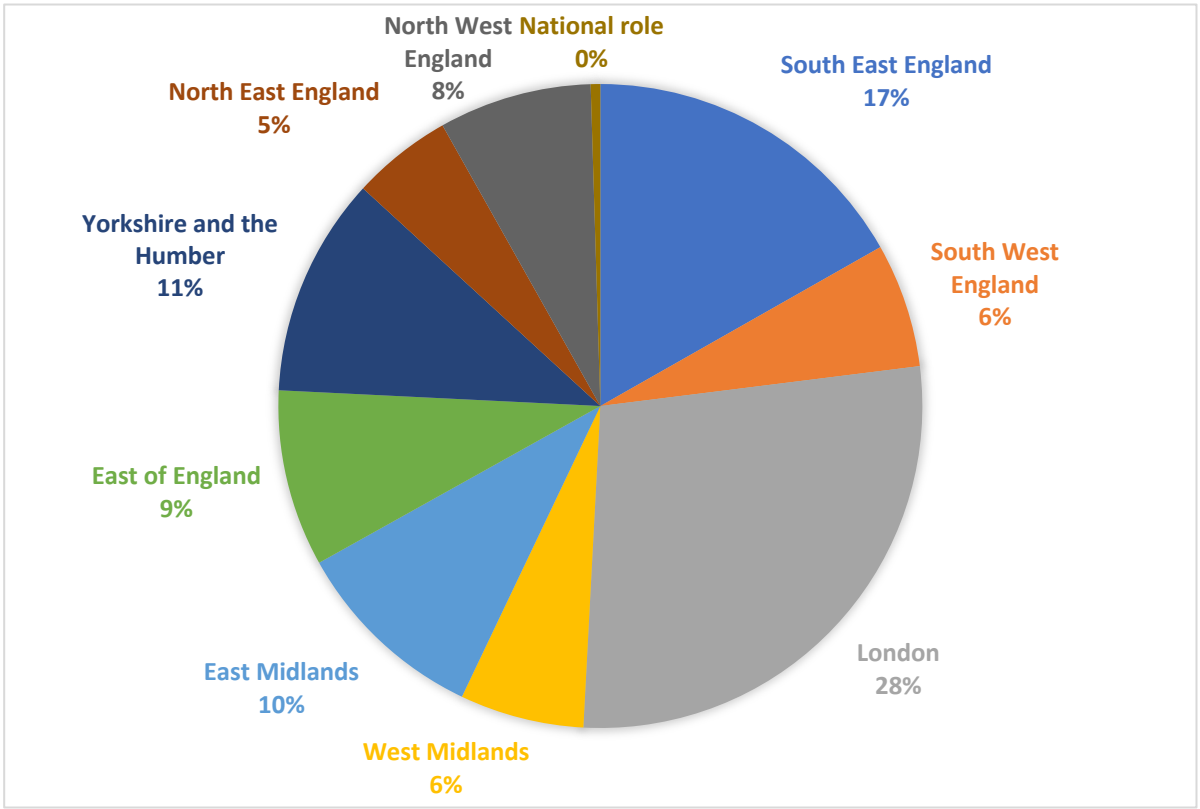
Figure 1.3: Proportion of respondents who participated in the interview stage



Regional representation

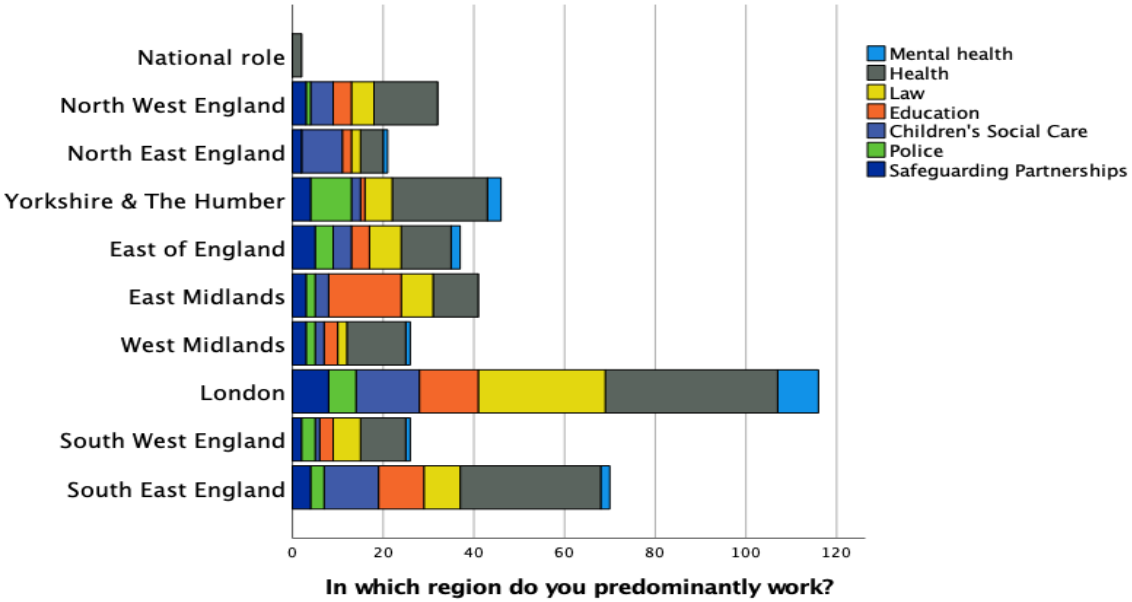
There were responses from all regions of England, although 45% of respondents came from London and the South East, most probably reflecting the base of the study team and contacts made in the first stage of the study. Regional breakdown is shown in Figure 1.4 below.

Figure 1.4: Pie chart showing responses by region (n=417)



There is a reasonable spread of professional groups by region as shown at Figure 1.5, which gives numbers rather than percentages to show the balance of responses across as well as between groups:

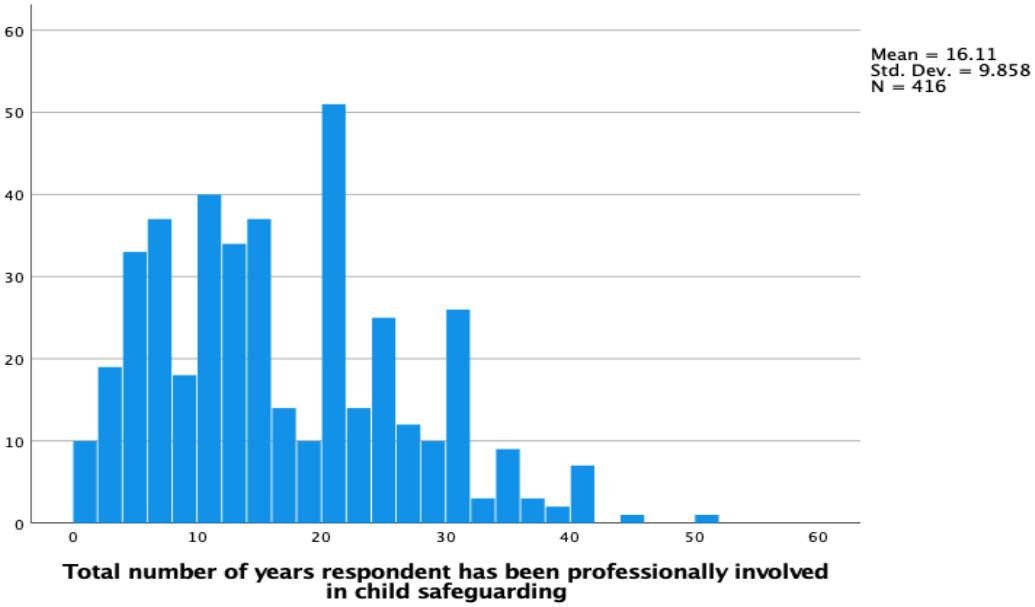
Figure 1.5: Professional groups by region (n=417)



Years of experience in safeguarding

There was a wide range of experience, from 1 – 51 years, median 15 years, mean 16 (Figure 1.6). It is notable that Children's Social Care respondents overall had most experience (mean over 24 years) and Police least (just under 7 years), reflecting the different career stage at which different professional groups may take on significant responsibility for child protection.

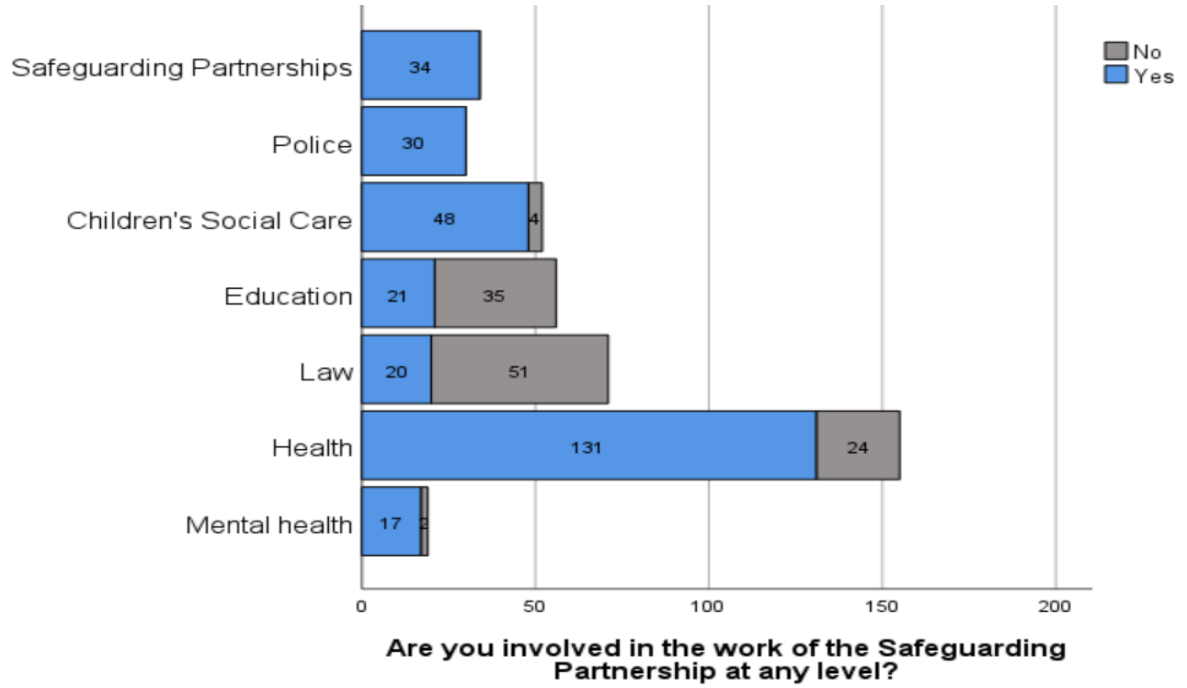
Figure 1.6: Respondents' safeguarding experience (n=416)



Involvement in the Safeguarding Children's Partnership

72% of respondents were involved in their local Safeguarding Partnership at some level, including all Police and Safeguarding Partnerships respondents; 92% of Children's Social Care (all but 4), all but 2 Mental Health respondents and 85% of Health respondents (see Figure 1.7). The proportion was, as expected, lower in Education and Law.

Figure 1.7: Involvement in local Safeguarding Partnership



Implications of the respondent body

In relation to interpretation of the findings, it is important to take into account the balance of respondents both between and within groups. Overall, we have a very senior group of respondents and although there is a mix of strategic and operationally-focused respondents, the strategic perspective is predominant, as intended. For some questions we asked whether respondents thought there were differences at operational compared with strategic level as the difficulty in translating work at one level to the other was highlighted by some interviewees in the first stage. We have also considered qualitative comments to help us to understand the strength of feeling among professionals in different positions within the system.

Structure of the report

The findings are set out under three main headings: Multi-Agency Working, including the role of schools (section 2); Professional Practice (section 3); and Service Provision (section 4). In each section, the findings from the interview stage are summarized before the key results of the survey are reported.

2. Multi-agency working

2.1 Safeguarding Partnerships

We were conscious that some Safeguarding Partnerships were still relatively new structures when the pandemic struck (they were required to be operational by the 29th September 2019), and this may have affected their ability to respond quickly and effectively to the impact of the measures to combat transmission of the virus. We took advantage of the opportunity to ask about how the shift from Local Safeguarding Children's Boards (LSCBs) to Safeguarding Partnerships was perceived to have affected arrangements under the conditions imposed by the pandemic.

Summary of interview findings

Interviewees in our study described a mixed picture of the establishment of Safeguarding Partnerships, including the extent to which changes had been made in comparison to the way the LSCB had operated. Nonetheless, a sense came through from a number of boroughs that the fact that lockdown came early in the life of Safeguarding Partnerships was in some respects an advantage. The pandemic was felt to have accelerated the process of embedding the new arrangements and encouraging closer working between the partners. A number of interviewees considered that having to work collaboratively to deal with the crisis and the way in which people had embraced the idea that 'we are all in this together' had helped to strengthen Safeguarding Partnerships, while others reported that overall partnerships had been enhanced, because communication had been stepped up.

However, while some participants felt that a smaller executive body was beneficial to decision-making, others suggested that Children's Social Care sometimes acted unilaterally. Comments included concerns that the tripartite structure of the partnerships was problematic in light of the key role played by schools during lockdown: 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 some unease expressed as to whether the new arrangements had tended to result in loss of some of the strength of the wider safeguarding community, and that a smaller executive and introduction of the Independent Scrutineer role had weakened operational input, an issue that had come to the fore as a result of the pandemic. 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 Partnership, 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 were 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.

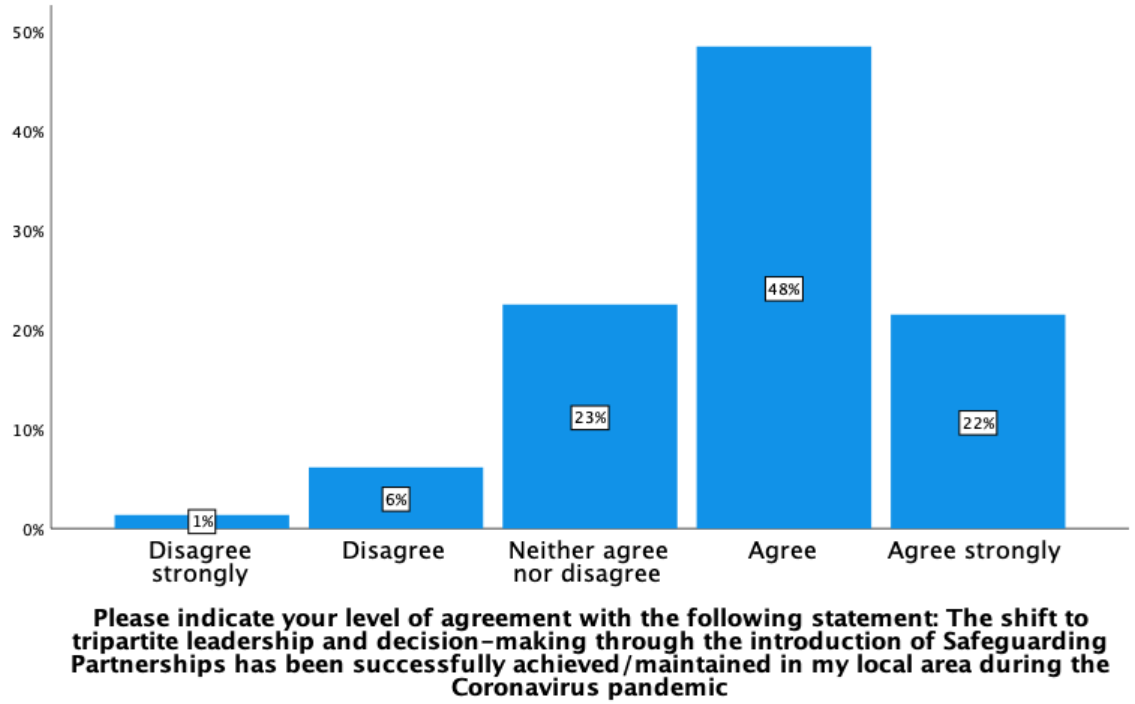
Survey results

By the time of the survey, there had been more time for Safeguarding Partnerships to be bedded down. We asked a number of questions about whether and/or how the shift from Local Safeguarding Children's Boards (LSCBs) to Safeguarding Partnerships had affected joint working during the pandemic.

The first question asked for a response to the statement: *the shift to tripartite leadership/decision-making through the introduction of Safeguarding Partnerships was successfully achieved/maintained in my local area during the pandemic.* 70% of respondents agreed/agreed strongly (7.5% disagreed/disagreed strongly): see Figure 2.1.

Figure 2.1: Shift to tripartite leadership

(n=293: respondents with some involvement in their local Safeguarding Partnership).



From this question, we cannot tell if Safeguarding Partnerships were well embedded and arrangements were working well before the pandemic or whether changes in the way Safeguarding Partnerships worked during COVID-19 helped to cement tripartite leadership, because the question asked about the achievement *or* maintenance of the tripartite leadership arrangements, although we know that our London-based interviewees felt that the pandemic accelerated the process of embedding the new arrangements and encouraging closer working between the partners. However, some qualitative comments enhanced the sense from interviews that strong working partnerships prior to the pandemic often underpinned perceived success in the new conditions. For example:

> There is significant extra active work being pursued to strengthen as a response to Covid but there were already strong relationships between the partners brought about by changes pre-Covid. – Local Authority Solicitor, East of England

> The working relationships across the three statutory partners has been extremely strong and this has not changed during the pandemic. – Designated Nurse for Safeguarding, Designated Nurse for LAC, Yorkshire & The Humber

> We already have strong relationships in place and this has helped and continued through the pandemic. – Business Manager, Yorkshire & The Humber

There were also a few very strong negative comments. These might suggest that in some areas the tripartite leaderships model had not been successfully implemented or may reflect deeper concerns about the appropriateness or feasibility of the model of tripartite responsibility:

> The shift from a Board to a Partnership was perhaps poorly understood and perhaps the scrutineer role has/had become blurred. – Children's Social Care, Yorkshire & The Humber

> I would argue that the LA still have to lead the partnership. Heath and police poor at consultation re changes that impact on practice. – Children's Social Care, North West England

> The challenge for Safeguarding Partnerships is achieving equity in responsibility as the local authority generally has the lead duty. The pandemic has widened some of the accountability gap with autonomous leadership directives on practice expectations for schools, police and health staff. Children's Social Care staff have been left carrying multi-agency responsibility for all partners at times during this pandemic. – Children's Social Care, London

> My organisation has had limited contact with the SG partnership during the last 10 months. Health appears to be the poor relation in the tripartite partnership. – Named Nurse for Safeguarding, Named Nurse for Looked After Children, South East England

> Although collaboration has improved, there is still predominantly single agency decision making. – Health (other), London

> Funding of the LSCP was a real sticking point with the LA focused on wanting to contribute less, but maintaining overall control of decision making with health not included in discussions at strategic level. – Named Nurse for Safeguarding, London

Notably, there were more negative responses to the survey question from schools than other agencies, with over a quarter of Education respondents stating that they disagreed or disagreed strongly with the statement, compared with 7.5% overall. This might reflect the more peripheral representation of schools on most Safeguarding Partnerships, a consideration that may also apply to comments above from Named Health professionals.

Given that successful tripartite leadership does not in itself guarantee improved joint working, we asked a separate question specifically about whether the replacement of Local Safeguarding Children Boards with Safeguarding Partnerships improved inter-agency collaboration in respondents' local area (n=279). Almost half (49%) of respondents gave a neutral response, which appears to be consistent with views from interviewees that many areas focused on maintaining successful working practices established through LSCBs and ambivalence in some areas as to whether the replacement of LSCBs with Safeguarding Partnerships was a necessary or proportionate response to criticisms as to the operation of LSCBs.

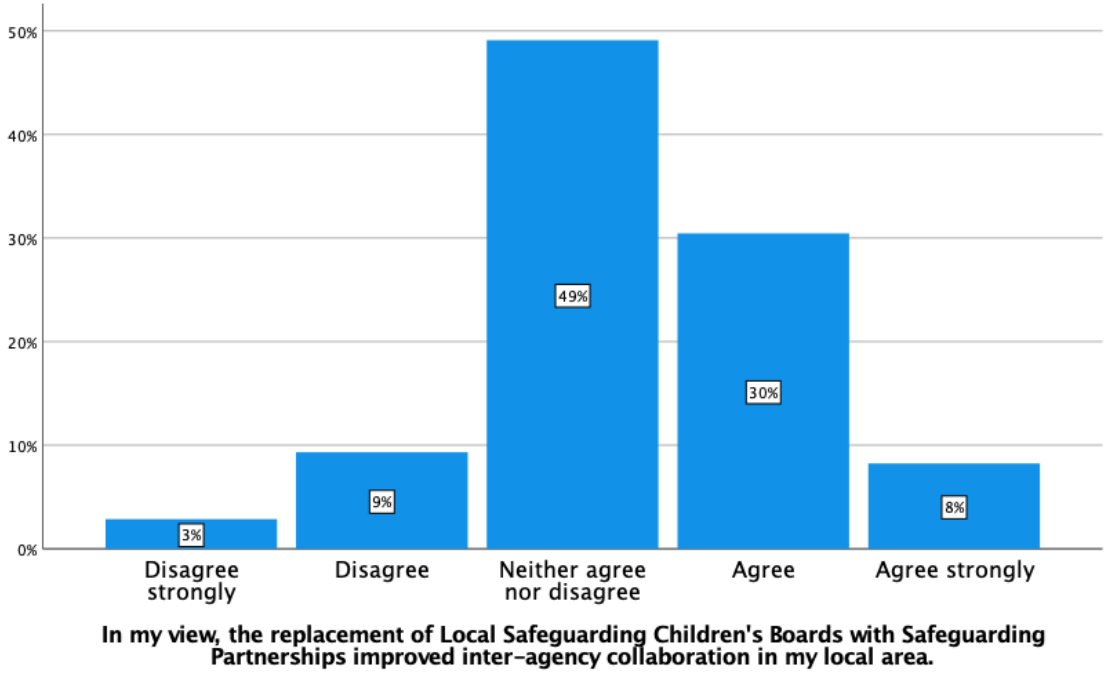
> In my area we had a very well working safeguarding board, therefore partnership has made very little difference. – Designated Doctor for Safeguarding, London

> Local Partnership arrangements have not vastly changed things compared with LSCB arrangements. – Named Doctor for Safeguarding, Yorkshire & The Humber

> In my area we worked very closely across all agencies when we were safeguarding boards so safeguarding partnerships didn't improve that as it was already in place. – Named Nurse, North West England.

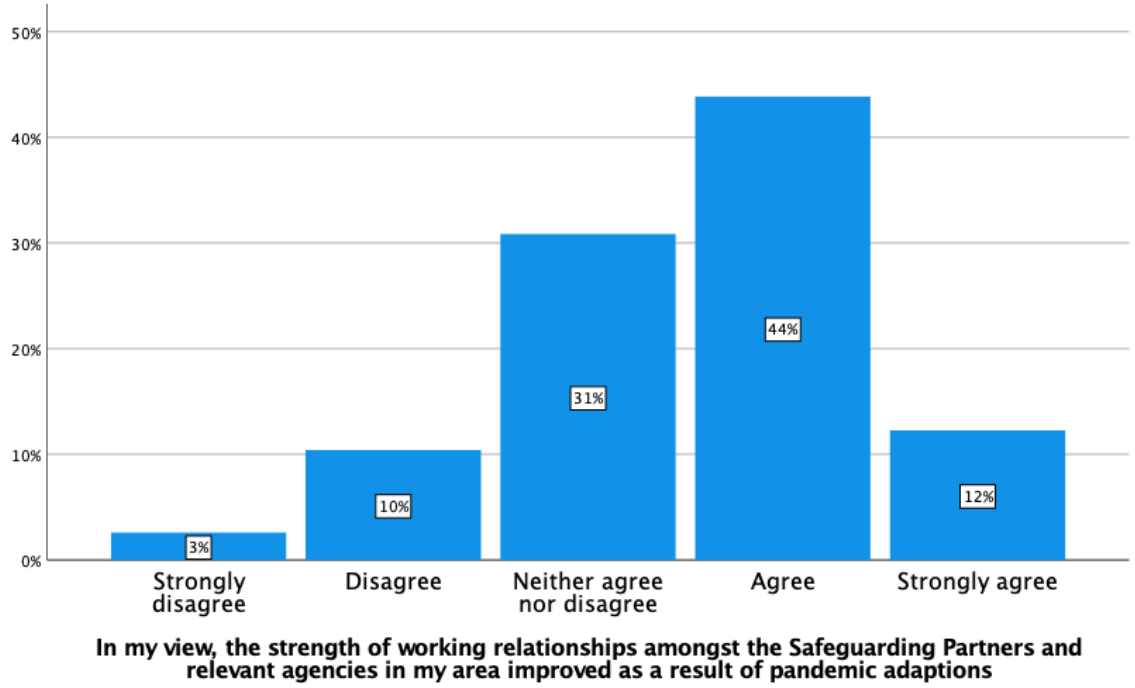
However, of the remainder, only 12% disagreed or strongly disagreed with the statement. More than three times as many (39%) agreed or strongly agreed (Figure 2.2). Police, Children's Social Care and Safeguarding Partnership respondents were most likely to select agree or strongly agree.

Figure 2.2: The replacement of Local Safeguarding Children's Boards and inter-agency collaboration (n=279: respondents with some involvement in their local Safeguarding Partnership)



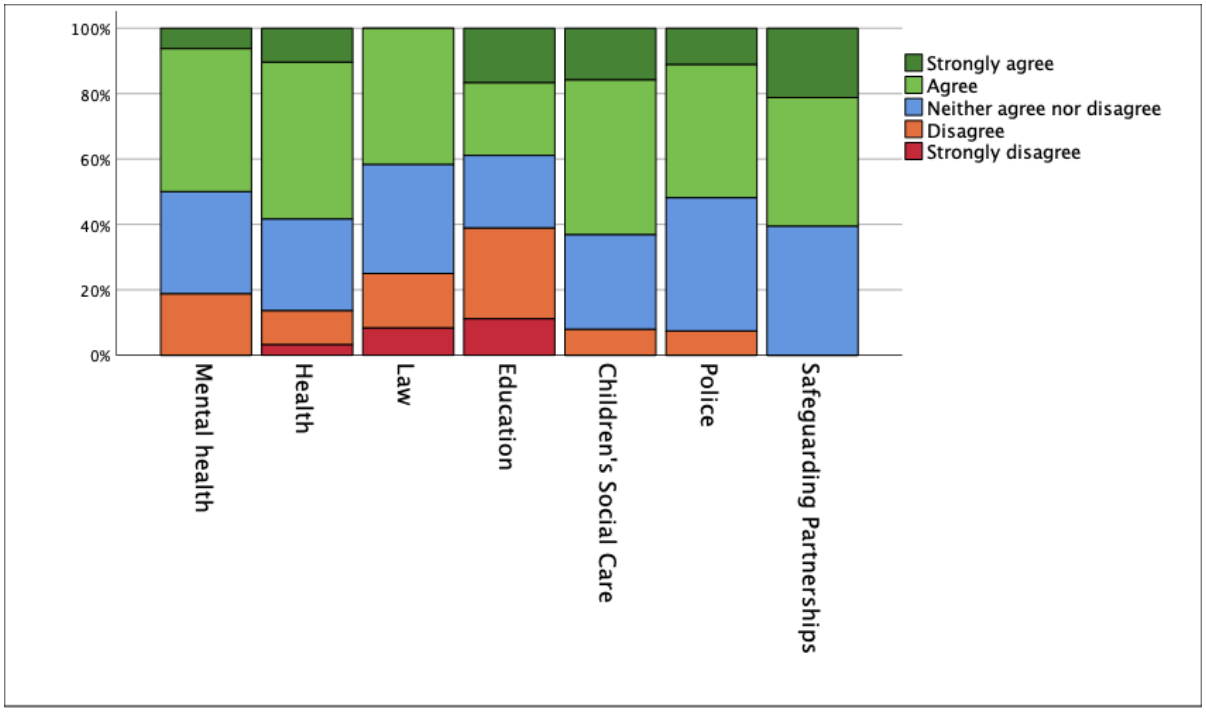
We also asked a question based on interview findings that the pandemic had encouraged closer working relationships between the partners and relevant agencies through the resort to online communication and the need for more regular discussions: *In my view, the strength of working relationships amongst the Safeguarding Partners and relevant agencies in my area has improved as a result of the adaptions made in response to the pandemic.* Figure 2.3 shows that more than half of respondents (56%) agreed/strongly agreed with that statement: 13% disagreed/strongly disagreed.

Figure 2.3: Strength of working relationships amongst Safeguarding Partners and relevant agencies (n=269: respondents with some involvement in their local Safeguarding Partnership)



No Safeguarding Partnership respondents disagreed with this statement and 61% agreed or strongly agreed; Children's Social Care, Police and Health also largely agreed. Education respondents were most likely to disagree (39%) (Figure 2.4).

Figure 2.4: Strength of working relationships by agency (n=269: respondents with some involvement in their local Safeguarding Partnership)



In my view, the strength of working relationships amongst the Safeguarding Partnerships and relevant agencies improved as a result of pandemic adaptations

Qualitative comments included the following:

> The Partnership was strong before but the legislation and pandemic have also helped. - Children's Social Care, South East England

> The changed legal status of the partnership has not affected inter-agency relationships but the Covid pandemic has impacted in a way to bring partners closer together. – Safeguarding Partnerships, North West England

The benefits of online working in relation to Safeguarding Partnership and relevant agency meetings was also reflected in commentary provided by survey respondents:

> We seem to have developed a lot of meetings over the past few months between teams that would otherwise not have met face to face in the past - as online meetings are easier to attend - so I think networking and getting to know other partners has improved over the past few months. – Named GP for Safeguarding, London

> Weekly 'Covid' response meetings proved valuable for cohesion, support and synergy. – Children's Social Care, South East England

Respondents (Children's Social Care, Health, Mental Health, Safeguarding Partnerships and Police) also highlighted that virtual working among partners and relevant agencies has allowed for 'easier accessibility to partner agency professionals', 'greater attendance across the partnership', 'and embedded [additional] regular meetings across all tiers of working within the safeguarding partnership.'

A counternarrative from one school respondent, however, commented: 'in many instances schools are not listened to or updated effectively.' (East Midlands)

2.2 Broader joint working arrangements

Summary of interview findings

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.

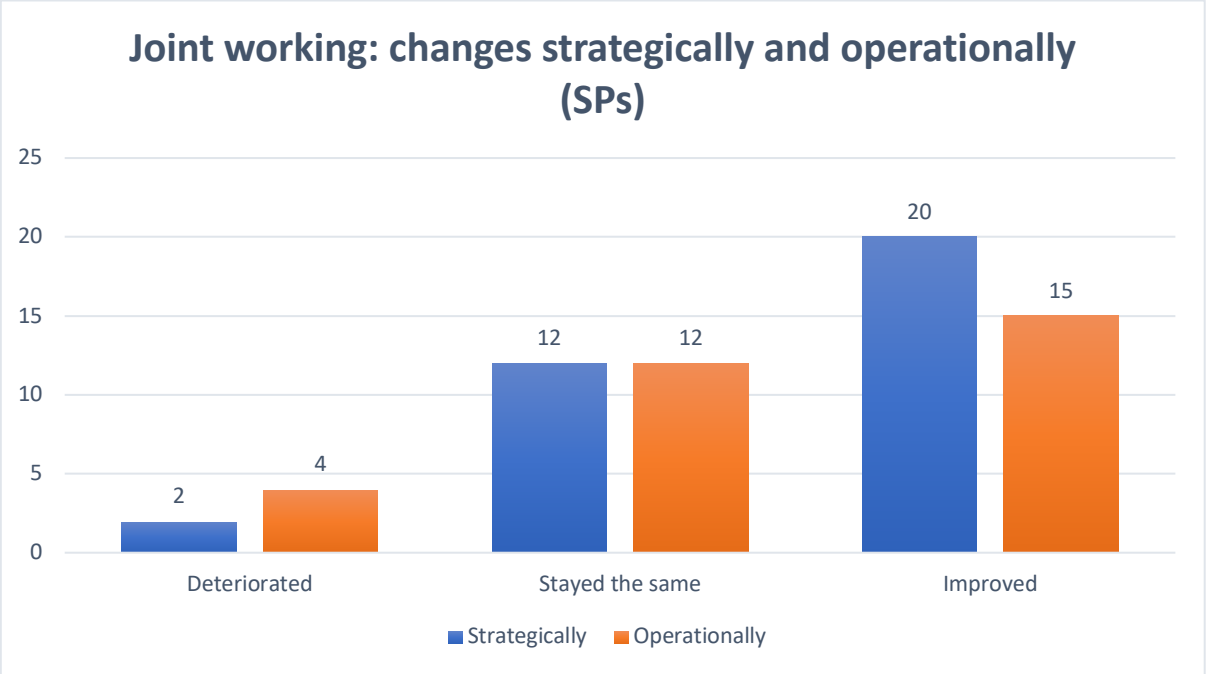
Although multi-agency arrangements tended to be a focus only after agencies had managed their own immediate priorities, the general consensus was that thereafter interagency working was a significant focus of attention. A sense that 'Covid brought everyone together' was conveyed by many interviewees. 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. Additionally, strengthened multi-agency working was thought to be more likely to be evident at strategic level and not always to be experienced by front-line professionals.

Survey results

We asked each agency to comment on how joint working with each other agency had changed over the pandemic, operationally and strategically. We also asked Safeguarding Partnership respondents to respond to a similar generic statement: *over the pandemic, joint working*

between agencies has improved/deteriorated/remained the same at strategic and operational level. Numbers in each group are small here so we looked for patterns across the group of questions. Among the Safeguarding Partnership respondents, 20/34 felt the strategic joint working had improved (59%) and 15/31 (48%) felt that joint working had improved operationally, with only 2 (6%) and 4 (13%) seeing deterioration (Figure 2.5).

Figure 2.5: Joint working strategically and operationally (Safeguarding Partnerships) (n=34/31)



Between individual agencies, there was a similar pattern but less positive, with a good proportion reporting no changes. The two tables below (Table 2.1A and B) show how each agency (the first column) responded as to whether they considered that joint working with each other agency had improved (in green) or deteriorated (in red). The numbers do not add to 100% as 'remained the same' is not reported. Three patterns are worth noting:

First, a general suggestion that joint working was more likely to have improved than deteriorated as between single agencies, indicated by bold green figures, e.g., all agencies were more likely to report improvements in strategic joint working with Education than deterioration. Second, a tendency for operational joint working to be more likely to have deteriorated than strategic joint working (as also reported by Safeguarding Partnerships), illustrated by more bold red figures in the second table than the first. Third, a distinct difference in opinion among other agencies as compared with Education. Both strategically and operationally, Education respondents were more likely to report deterioration than improvement in joint working with all other agencies as highlighted in the top row of each table. Yet strategically particularly, all other agencies reported good proportions of improved joint working with Education. The difference is particularly marked in relation to Children's

Social Care, with 43% of Education respondents reporting deterioration in joint working with Children's Social Care colleagues strategically and 51% operationally, while 58% of Children's Social Care respondents reported improved strategic joint working with Education and 48% improved operational joint working. These are small numbers because they are single agency responses but may give a sense of the pressure that schools felt under during the lockdown conditions. They are particularly notable because all other agencies were more likely to report improved joint working with Children's Social Care than deterioration, as is shown by the first column of each table. They are also consistent with poorer experiences of inter-agency working reported by Education participants to the first stage.

Table 2.1: Joint working as perceived by different agencies

A Strategic:

[unchanged omitted]	CSC	Health	MH	Police	Education
Education felt joint working with x agency deteriorated/improved:	**43%** 18%	**36%** 11%	**36%** 9%	**12%** 9%	
CSC		11% **35%**	24% 24%	9% **43%**	6% **58%**
Health	10% **47%**		19% **26%**	7% **33%**	15% **29%**
Mental Health	24% **41%**	6% **41%**		9% **46%**	15% **31%**
Police	0% **37%**	0% **27%**	**17%** 14%		7% **22%**

B Operational:

[unchanged omitted]	CSC	Health	MH	Police	Education
Education felt joint working with x agency deteriorated/improved:	**51%** 9%	**44%** 12%	**42%** 17%	**21%** 10%	
CSC		**27%** 18%	**30%** 20%	14% **27%**	13% **48%**
Health	23% **33%**		**33%** 26%	10% **24%**	**29%** 20%
Mental Health	29% **35%**	13% **38%**		9% **18%**	21% 21%
Police	8% **24%**	4% **20%**	8% **12%**		17% 17%

Some of the pressures for schools were elaborated on in the qualitative comments, which included:

> The care systems have been woefully inadequate. Schools are constantly checking if our vulnerable families are coping, have had contact with social workers and in many cases, we are providing the link between them and chasing them up more than ever before. – Education, London

> Massive lack of communication between social service and schools and pressure to close cases at beginning of pandemic. – Education, East of England

Four Education respondents specifically felt that in-person work (e.g., home visits) with vulnerable children and families had been primarily left to schools, whilst noting that Children's Social Care did not take on the same level of responsibility for in-person contact.

> Social care have a key role in safeguarding but in my experience they (social workers) were requested/their role/line managers outlined they should work from home. This put greater pressure on schools and was hard to understand when we were still completing face to face work. We were asked by some social workers to complete home visits as it was unsafe for them due to the risk of Covid??– Education, South East England

> Social Care need to do thorough assessments regardless of us being in lockdown. To my knowledge all social workers in [area] are working from home and not visiting families and still they are being vaccinated while teaching staff take on more of their role. – Education, North West England

> All agencies need to commit to in person work. Schools did this right the way through but were constantly being told by other services that they 'weren't allowed to attend assessments or work in person. Health service professionals/ ep service / family support were worse culprits. Totally frustrating for school staff who have been with children and families in need every single day. Don't we count? Why are we safe to work with? Child with complex needs on a 1-1 basis, whilst supporting mum with home visits to check welfare, providing food etc, but no other agency prepared to do anything but make phone calls. – Education, North West England

Another education respondent stated that 'the working relationships between Social Care, Police and schools has been very difficult with resources stretched to breaking point' (East of England).

It is important, however, to note where relationships worked well, such as this 'shining example' of adaptation to practice:

> Closer working relationship school/ social worker. At school's request Social worker video conferenced family and fed back to school on child's well-being that school had been unable to contact. – Education, South East England

Overall, Police seemed to attract the least negative responses and also be least likely to consider that joint working with other agencies had deteriorated: all agencies except Education were more likely to report improved than deteriorated joint working with Police, but here Education was much less dissatisfied with joint working with Police than with other agencies. This may reflect the extent to which front-line police officers were still available 'on the ground' compared to other professional groups:

> The pandemic has been incredibly challenging for all partners, the front-line police specialist teams continued working from the police stations during the pandemic whereas colleagues from Children's Services, Probation etc. worked from home. This clearly made it more difficult to work in partnership on a day-to-day basis when dealing with operational issues. Police technology in my force (lack of Teams or Zoom) also created issues for us in terms of engagement. – Police, West Midlands

One comment from a Designated Nurse for Safeguarding resonates with similar commentary from health researchers during the pandemic and with the views of interviewees and raises questions for efficient practice in the future: 'The relationships during the pandemic have led to decrease in bureaucracy and an increased emphasis on making things happen.' (West Midlands).

2.3 Representation on Safeguarding Partnerships

Summary of interview findings

Commentary from interviewees in the first stage of the study highlighted the complexity of local arrangements. This is particularly the case in relation to Health, where the Clinical Commissioning Group (CCG) is a Safeguarding Partner, but providers are not represented at executive level and are often privately-run organisations. As one Mental Health participant noted: 'Police and Local Authority are integral organisations but health is much more multifaceted organisationally'. A number of interviewees expressed concerns about the new arrangements, with one interviewee describing 'losing a great deal of the strength of the wider partnership' as a result of the shift from Local Safeguarding Children's Boards (LSCBs) to the Partnership model, citing engagement with some parts of Education, some parts of Health and some elements of the justice system, adding that 'COVID has not helped'. A Mental Health participant also described a move away from operational involvement, reporting that 'the safeguarding partnerships felt increasingly remote' with the advent of a partnership Executive of very few people with limited delegation, resulting in a disconnect in terms of getting operational information at Safeguarding Partnership level. S/he concluded that 'Covid has shown that you really need that operational input, not just the CCG'. Other participants commented on the absence of Mental Health from the core partners.

While Education at local authority level is of course represented in the statutory partnership, schools' representation provoked the most commentary in the first stage, given the key role that they have played during the pandemic. For example, a Police participant identified the absence of school involvement in the partnership – a pre-existing issue – as particularly problematic in the context of school closures. We were also interested in schools' engagement as a result of evidence from a recent study on the role of schools in safeguarding and child protection (Baginsky et al., 2021), in which Driscoll was a co-investigator, that schools can feel that their expertise and perspectives are inadequately respected and valued and that they sometimes feel they are not sufficiently informed or included in decision-making. From the first stage of our study, it appeared that many LSCBs with strong representation from schools chose to retain that in their new arrangements.

Survey data

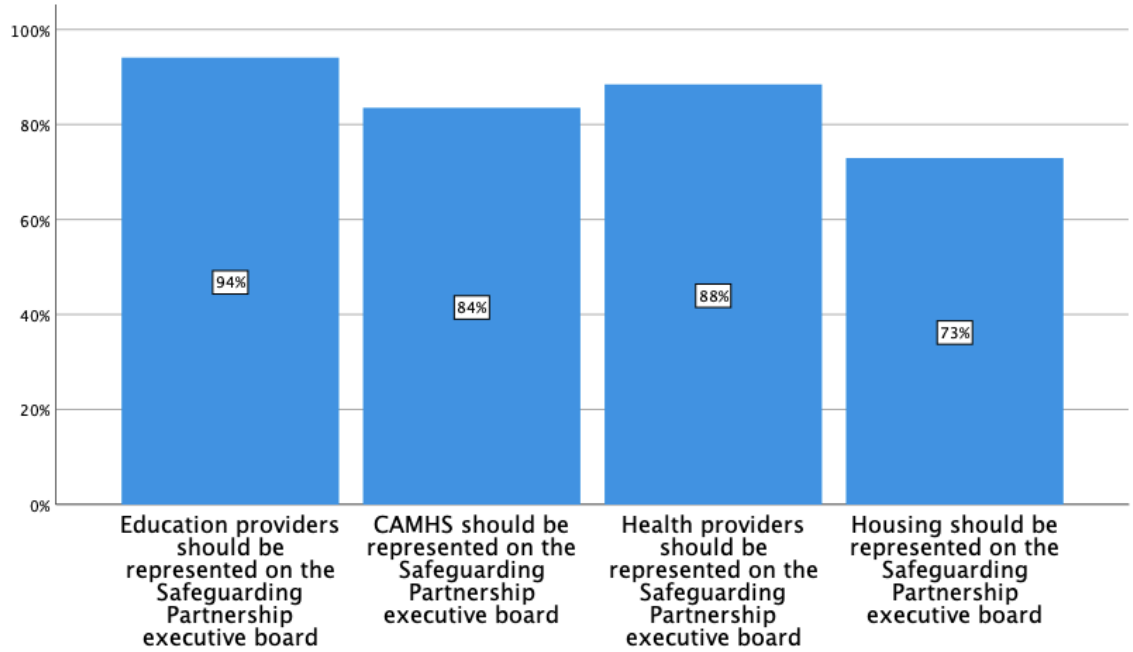
In the survey, we therefore asked a deliberately slightly provocative question about the status of agencies/organisations that are not statutory safeguarding partners but are relevant

agencies in the work of Safeguarding Partnerships. We asked whether, given respondents' experience during the pandemic, they agreed that Education providers, CAMHS, Health providers and Housing should either be represented on the Executive Board or have greater involvement in sub-groups. Logically, we might have tried to make this an either/or question, but that was challenging on the survey platform. Although we were aware that the tripartite division of responsibility is statutory, we knew from the first stage interviews of at least one Safeguarding Partnership which included attendance by other agencies at Executive Board meetings for the purposes of discussion: qualitative commentary to the survey demonstrated that in London this model has also been used to include attendance on behalf of Mental Health and by the health provider safeguarding lead, which it was considered 'added to the breadth of understanding by the executive and subgroups' (Designated Doctor for Safeguarding, London).

We had 255-304 responses to these questions, which were not asked to Law respondents. While we are not making concrete proposals and appreciate that large bodies can be unwieldy, we wanted to get a picture of the strength of feeling around multi-agency working and the engagement of relevant agencies to build on the picture presented by comments made in interviews.

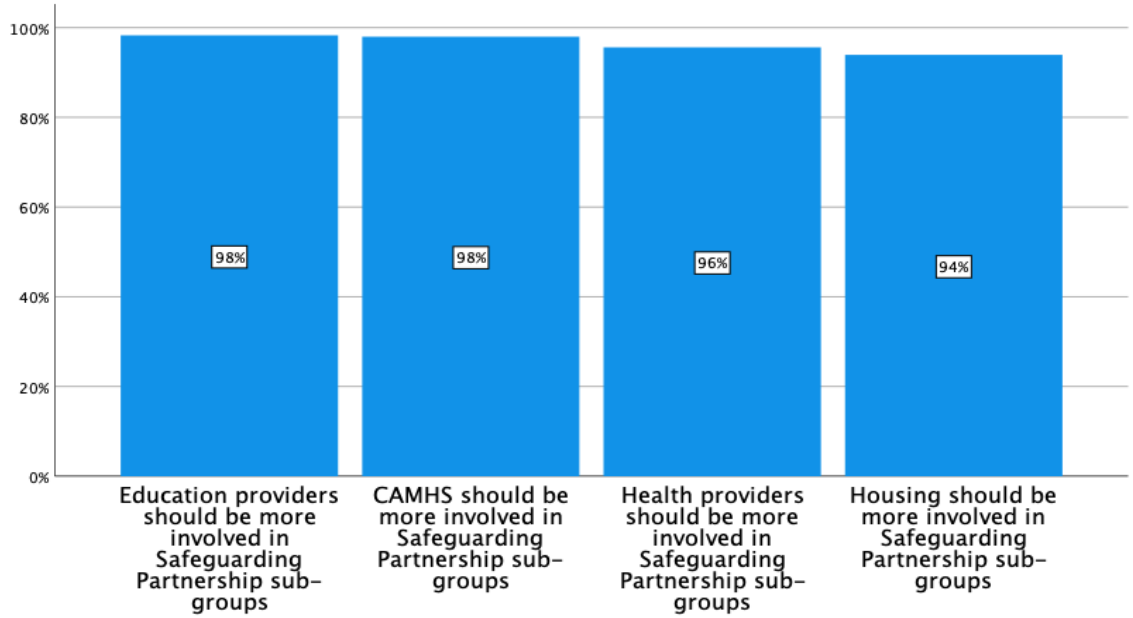
The responses suggest considerable strength of feeling about the importance of schools' engagement in local arrangements in particular, with 94% of 304 respondents agreeing that Education providers should be represented on the Executive Board: all Education, Mental Health and Police respondents, 96% of Health and 79% of Children's Social Care. In respect of Health providers, the figure was 88%, for CAMHS 84% and for Housing 73% (Figure 2.6). Even stronger agreement is evidenced for greater involvement in the sub-groups: 98% for Education providers and CAMHS, 96% for Health providers and 94% for Housing (Figure 2.7). We thought that the strength of feeling that we gleaned from the interviews as to the absence of the representation of Health providers might be a problem particular to London where the health estate is particularly fragmented, but these results suggest it is a nationwide issue.

Figure 2.6: Extending representation on the executive board
(n=304 Education providers; n=291 CAMHS; n=303 Health providers; n=255 Housing. Law excluded)



From your professional experience during the pandemic, please state whether you agree or disagree with the following statements in relation to the future (long-term) operation of Safeguarding Partnerships: [agency] should be represented on the executive board of the local Safeguarding Partnership

Figure 2.7 Relevant agencies' involvement in the work of Safeguarding Partnerships
(n=293 Education providers; n=299 CAMHS; n=297 Health providers; n=284 Housing. Law excluded)



From your professional experience during the pandemic, please state whether you agree or disagree with the following statements in relation to the future (long-term) operation of Safeguarding Partnerships: [agency] should be more involved in the work of the Safeguarding Partnership sub-groups

The few qualitative comments on this issue focused on schools:

> 'It's a shame Education are not a partner, as they see Children for the largest period of time.' – Named Nurse for Safeguarding, Yorkshire & The Humber

> 'I am still mystified why education was not included in it [Safeguarding Partnership] though, they seem essential.' – Named GP for Safeguarding Children, London

When asked about improving outcomes for child safeguarding, one Education respondent mentioned including Education (presumably meaning schools) as a partner alongside the Local Authority, Health, and Police.

Since completion of our research, the Child Safeguarding Review Panel Annual Report (Child Safeguarding Review Panel, 2021) has also concluded that partnerships have demonstrated a keen desire to ensure schools are a strong influence in local multi-agency safeguarding arrangements [para 45] and Sir Alan Wood has published his review of the implementation of Safeguarding Partnerships (Wood, 2021). In it, he responds to concerns expressed by some partnerships that schools were not sufficiently engaged in their work and by others that schools were excluded. Sir Alan asserts that there 'is clear evidence and example of how successful engagement has been possible in most areas. However, more can and should be

done to ensure head teachers and designated leads in schools can work more effectively with the local arrangements and where possible feed in a consensual view from the broad range of schools in any area' (p8). However, one of the most frequent challenges raised in responses to Sir Alan's survey to Safeguarding Partners was that 'fewer relevant agencies are proactively engaged with the arrangements compared to the time of the LSCB' (p13). This is an area that deserves further consideration, particularly given the role played by schools during periods of lockdown and the evidence of schools' experience of multi-agency working set out above and at 2.8 below.

2.4 Consulting Safeguarding Partnerships on changes made during the pandemic

Based on evidence from the interview stage that initial decision-making tended to be adult and public health facing and that decisions were made at a single agency level without full understanding of the potential implications for other safeguarding agencies, we asked: *Overall, are you satisfied with the extent to which your Safeguarding Partnership was consulted on local changes potentially impacting on child safeguarding, such as redeployment of universal health staff and closure/repurposing of services such as children's centres?* (N= 344; Law excluded).

Overall, 29% of respondents were satisfied/very satisfied and 27% dissatisfied/very dissatisfied. There were higher proportions of satisfied responses from Children's Social Care (54%), Safeguarding Partnerships (47%) and Police (43%) (Figure 2.8). There also appears to be a more positive picture presented than was given in interviews undertaken in June-September 2020, perhaps suggesting greater discussion over time and likely to take into account adaptations in redeployment patterns in later months. The highest levels of dissatisfaction were registered by schools (48%) and Health (45%) respondents (Figure 2.9). Again, it is important to note that there are relatively small numbers in each group.

We explored this question further in the survey by asking whether safeguarding leadership within a particular agency and Safeguarding Partnerships should have been consulted about redeployment (see page 92).

Figure 2.8: Consultation of Safeguarding Partnerships over local changes
(n=273, Law excluded)

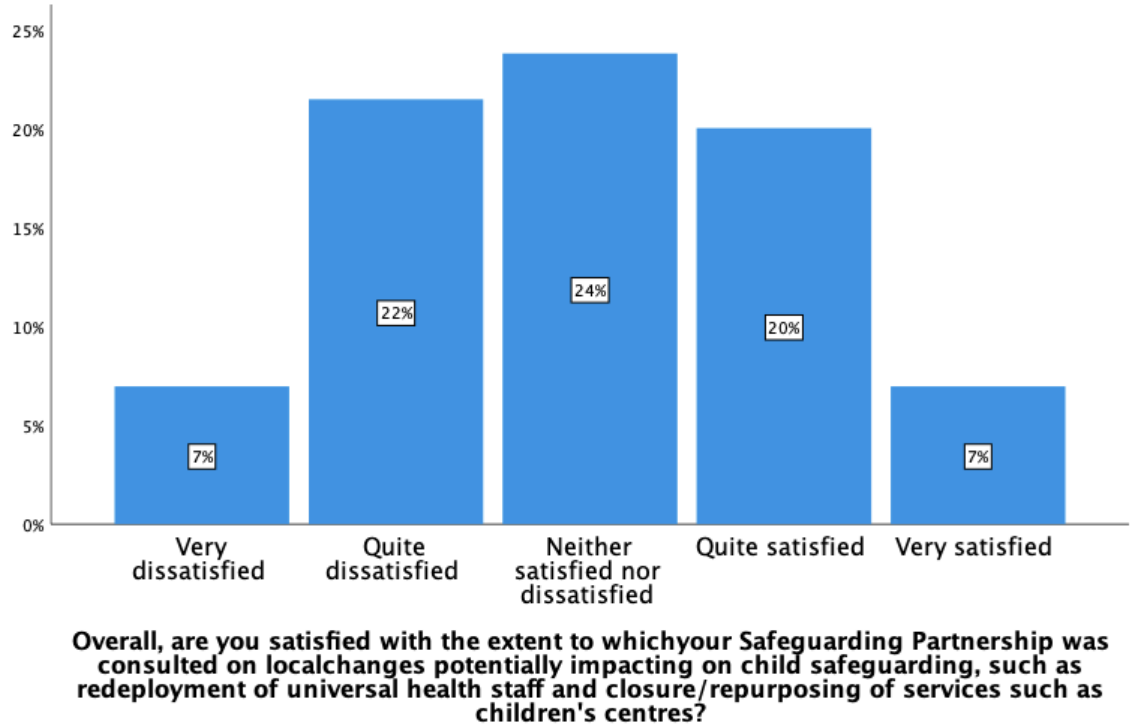
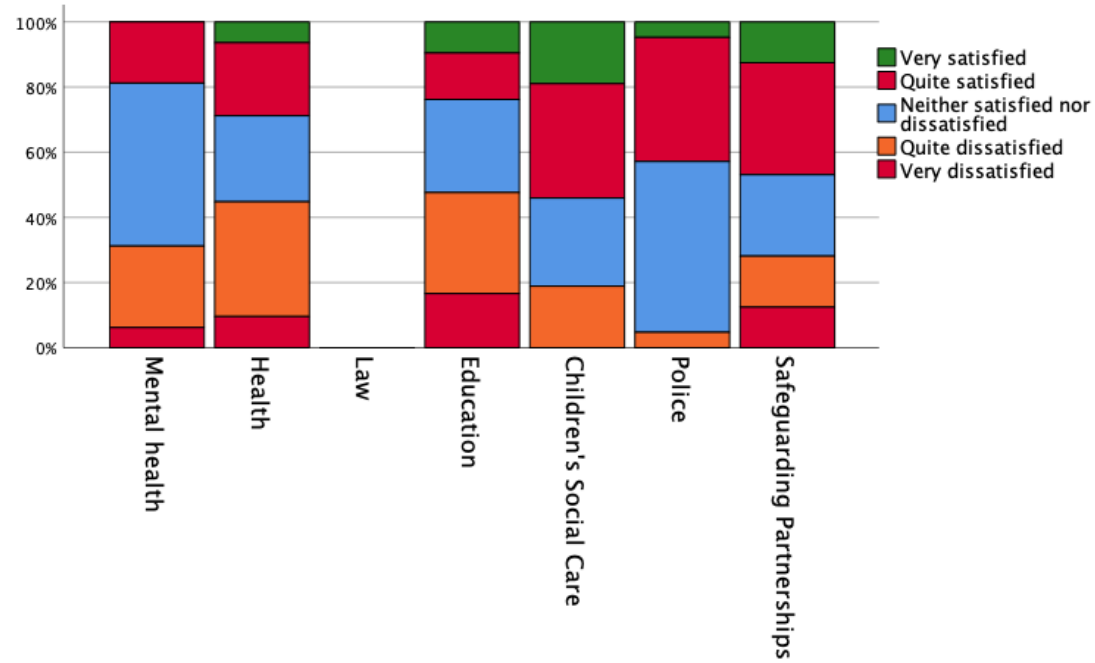


Figure 2.9 Satisfaction with consultation by agency (n=273, Law excluded)



These results seem consistent with the extent to which schools are unhappy with joint working arrangements but may reflect the fact that school respondents may not be as well informed about the business of Safeguarding Partnerships as others. Relatively poor Health satisfaction may reflect ongoing concern about issues such as redeployment and also the fragmentation of the provider sector in particular.

The question arises as to what the implications might be of the transition to Integrated Care Systems under the Health and Social Care White Paper *Integrating care: next steps to building strong and effective integrated care systems across England* (NHS England and NHS Improvement, 2020) and in particular, whether there is a need to draw on lessons about representation of different professional groups and agencies and how to ensure that safeguarding is not a poor relation in the new arrangements.

2.5 Revised risk assessments

Summary of interview findings

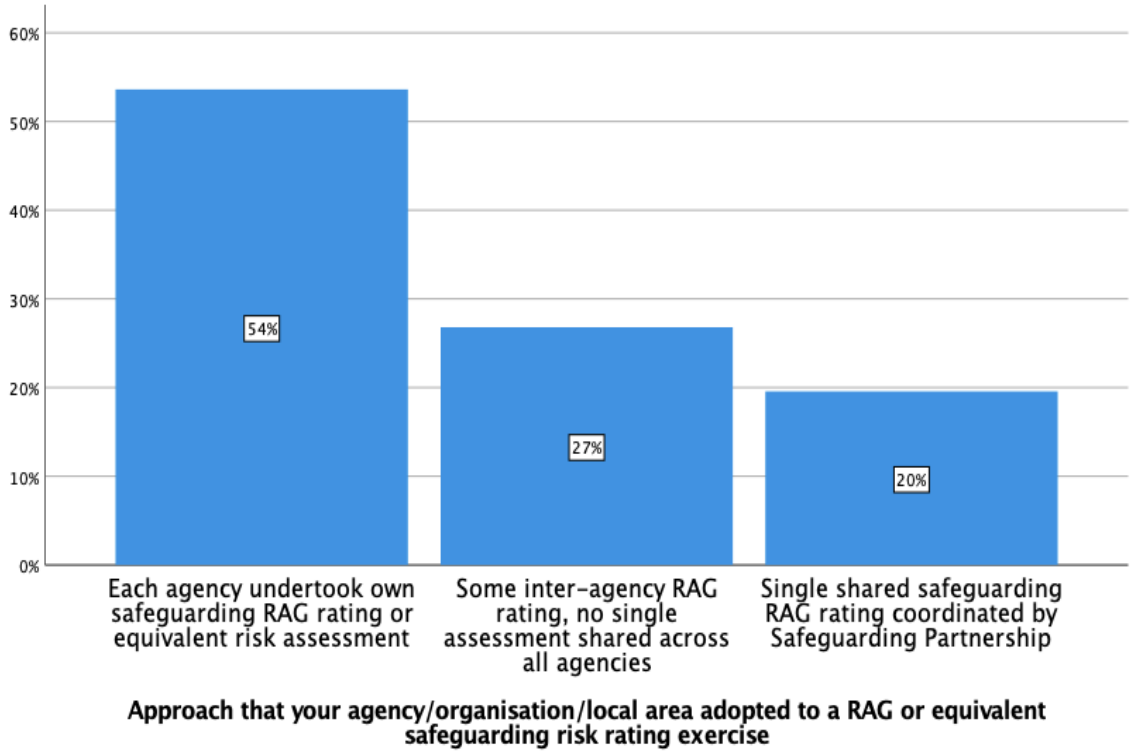
Revised risk assessment for cases known to services took place in a variety of ways. RAG (Red-Amber-Green) rating of risk was carried out by social care in accordance with guidance from the Principal Social Worker (Buzzi and Megele, 2020). In some cases, all children known to services in the preceding 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 Children's 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 multiagency teams realised the benefits, particularly with some increasing complexity of cases. 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.

Survey results

We were interested in the very different accounts of the ways in which local areas re-evaluated the risks to children known to services under the COVID-19 restrictions by our interviewees. In particular, we sought more information on the perceived effectiveness of a multi-agency approach to RAG-rating. We asked *whether each agency undertook a risk assessment exercise individually; whether there was some inter-agency coordination, but no*

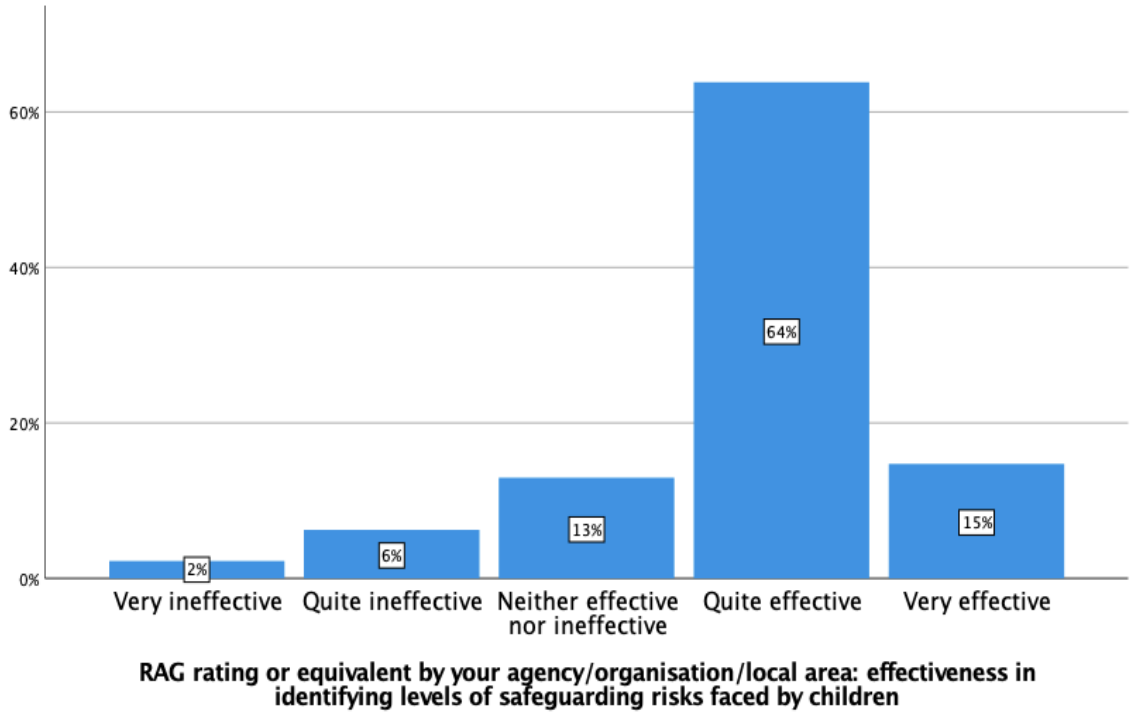
single assessment shared across all agencies; or whether there was a single RAG-rating exercise or equivalent coordinated by the Safeguarding Partnership (n=235, Law excluded).
Over half of respondents reported that each agency undertook a separate risk assessment review exercise, but 27% reported some inter-agency coordination and 20% reported a single RAG rating exercise or equivalent for the local area coordinated by the Safeguarding Partnership (Figure 2.10). Caution might be needed here as Safeguarding Partnership representatives were most likely to report joint agency assessment (at 40%) and because of small numbers in groups other than Health. It may also be pertinent that schools were primarily concerned with assessments of 'vulnerable' children for the purposes of school attendance: there was some commentary from Education respondents noting that they were 'unaware' of the RAG rating exercise and that there was no information shared regarding the process.

Figure 2.10 Approach to risk reassessment exercises (n=235, Law excluded)



At whatever level the exercise was carried out, most respondents (79%) felt that the exercise had been quite effective or very effective and only 9% thought it had been very or quite ineffective (Figure 2.11).

Figure 2.11 Perceived effectiveness of risk reassessment exercises (n=224, Law excluded)



We investigated whether there was a relationship between whether a joint agency assessment process was employed and respondents' views on the effectiveness of the RAG rating exercise. This showed as close to significant (asymptomatic significance (2-sided) .055), although some counts are small (Table 2.2).

Table 2.2: Relationship between nature of risk assessment and perceived effectiveness

Approach that your agency/organisation/local area adopted to a RAG or equivalent safeguarding risk rating exercise * RAG rating or equivalent by your agency/organisation/local area effectiveness in identifying levels of safeguarding risks faced b children? Crosstabulation

			RAG rating or equivalent by your agency/organisation/local area effectiveness in identifying levels of safeguarding risks faced by children?					
			Very ineffective	Quite ineffective	Neither effective nor ineffective	Quite effective	Very effective	Total
Approach that your agency/organisation/local area adopted to a RAG or equivalent safeguarding risk rating exercise	Each agency undertook own safeguarding RAG rating or equivalent risk assessment	Count	5	10	20	63	18	116
		% within Approach that your agency/organisation/local area adopted to a RAG or equivalent safeguarding risk rating exercise	4.3%	8.6%	17.2%	54.3%	15.5%	100.0%
	Some inter-agency RAG rating or equiv', no single assessment shared across all local agencies	Count	0	1	6	47	7	61
		% within Approach that your agency/organisation/local area adopted to a RAG or equivalent safeguarding risk rating exercise	0.0%	1.6%	9.8%	77.0%	11.5%	100.0%
	Single shared safeguarding RAG rating or equiv' for local area coordinated by Safeguarding Partnership	Count	0	3	3	30	8	44
		% within Approach that your agency/organisation/local area adopted to a RAG or equivalent safeguarding risk rating exercise	0.0%	6.8%	6.8%	68.2%	18.2%	100.0%
Total		Count	5	14	29	140	33	221
		% within Approach that your agency/organisation/local area adopted to a RAG or equivalent safeguarding risk rating exercise	2.3%	6.3%	13.1%	63.3%	14.9%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	15.248[a]	8	.055
Likelihood Ratio	18.147	8	.020
Linear-by-Linear Association	5.600	1	.018
N of Valid Cases	221		

a. 5 cells (33.3%) have expected count less than 5. The minimum expected count is 1.00.

Education and Mental Health were most likely to report a single agency assessment and most likely to feel dissatisfied with its effectiveness. Feelings of dissatisfaction as to the effectiveness of RAG rating by Education professionals may be further understood from additional commentary by Education respondents, which included the following:

> Schools were not consulted- we were instructed which children when we had a much more extensive list and more knowledge of families. The social services not going to homes has made the work in schools so much more. We still don't get consulted enough. Our viewpoint is not considered, family workers who were not going to homes have more impact than schools who work long term with children and families and see them daily. – Education, South West England

> The lack of shared understanding and the lack of acknowledgment that in the significant majority of cases, schools will know families best - there is a reluctance to accept this and take advantage of the knowledge schools have. Also, other agencies

> are reluctant to take overall responsibility for specific cases and even when that has been agreed, communication is poor and actions are not carried out in a timely manner. – Education, London

There was some criticism of single agency approaches, with one Safeguarding Partnership respondent in the East Midlands commenting that the process was 'done individually, not shared and no challenges accepted' and a Designated Nurse for Looked After Children in South East England noted an absence of 'sharing risk assessments between health and social care', although other qualitative comments mentioned agencies leading on undertaking a RAG rating/single risk assessment exercise with additional inter-agency input, communication and cross-referencing (Children's Social Care, Health, Safeguarding Partnerships). Respondents in Children's Social Care and Health also highlighted that a concern of RAG rating is that whilst it 'worked for children with known risk' (Named Nurse for Safeguarding, Named Nurse for LAC, North West England) and those who 'already have involvement' (Designated Nurse for Safeguarding, South West England), it does not allow for consideration of unknown children.

2.6 Scrutiny/sharing of data/trends

Summary of interview findings

Our interview participants described a number of strategies to support information sharing as a result of concerns as to likely changes in the level of risk pertaining to individual cases (Law and Named Health respondents excluded). One area extended the work of the Multi-Agency Strategic Hub (MASH) by widening the groups of children considered for interagency discussion. Others described extending reassessment processes to wider pools of children. GP practices in a few boroughs routinely received lists of vulnerable children from social care, and most met regularly to discuss these. Some areas encouraged school nurses and health visitors to be part of the process of engaging those that were vulnerable on their safeguarding caseload, although this met resistance in one area, not least because of sickness and extensive redeployment of universal services. Increased monitoring or attention to 'normal' data collected was also mentioned frequently as an important tool for risk management, and useful for the future.

Survey results

We therefore asked a number of questions in the survey about the remit of the MASH, increased data sharing within and between local authorities and increased scrutiny of data and/or trends at Safeguarding Partnership level (Figure 2.12 and Figure 2.13). These questions were not asked to Law respondents or Named Health respondents. To those respondents who reported use of a strategy, we asked a follow-on question as to whether they supported retaining the approach after the pandemic.

33% of 111 respondents (excluding 'don't knows) reported that the remit of the MASH was widened to encompass more groups of children, and 30/36 felt that should be retained, with six disagreeing.

70% of 133 respondents reported increased sharing of data and trends within their local authority area and almost all who answered the retention question [85] supported retention (97%).

47% of 101 respondents reported increased sharing of data and trends between local authority areas: only one person among those responding in relation to retention [39] opposed retention.

67% of 116 respondents reported increased scrutiny of data and trends at Safeguarding Partnership level, with only 4 respondents of the 72 commenting on whether such increased scrutiny should be retained opposing that proposal.

Figure 2.12: Strategies to support information-sharing (Law and Named Health excluded)

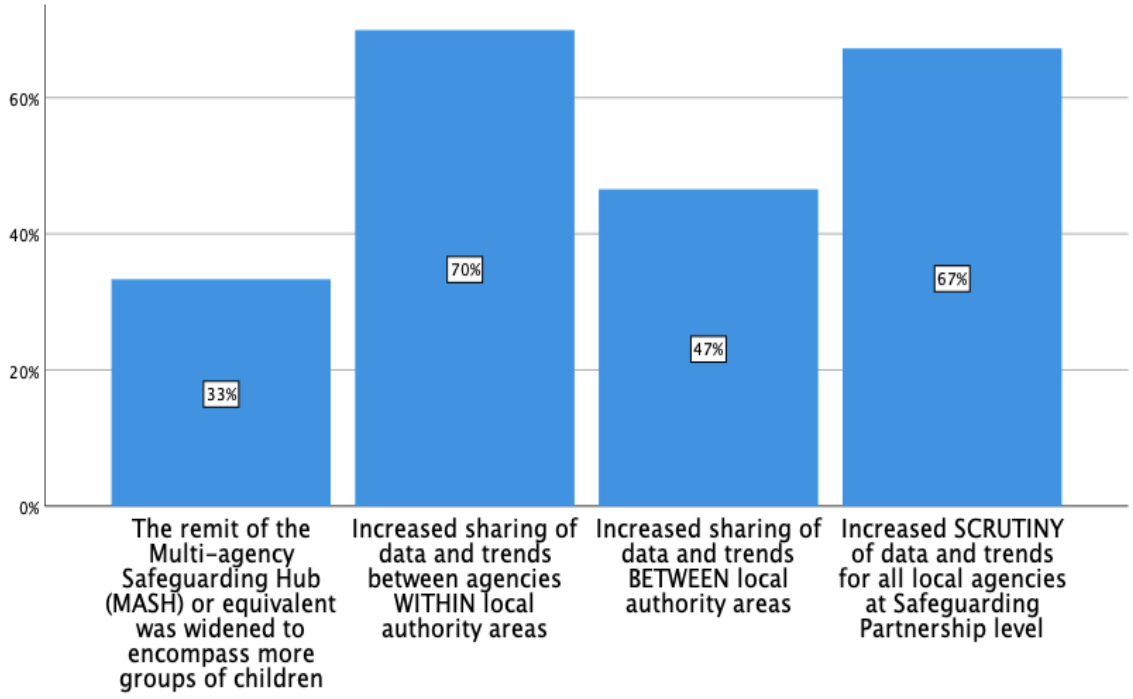
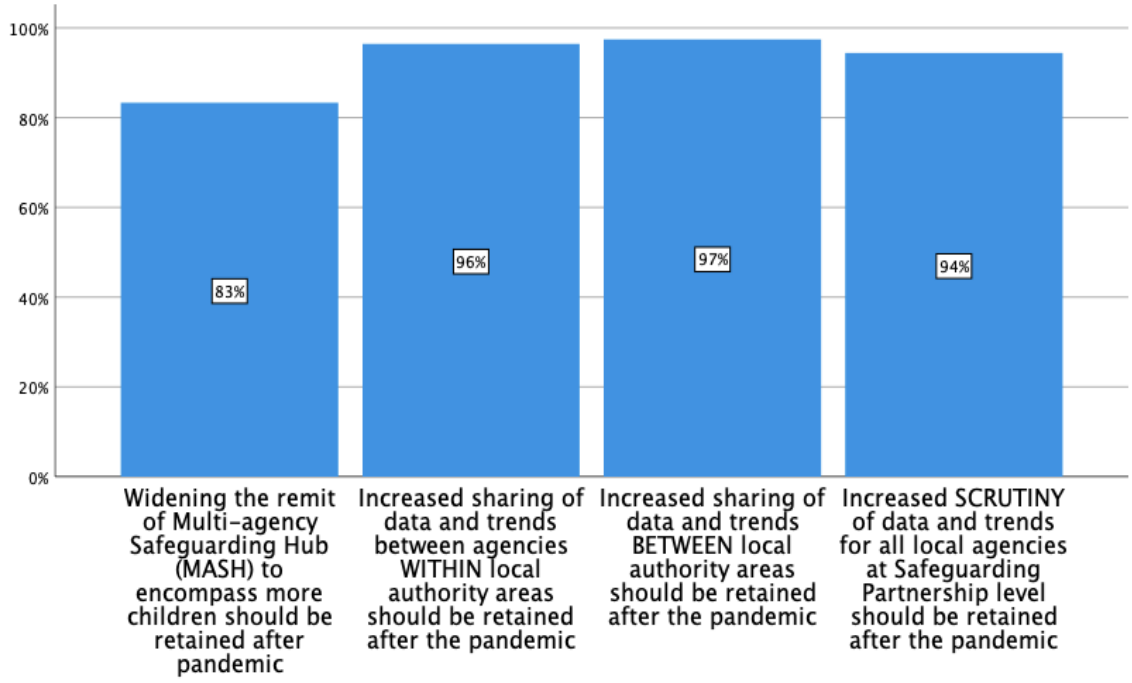


Figure 2.13: Support for retention of information-sharing strategies (Law and Named Health excluded)



Following on from these questions, we asked '*From your experience during the pandemic would you support introducing a system where all agencies share pre agreed information relating to safeguarding children?*' (n = 280). 98% of respondents answered yes – no agency returned a 'yes' response lower than 94%. This level of agreement suggests that the pandemic may have exacerbated perennial concerns about inter-agency communication. Open comments from Children's Social Care, Health, and Mental Health respondents suggested a central and universal IT information sharing system would 'allow professionals to have an holistic view of the family's experience and professional input' (Named Nurse for Safeguarding, East Midlands).

2.7 Voice of the child

Survey results

We asked two questions about how well the voice of the child could continue to be heard at strategic and individual level during the adaptations introduced during the pandemic. As expected, more respondents considered that the voice of the child was less readily heard than felt that it was more readily heard, but this was less pronounced at strategic level (47% less readily and 20% more readily) than individual level (59% less readily and 16% more readily) (Figure 2.14). At individual level, Children's Social Care respondents were most optimistic by some way (30% less readily heard and 35% more readily heard) (Figure 2.15A). At strategic level, Education was least optimistic by a pronounced margin (68% less readily heard compared with 3% more readily heard) (Figure 2.15B).

Figure 2.14: Hearing the voice of the child
N = 272 (individual); n = 253 (strategic)

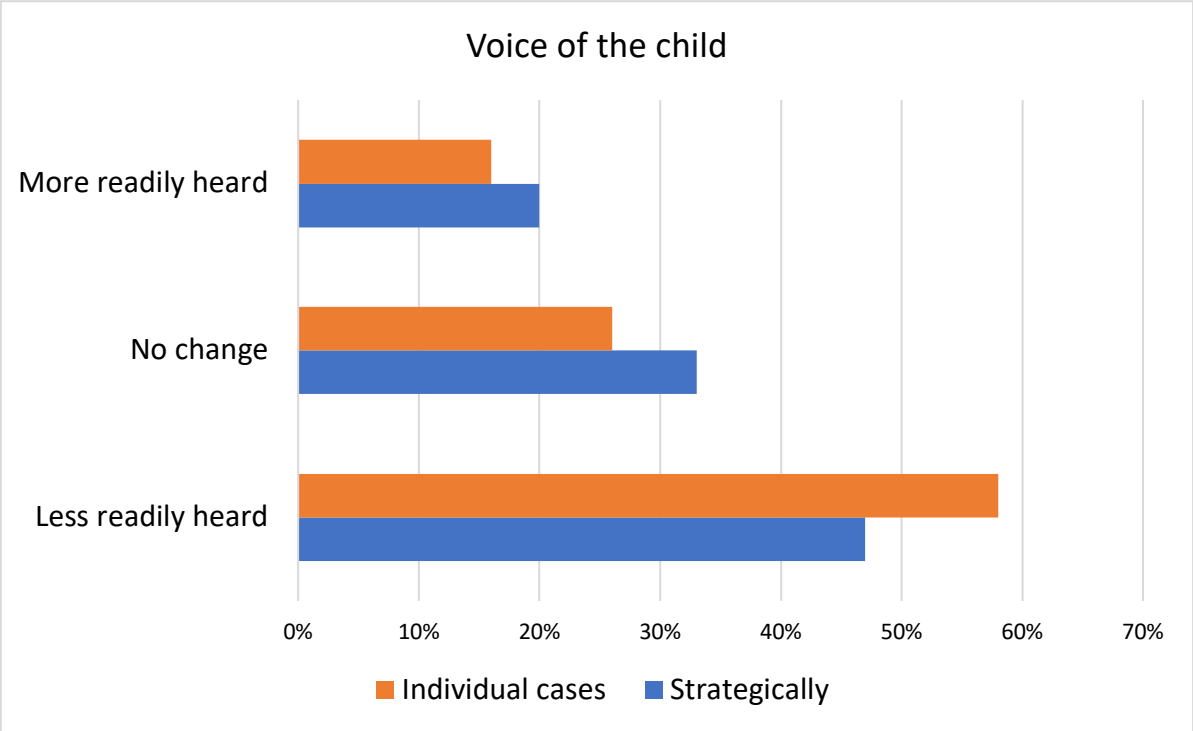
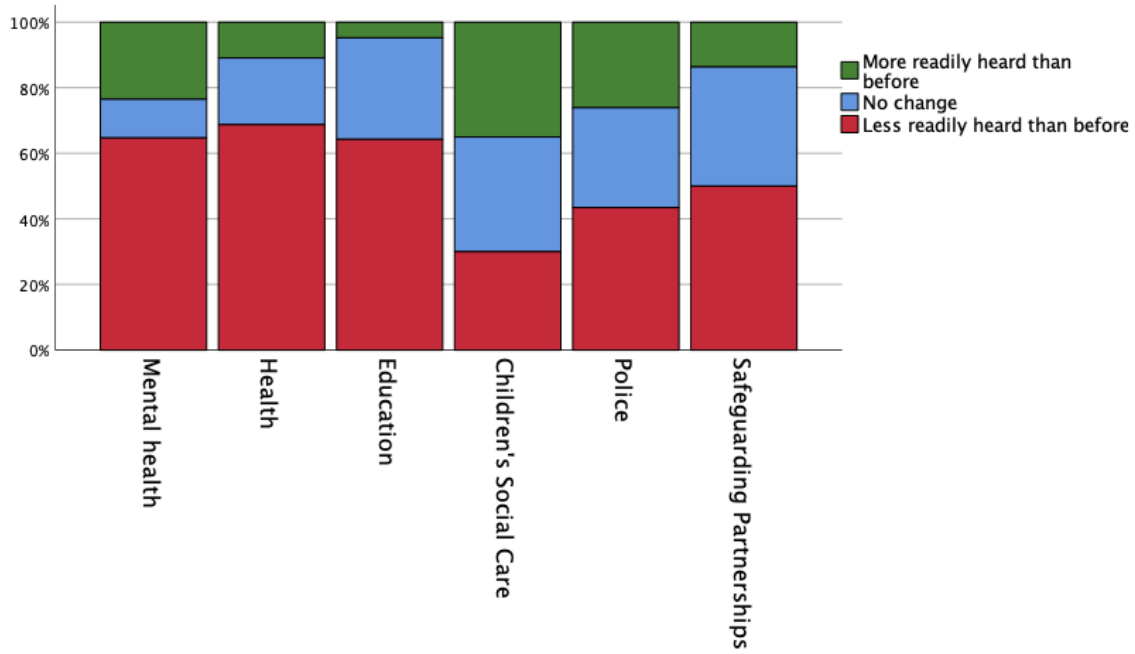
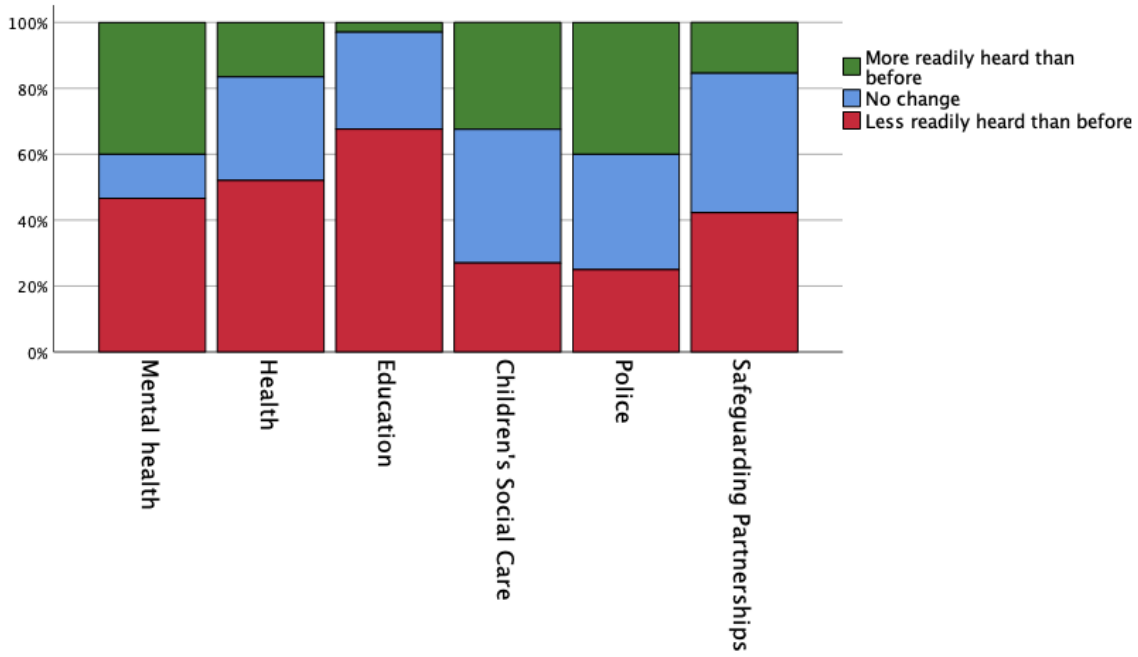


Figure 2.15A: Hearing the individual voice of the child by agency (n=272; law excluded)



During the pandemic, the voice of the child has been heard…
in relation to individual cases

Figure 2.15B: Hearing the voice of the child strategically by agency (n=253; law excluded)



During the pandemic, the voice of the child has been heard…
at strategic level

The importance of understanding the experiences and perspectives of children was highlighted by qualitative comments, such as these:

> Listen to the voices of young people and families about what helps. Especially the voice of the Looked After Child. – NHS England, London
>
> Learn from this experience, particularly listening to children's experiences. – Designated Nurse for LAC, North West England

Recommendations:

1. Ongoing evaluation as to the effectiveness of Safeguarding Partnerships in coordinating local areas' safeguarding children services and providing strategic leadership. In particular, consideration as to how best to ensure that all relevant agencies, including schools, health providers, and mental health providers, are fully engaged in the work of Safeguarding Partnerships in the light of the critical role played by schools during periods of lockdown and the forthcoming Integrated Care legislation.
2. Arrangements for multi-agency collaboration and cooperation for the protection of children become of heightened importance during periods of lockdown: robust safeguarding contingency plans should be prepared in advance of any future

crises with full input from Safeguarding Partnerships, including in relation to redeployment of all staff with safeguarding responsibilities.

3. Consideration to building on some of the initiatives for joint risk assessments and enhanced scrutiny and/or sharing of data and trends to enhance risk management in the future. In particular, thought should be given to extension of the NHS Child Protection-Information Sharing Programme to a wider range of agencies.
4. Attention to processes and mechanisms through which hearing the voices of all children can be adequately assured in any future incidents in which universal services are closed, with attention to particular/special needs of children and families and barriers such as digital poverty.

2.8 The role of schools

Summary of interview findings

Stage 1 of our research took place between the partial reopening of schools on 1st June 2020 and the start of the new academic year in September 2020. During the first lockdown period in March - May 2020, "vulnerable" children entitled to a school place were defined as children who

- are assessed as being in need under section 17 of the Children Act 1989, including children and young people who have a child in need plan, a child protection plan or who are a looked-after child
- have an education, health and care (EHC) plan and it is determined, following risk assessment, that their needs can be as safely or more safely met in the educational environment
- have been assessed as otherwise vulnerable by educational providers or local authorities (including children's social care services), and who could therefore benefit from continued attendance. This might include children and young people on the edge of receiving support from children's social care services, adopted children, those at risk of becoming NEET ('not in employment, education or training'), those living in temporary accommodation, those who are young carers and others at the provider and local authority's discretion.

(Department for Education (DfE), 2020). This definition was later extended (8th March 2021) to include children who:

- are assessed as being in need under section 17 of the Children Act 1989, including children and young people who have a child in need plan, a child protection plan or who are a looked-after child
- have an education, health and care (EHC) plan

- have been identified as otherwise vulnerable by educational providers or local authorities (including children's social care services), and who could therefore benefit from continued full-time attendance, this might include:
    - children and young people on the edge of receiving support from children's social care services or in the process of being referred to children's services
    - adopted children or children on a special guardianship order
    - those at risk of becoming NEET ('not in employment, education or training')
    - those living in temporary accommodation
    - those who are young carers
    - those who may have difficulty engaging with remote education at home (for example due to a lack of devices or quiet space to study)
    - care leavers
    - others at the provider and local authority's discretion including pupils and students who need to attend to receive support or manage risks to their mental health

(Cabinet Office/Department for Education, 2021).

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 interviewees reported that 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 term and translate into increased levels of home schooling. In the first stage of 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 infection but

were being asked to encourage other parents to send their children to school. Participants expressed mixed views as to whether attendance requirements should have been stronger or possibly even mandatory.

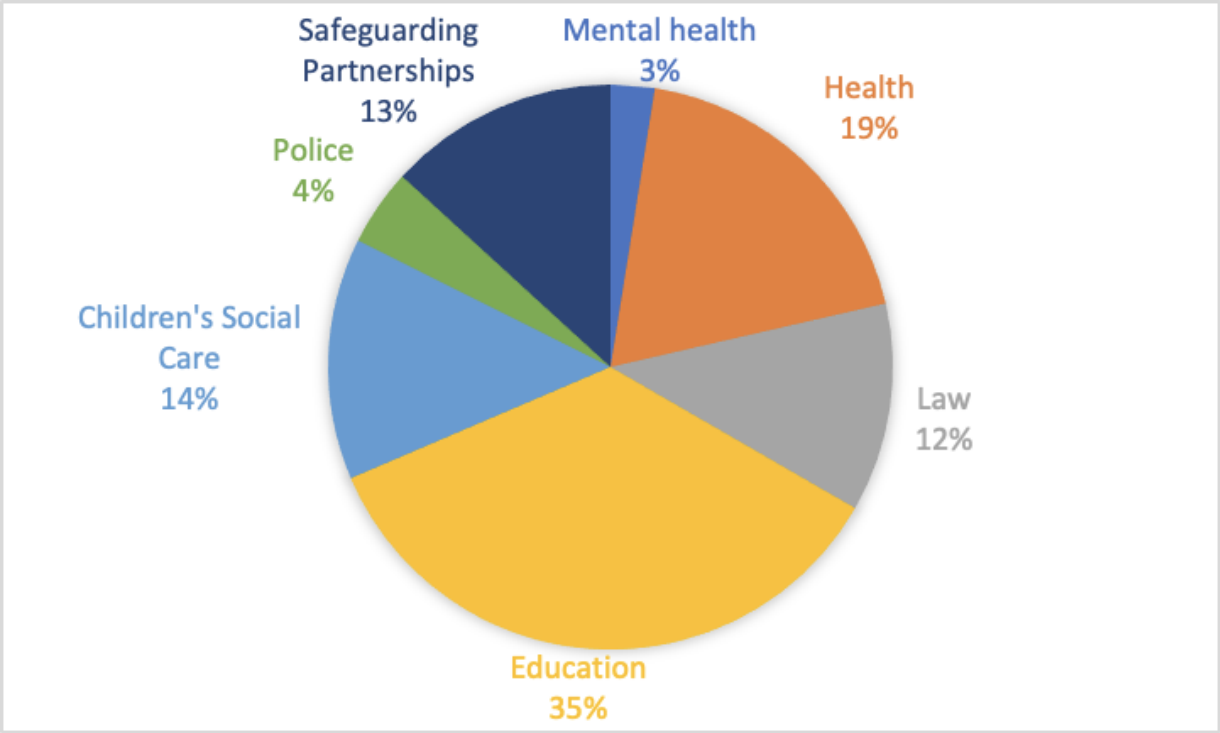
Where children deemed to be vulnerable remained at home, 'keeping in touch' strategies were implemented, such as regular, generally weekly, calls to families, amounting to a 'huge increase' in contacts with known vulnerable children. Participants reported that, in general, positive relationships were 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 liaison officers to follow up on families who did not respond to contacts, but this was felt by others to be heavy handed.

Survey results

We included a section in the survey on the role of schools in safeguarding during the pandemic not only because of the concerns of interviewees recounted above but also because the findings of the earlier study of Baginsky et al. (2021) in which Driscoll was a Co-Investigator suggest that schools were feeling increased pressure prior to the pandemic as a result of rising child poverty, the effect of austerity measures on Children's Social Care and reductions in their own budgets. That research suggested that schools had invested in a range of pastoral staff and had also relied on multi-agency early help arrangements but were beginning to sacrifice pastoral posts in order to preserve teaching posts against a backdrop of difficulties in accessing Early Help support for families. School staff in that study also reported undertaking a variety of roles which they would previously not have regarded as within the remit of schools or beyond their professional expertise, particularly in relation to family support and children's mental health.

This section first addresses issues relating to school attendance before reporting on the wider implications of practice during the pandemic for schools' safeguarding responsibilities. There are reduced responses to parts of this section as a result of a filter question asking whether respondents had knowledge or views on the involvement of schools in safeguarding arrangements during the pandemic. The proportions of respondents are different in this section therefore, with over a third from Education in some parts (Figure 2.16).

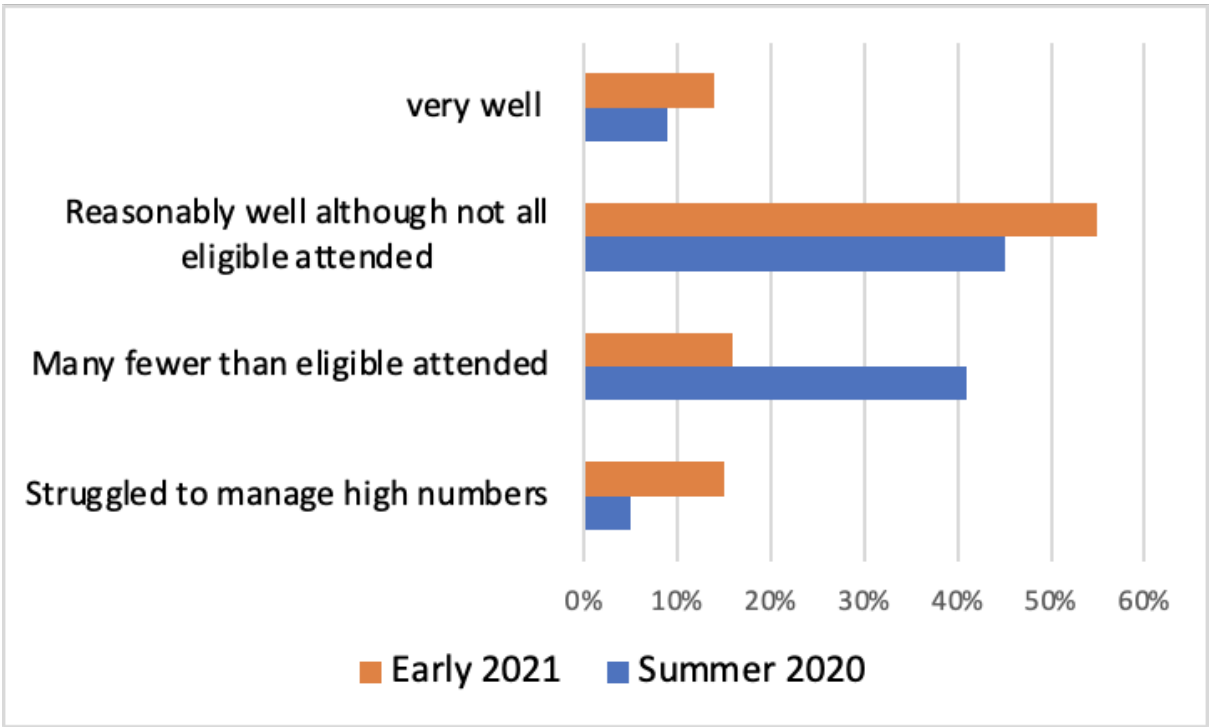
Figure 2.16: Respondents to section on schools' role (n=159)



2.8.1 School attendance

We asked ***How well did the guidance on school attendance work in your local area for vulnerable children without clinical contraindications?*** Responses (Figure 2.17) reflect government statistics showing a steady increase of vulnerable groups of children attending schools during the Spring term 2021 (5th January to 5th March 2021, before wider reopening on 8th March), rising to around half of children with a social worker and just under a half of pupils with an EHCP plan (Gov.uk Explore Education Statistics, 2021). Worries that opening up attendance to larger numbers of children would cause difficulties did not manifest for most.

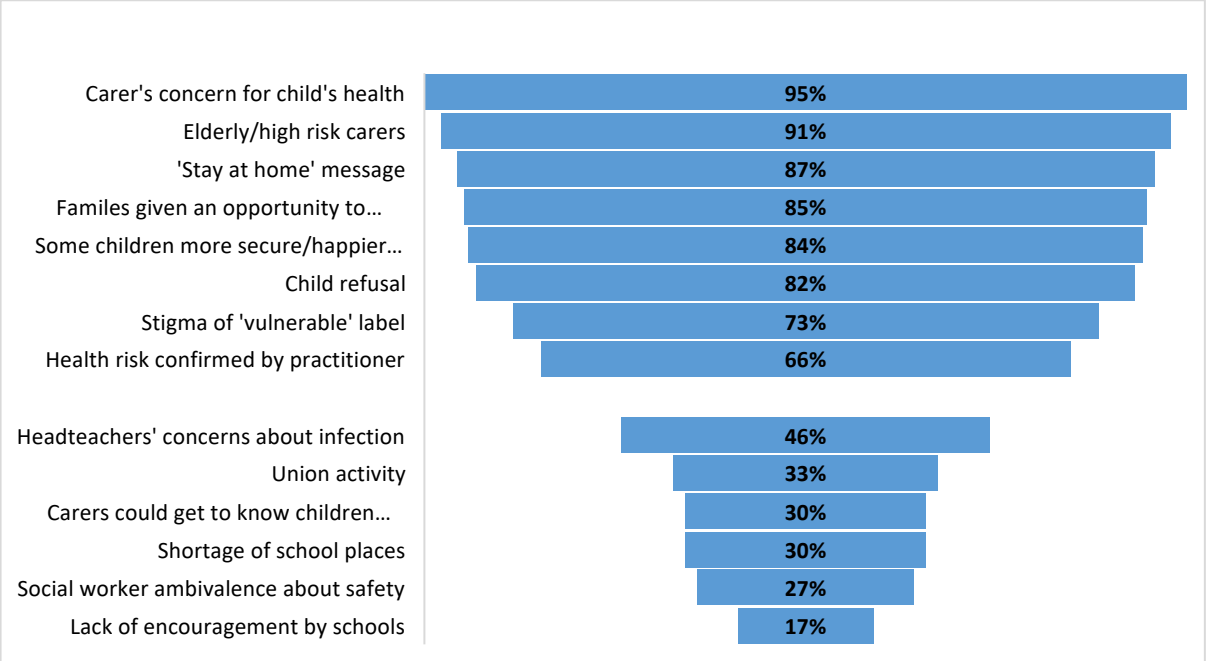
Figure 2.17: Vulnerable children's attendance at school (n=101 summer 2020, n=99 early 2021)



How well did the guidance on school attendance work in your local area for vulnerable children without clinical contraindications?

Our interviewees had also speculated or commented on the apparent reasons for the reluctance of some families to send children who were eligible to attend to school. We listed the reasons suggested in interview and asked survey respondents to indicate if each factor could contribute to non-attendance (i.e., they did not rank factors but simply indicated yes/no as to whether that factor could contribute to children's non-attendance). We counted 'yes' responses (n= 79-130 depending on the question) and these are reported as percentages of those answering yes or no at Figure 2.18.

Figure 2.18: Reasons thought to contribute to non-attendance of vulnerable children



Additional open comments from Health and Education respondents included:

> Families opting to 'stay below the radar', those with poor previous attendance opting to avoid school and 'EHE' [Elective Home Education] – Designated Doctor for Safeguarding, East Midlands

> In order to have more pupils at my special needs school, I needed more support from health and social care colleagues – they were working remotely and that wasn't good enough. – Education, London

> Parental anxiety was the highest risk. – Designated Doctor for Safeguarding, London

> Some families used Covid as an excuse for not sending the children but also some parents have said that for some children not having to get ready for school resulted in a calmness in the house? – Named Nurse for Safeguarding, South West England

> Foster carers did not allow children to access school provision in first lockdown due to concerns about transmission. – Designated Nurse for LAC, South East England

We asked respondents what strategies they had used to increase attendance over time and how effective they thought they had been. [N.B.: small numbers at this stage of the section should be taken into account: only Education, Children's Social Care & Safeguarding Partnership respondents were included, from those who had opted to answer this set of questions [n= 69-77] (Table 2.3)].

Table 2.3: Strategies used to boost attendance and perceived effectiveness

	Used	Appeared to improve attendance to an extent/ significantly
Encouragement of DSL/school staff known to family (74)	97%	83% [of all responses]
Using parental concerns about behaviour/schoolwork (71)	91%	68%
Encouragement of social worker (77)	87%	64%
Advice from health/mental health professionals (72)	75%	53%
Coordinated multi-agency contact (72)	71%	51%
Virtual parents' group meetings (69)	52%	34%
Contact from School Improvement Service (74)	43%	23%
Youth mentoring (69)	43%	22%

Safeguarding Partnership respondents were most likely to say that the effect of strategies were unknown, which may suggest there could be more local agency coordination and sharing of strategies in this area.

In the light of interviewees' concerns about the safeguarding implications of children known to services being out of school, we asked: *Do you consider primary / secondary school attendance should be mandatory for all vulnerable children in families with low clinical risk?* **87%** of respondents stated that attendance should be mandatory for all ***primary school*** vulnerable children in families with low clinical risk: (n = 295; health 92%). **85%** of respondents stated that attendance should be mandatory for all ***secondary school*** vulnerable children in families with low clinical risk: (n= 285; health 91%).

Two of the 125 responses to the open question *If you could improve one aspect of safeguarding/child protection process or practice in order to improve outcomes, what would it be?* addressed this point:

> Mandatory to attend school if on SEND list or Child Protection/Child in Need/Early Support. – Education, London

> Keep vulnerable CYP at school. – Designated Nurse for Safeguarding, East of England

One suggestion of a 'shining example' of practice adaptations was:

> Children on Child protection and child in need plans HAD to attend school as directed by their social worker and written in the plan. – Education, North West England.

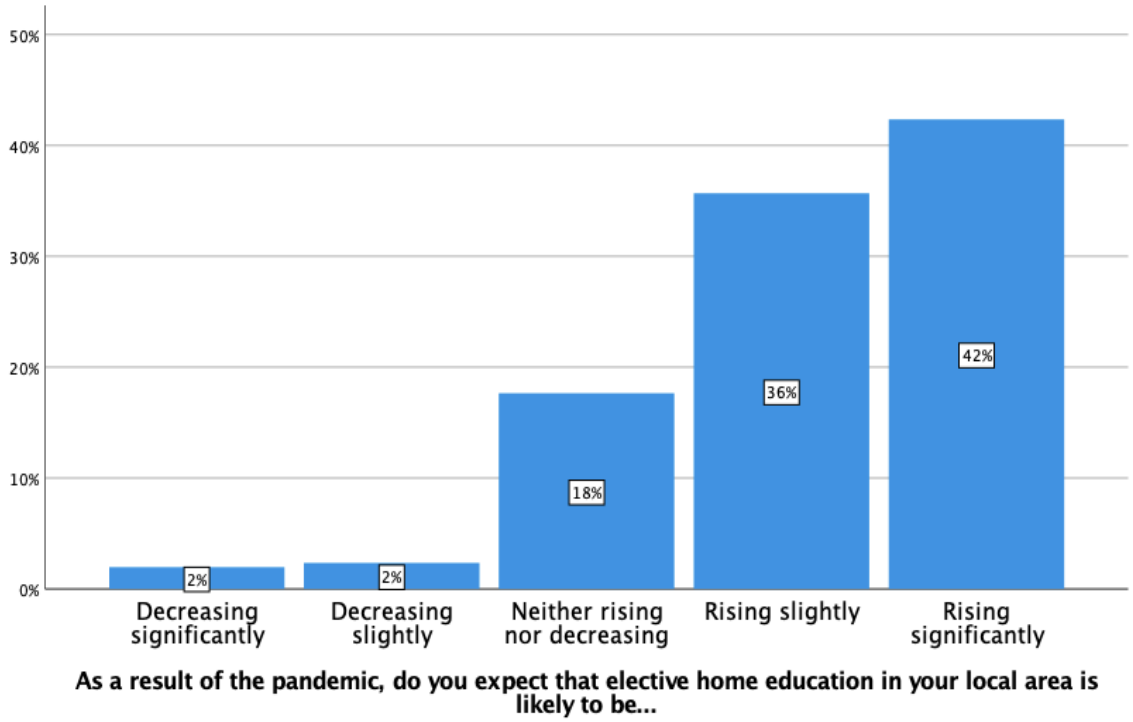
This example was, understandably, the subject of some controversy at the Policy Lab to disseminate the survey findings in April 2021, where delegates highlighted worries that it might operate in a discriminatory fashion and raised questions as to whether such practice was ethical.

2.8.2 Elective Home Education

We asked about fears that Elective Home Education (EHE) may increase as a result of relaxations in school attendance during lockdown (n=255). Elective Home Education remains largely unregulated and this was a significant concern for our school participants to the safeguarding in schools project (Baginsky et al., 2021). The Wood Report (Wood, 2021) and the Child Safeguarding Review Panel Annual Report (Child Safeguarding Review Panel, 2021) both endorse the urgency of guidance on the protection of children being educated at home or in unregistered schools.

78% of respondents to this question expected that Elective Home Education would rise as a result of the pandemic (Figure 2.19).

Figure 2.19: Is Elective Home Education expected to rise? (n=255)



When asked about areas of concern relating to the pandemic, additional qualitative comments reinforced survey respondents' expectations, as shown below:

> Number of electively home educated doubled from 200 to 400 following start pandemic. – Designated Doctor for Safeguarding, London
>
> It is also concerning that we are seeing a significant increase in the number of children being electively home educated as a result of the pandemic, a number of which could be at risk of harm. – Independent Scrutineer /Chair, East of England
>
> A significant percentage of children did not return to education following the end of lockdown periods (analysis is required as to the underlying reason (genuine COVID concerns or a parenting issue). - Police, Yorkshire & The Humber

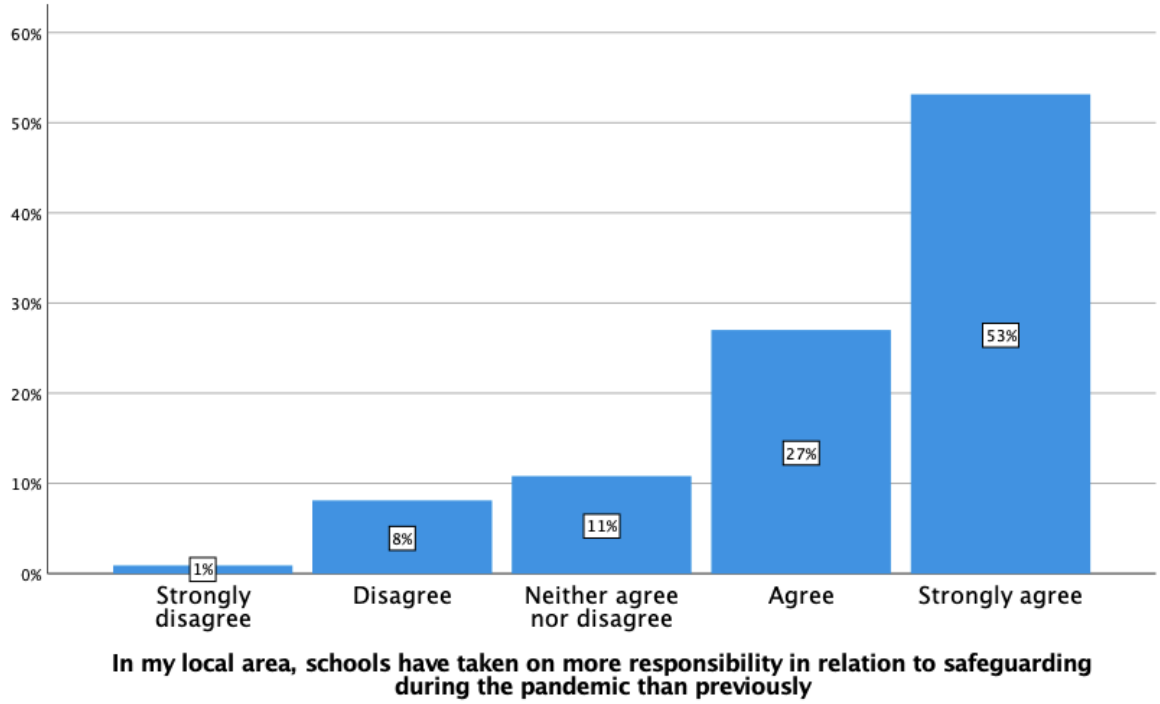
Three respondents commented on EHE in response to the open question *If you could improve one aspect of safeguarding/child protection process or practice in order to improve outcomes, what would it be?*

> Ban EHE for vulnerable children. – Children's Social Care, London
>
> Review the use of and monitoring of home elective education. – LA Solicitor, London
>
> Elective Home Education information sharing. – Business Manager, London

2.8.3 The burden on schools

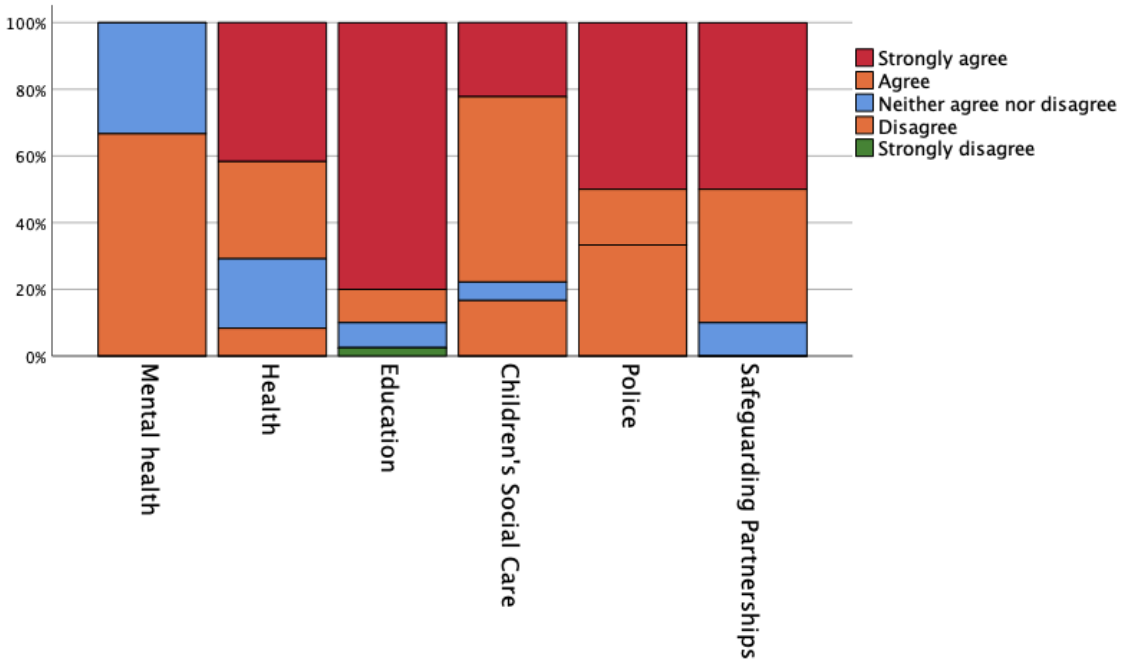
In the light of commentary from some interviewees in the first stage of the study, we asked whether respondents agreed that ***Schools have taken on more responsibility for safeguarding during the pandemic than previously*** [n=111]. 80% of those responding to this question agreed or strongly agreed that schools have taken on more responsibility for safeguarding during the pandemic (Figure 2.20).

Figure 2.20: Have schools taken on more responsibility for safeguarding? (n=111, Law excluded)



For Education [n=40], 80% strongly agreed and 10% agreed (Figure 2.21).

Figure 2.21: Schools taking on more responsibility by agency



In my local area, schools have taken on more responsibility in relation to safeguarding during the pandemic than previously

Qualitative comments from various parts of the survey endorse the findings from the safeguarding in schools research (before the pandemic) (Baginsky et al., 2021) that some school staff are questioning the role they now play in relation to child protection.

> As a HT (headteacher) I had to fight even harder to get other professionals to do their roles effectively even more was left to us and it was already too much! – Education, London

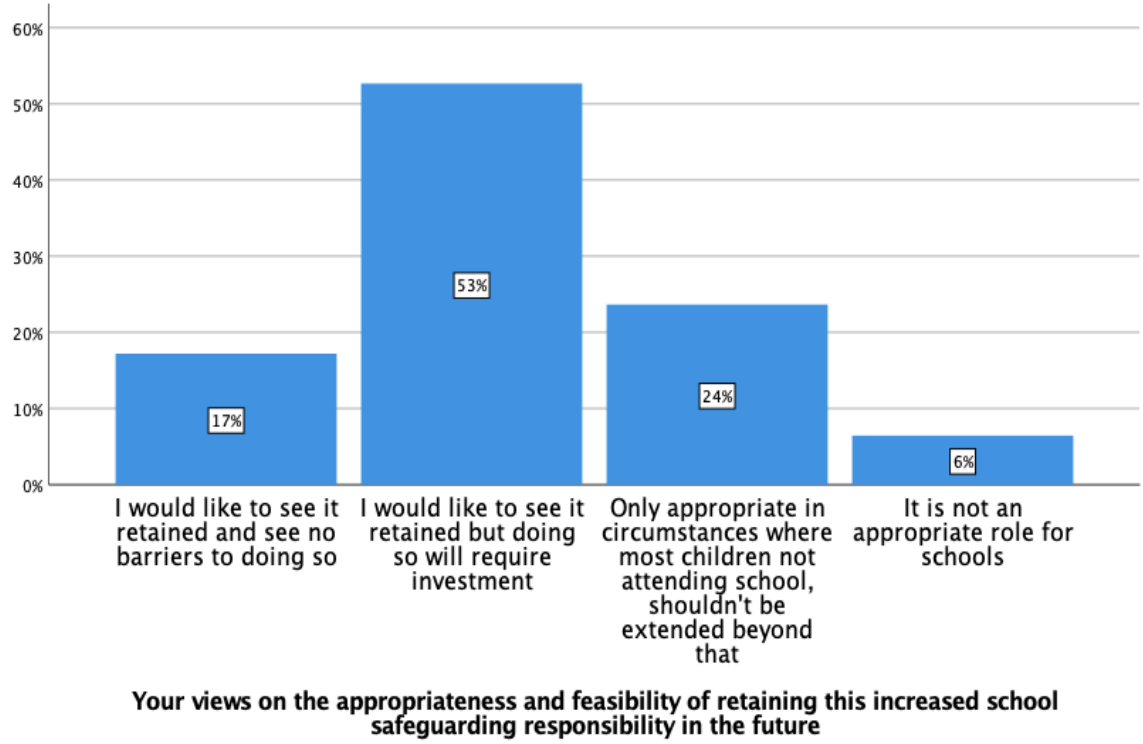
> Schools need help...Over time there has been a gradual creep towards schools taking on more responsibility for communities and what would traditionally be social care. This has been vastly accelerated during the pandemic. We cannot sustain this. It needs to be planned for and supported with staff who can fulfil the specialist roles. – Education, South West England

> Schools need more support- the expectations have increased so much and it is not only time consuming but a huge responsibility for schools. We have different regulations and expectations around parents so it makes it really hard to navigate areas around home which are not part of education. It feels as if we are taking responsibility for families without the power to make changes or hold families to account. The responsibility is really stressful and certainly not part of education. As professionals we are dealing with situations we aren't trained for or supported with. – Education, South West England

Those who agreed schools have taken on a greater role in safeguarding were asked if they would like to see that retained. Over half of respondents to this question (n=93) said they

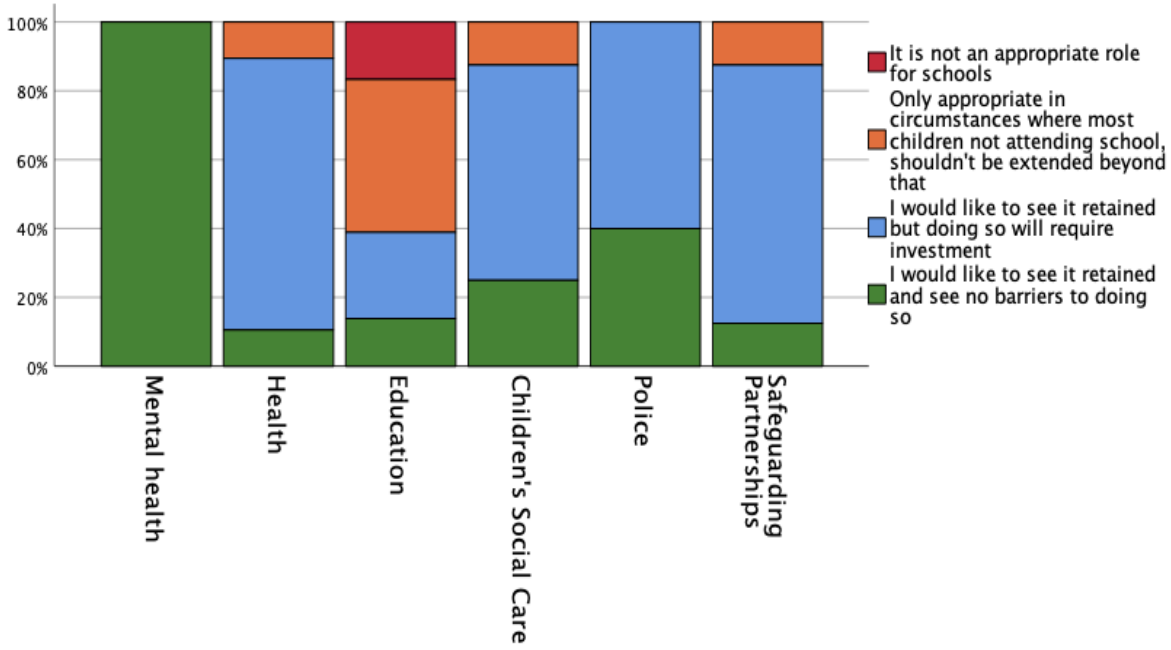
would like to see it retained but felt that to do so would require additional investment (Figure 2.22).

Figure 2.22: Feasibility of schools retaining increased involvement (n=93, Law excluded)



There were perhaps inevitable differences between agencies in perspectives here, with schools most likely to consider that it is not an appropriate role for schools or only appropriate in circumstances where most children are not attending school (Figure 2.23).

Figure 2.23: Feasibility of schools retaining increased involvement by agency (n=93, Law excluded)



Your views on the appropriateness and feasibility of retaining this increased school safeguarding responsibility in the future

2.8.4 Provision of support for children and families where children are not in school

We asked about provision of support by schools for children not in school to get a sense of what was considered most important and whether that had changed over time and with experience. We particularly asked about follow-up of non-responsive families with police liaison as that was contentious in the London interviews, with some (most likely to be from Children's Social Care) feeling it was inappropriate and others feeling that it worked well: one DSI interviewed reported a different stance being taken by each of the three local authority areas he worked with. At this point numbers are quite small and for this section about half or a little more are Education responses.

The table below (Table 2.4) lists strategies in order of most common use in the first lockdown. It suggests more need for online support for IT provision, despite the government scheme to provide laptops. Dips during periods when schools were open to most children seem likely to reflect challenges for schools in keeping in touch with non-attenders while managing social distancing in school for the majority of children and continuing online teaching. It is interesting to note that over half of respondents appear to have used police liaison to follow up with non-attenders and numbers for intended future use are the same as those that used the strategy in the first lockdown, suggesting those that did use it found it worthwhile. The

only strategy with less support for use in future than use in the first lockdown is regular contact in holidays as well as termtime. Numbers are small so we should not read too much into them but may suggest this is a big commitment for schools.

Table 2.4: Support for children not in school

	During the first lockdown when schools were closed, schools in our area provided:	**When schools are open to most children, schools in our area provide:**	**In future lockdowns schools will provide:**
Regular contact termtime only (79/70/77)	96%	91%	97%
Food parcels (75/71/72)	91%	68%	88%
IT for online learning (78/74/74)	82%	80%	97%
In person/doorstep visits (77/75/75)	81%	67%	84%
Books & Games (68/69/70)	76%	61%	80%
Follow up of non-responsive families by CSC (75/72/73)	76%	74%	82%
Regular contact termtime and holidays (61/70/70)	73%	57%	67%
Follow up of non-responsive families with police liaison (72/69/70)	57%	51%	57%
Other: 1 x parent group meetings; 1 x support around EHE			

A number of 'shining examples' of adaptations to practice and other qualitative comments referred to schools' support for children not attending schools:

> Teachers have been amazingly proactive in contacting students/ children regularly - phoning / on line contact, chasing up on concerns and even visiting children at home. they have gone way beyond their remit, in schools which have reduced pastoral care due to cuts. – Designated Doctor for Safeguarding, Yorkshire & The Humber

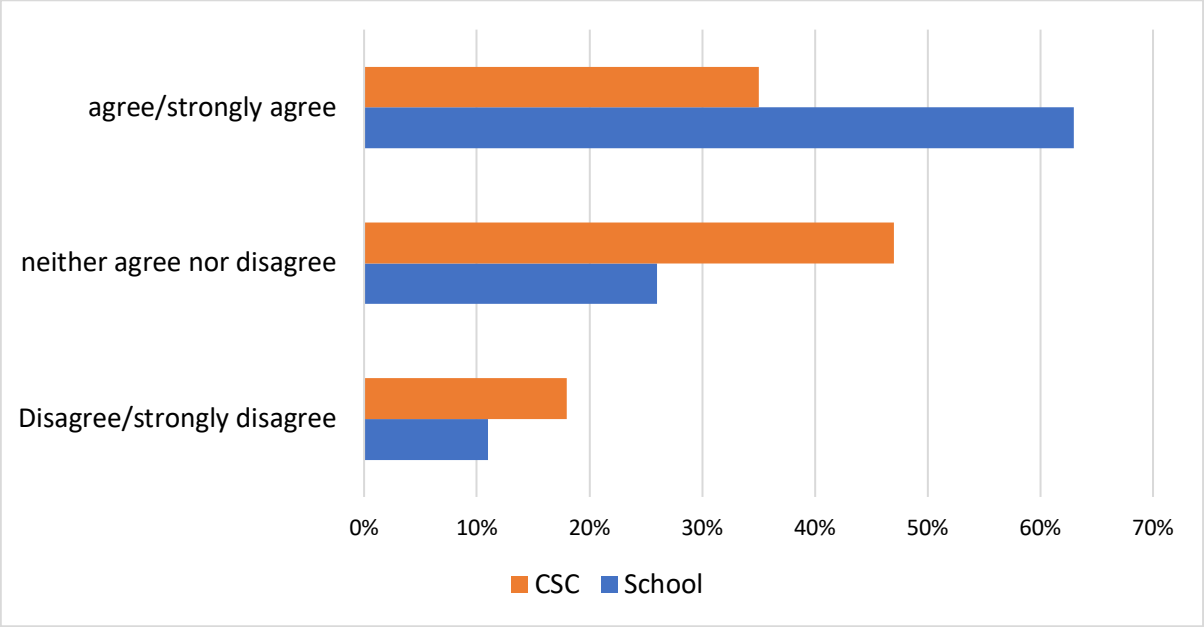
> Schools visiting families with food parcels whilst having conversations with children to ensure their safety. – Children's Social Care, London

> Home visits from school to the doorstep. Working with community groups and food banks to provide for families we know. Schools really do know their communities well. Live lessons - for parents we could never get into school these have actually worked really well - we are training parents whilst teaching children. – Education, South West England

> Mini-bus to pick up primary school pupils at risk. Taking work and laptops to the homes and tutoring on the door step too. Taking gifts of fruit and resources. SEND pupils being given activity bags full of games and other resources to support learning at home. – Education, London

The interviews also suggested that families saw school interventions as less threatening and more supportive than usual during the first lockdown and this could improve relationships (see also Ferguson et al., 2020). This is significant because one of the findings from the safeguarding in schools study (Baginsky et al., 2021) was that school staff worried that when they made a referral and it was unsuccessful, or where they led or managed Early Help arrangements but struggled to access adequate support, this could damage relationships with families in circumstances where families had no other professional support available to them. We have small numbers at this point again as we only asked Education, Children's Social Care and Safeguarding Partnership respondents and the Education section filter applied. We asked the same question as to whether Keeping in Touch arrangements improved relationships between families and schools, and between families and Children's Social Care. Results suggest that there was some effect, stronger for schools, which is unsurprising given the nature of the work of each agency (Figure 2.24). We also asked those who agreed that relationships had improved whether those better relationships had been maintained and all respondents answering that question agreed that they had, at least in part. That question was predicated on a time when school attendance had returned to normal however, which was not the case at the time the survey was live.

Figure 2.24: Effect of 'keeping in touch' arrangements on relationships with families (n=73 for schools, n=68 for CSC; Mental Health, Health, Police and Law excluded)



Did Keeping in Touch arrangements improve relationships with families?

One qualitive comment highlights that these improved relationships were not coincidental but may have resulted from a planned strategy, the aim of regular, weekly contact with families being described as to 'build positive and supportive relationships to get help in quickly as and when required.' (Education, East Midlands)

2.8.5 Specialist support in (or through) schools

In the context of austerity measures, there had been some concerns expressed in interviews that specialist posts that were removed from schools might not be reinstated, on the basis that schools had managed without in the interim. We asked about the status of some of those posts and whether they should be reinstated in person in schools when possible. 'No change' in this context is likely to mean they were not in place prior to the pandemic, since it is unlikely that any remained in person in schools during lockdown. Reassuringly, most posts were not removed without a remote replacement, although this was most likely in relation to police officers and school nurses (Table 2.5). Preservation through remote access was most common for counsellors and educational psychologists.

Table 2.5: Specialist posts in schools

	Removed & no remote access	Removed but remote access	No change
Social Workers (77)	5%	57%	38%
Police officers (66)	13%	36%	52%
School nurses (91)	19%	60%	21%
Counsellors (55)	4%	67%	29%
Educational psychologists (70)	7%	74%	19%

There was a general preference for restoring to pre-COVID arrangements (Table 2.6), with most strength of feeling in relation to nurses (breakdown by agency suggests this is not affected by the proportion of respondents in each agency). The level of support for police officers in schools matching that for counsellors is perhaps a surprising finding.

Table 2.6: Views on restoration of specialist posts in schools

	Restore to pre-Covid	Retain partial restoration/ new arrangements	Reinvent: changes needed
Social Workers (88)	66%	24%	10%
Police officers (89)	76%	16%	6%
School nurses (98)	80%	9%	10%
Counsellors (87)	76%	13%	11%
Educational psychologists (88)	75%	18%	7%

One respondent commented on improved attendance at appointments as a result of adaptations to school nursing practice:

> Our school nurses arranged to see young people in parks and outdoor areas, they were keen to get out of the house and many of these were children who wouldn't have turned up to appointments in school time pre-lockdown. – Named Nurse for Safeguarding, London

We also asked about provision for mental health support and support for disclosure of maltreatment in or through schools in open questions, which attracted 61 and 54 comments respectively. These provide a picture of varied provision, with some very positive comments but many suggesting that provision is patchy and uncoordinated. The full list is provided at Appendix 4 (Mental Health support in/through schools) and Appendix 5 (Support for disclosure). Examples of mental health support provided by schools included:

> Regular check ins, mentoring sessions, face to face walks outside, creative activities such as signing or art-based activities - face to face or remote. – Education, East Midlands

> Re-focusing on curriculum, including time for 'recovery curriculum' activities/accessibility of staff to respond to voices of young people/families. More holistic approach to building trust/relationship with young people/ families. – Education, London

> Daily student support emails with reminders and advice as where to access support - including apps, school nurse, chathealth provision, use of the website, Twitter and sharing information with parents too. This has been much increased and should continue going forward. – Education, East Midlands

Some discontent or concern was also expressed by schools and other agencies, as evidenced by the following comments:

> Area has put nothing in place – individual schools are doing their own thing. – Education, North West England

> There has been a huge amount of information and resources passed onto schools and it has been very challenging to filter the information. It seems like many agencies, in trying to be supportive, have actually caused additional work and the resources are of very varying quality. Professionals working with children want to be open to any support/advice to improve the service however the information has flooded in without any quality control. – Education, London

> This needs to be done in conjunction with local CAMHS and schools to avoid repetition and counterproductive working. Schools also need to get better at understanding thresholds of harm and sharing identified concerns earlier rather than cataloguing them before making a referral later down the line. – Mental Health Safeguarding Lead for Children, East of England

Initiatives to support disclosure included the following:

> All schools asked to complete a Covid-19 Safeguarding Impact Review - what else could they do to improve visibility of children; contact by DSLs; doorstep visits for children not engaging/seen. – Business Manager, South West England

> Social care has developed a team who are working in the most deprived schools in the borough. – Designated Doctor for LAC, London

Smaller class sizes when at school has increased the ability of CYP to feel safe and supported and to build relationships with staff. – Designated Doctor for Safeguarding, East Midlands

The use of a 'worry button' on google classrooms that goes directly to a member of the teaching staff. – Named Midwife for Safeguarding, London

High school pastoral team in touch with students. This is very variable from school to school. – Named Doctor, Yorkshire & The Humber

Nothing put in place as an area, as a school we have constantly posted the available reporting routes for children - this is mostly visible to those with online access and those whose parents collect work. The true vulnerable have no reminders to what is available - there should be a big upturn on tv advertising to alert children to what to do. – Education, North West England

Not enough has been done to enable children safely talk about what life is like at home during the pandemic. – Children's Social Care, London

Recommendations:

5. Concerted intervention by both education and safeguarding professionals to reengage 'vulnerable' children not attending school during the pandemic, to limit numbers of children who do not return to mainstream schooling.
6. Legislation to improve monitoring and regulation of Elective Home Education.
7. A review of the role of schools and school staff in safeguarding, including specialist provision within schools, staff training, and the appropriateness and burden of early help work, and monitoring and evaluation of recent investment in mental health support in schools.
8. Consideration of how to ensure that schools' knowledge of children and families is fully respected in multi-agency discussions and taken into consideration in individual safeguarding / child protection cases.

3. Professional Practice

3.1 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'.

Summary of interview findings

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. While respondents 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 and Manthorpe, 2020; Ferguson et al., 2020; Talbot, 2020). There was also 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 in-person visits to families wherever possible, following assessment of risk in each case (Department for Education, 2021).

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, respondents 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

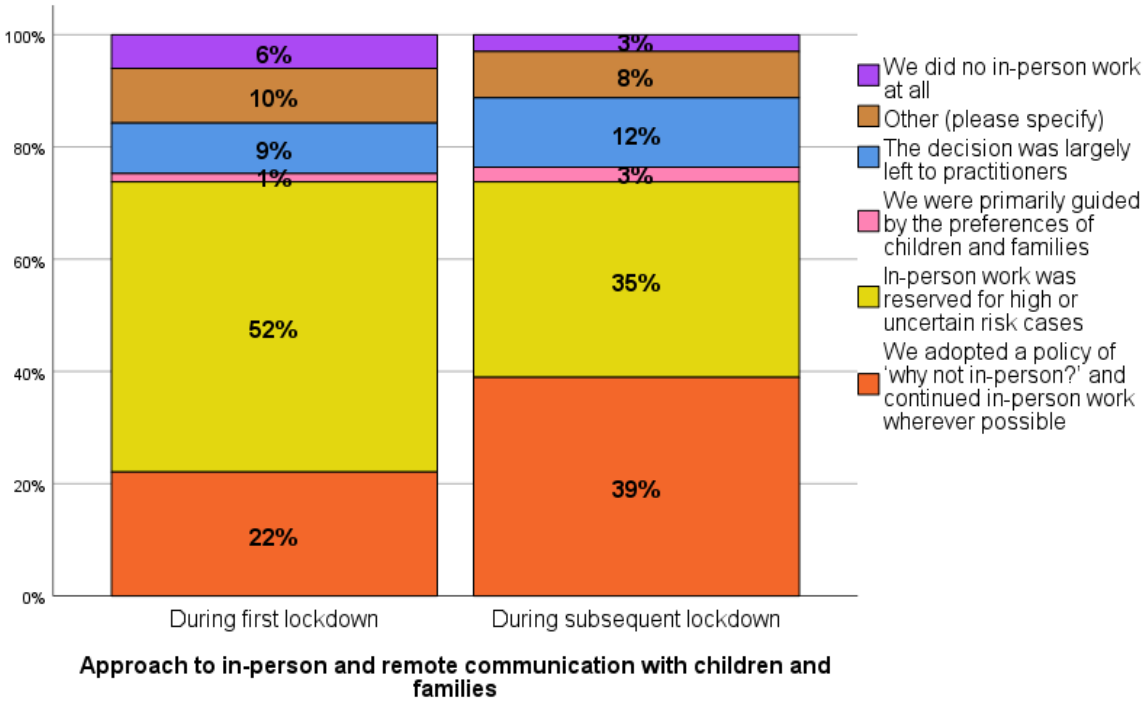
those who engaged better remotely, including some young people in care. Online engagement was felt to be particularly successful for maintaining relationships and 'checking-in' with children and families. Some online direct services such as online counselling were also often described as possible and helpful for children and families, while building new relationships, assessing risk and managing risk were thought to be more problematic at a distance and online.

Survey results

3.1.1 Use of different modes of communication

Figure 3.1 shows the use of in-person and remote communication with children and families for safeguarding purposes during the first lockdown period and subsequent lockdowns based on the survey data. In the first lockdown 52% of respondents said that in-person work was generally reserved for cases that were assessed as high risk or where the risk was uncertain, with only 22% of respondents indicating they adopted a 'why not in-person' approach. Through subsequent lockdowns the 'why not in-person' approach appears to have been used more frequently (39%), rather than reserving in-person contact for high risk or uncertain 'cases' (which reduced slightly to 35%), and the policy of no in-person work at all reduced from 6% through the first lockdown to 3% during subsequent lockdowns. In subsequent lockdowns there was also a small increase in the decision being left largely to practitioners (9% - 12%). Being led by the preference of children and families was rarely the key factor guiding use of in-person or remote communication (2% and 3% respectively). Overall, it appears that the initial caution regarding in-person communication reduced in subsequent lockdowns but that this appears to be an organisational/managerial decision or policy, and this was not led by the preferences of children and families, nor practitioners in the majority of circumstances. While several respondents from Health (like some interview participants from stage 1) said that they followed national guidance on in-person visits, others also indicated that different health providers had different stances related to overall modes of communication with children and families and that this has changed during the course of the pandemic.

Figure 3.1: Overall approach to communication with children and families during first and subsequent lockdowns (n=267; not answered by Safeguarding Partnerships or Education)

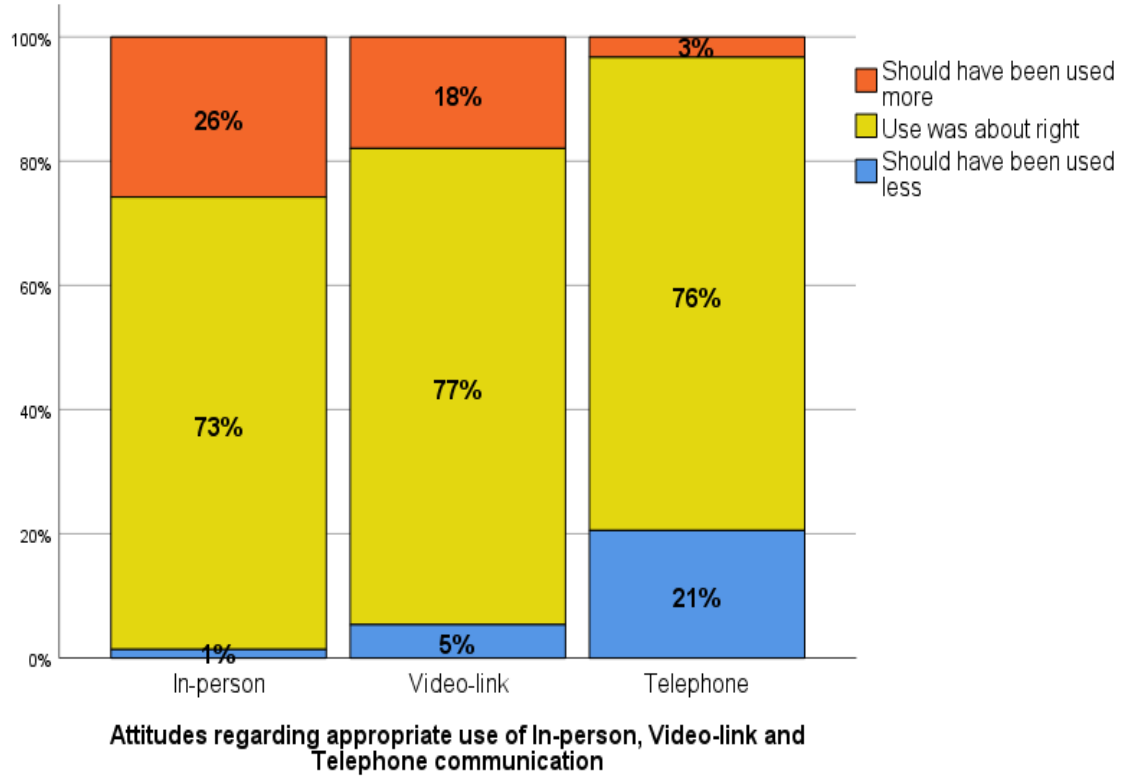


Some differences in the overall approach to communication with children and families were also seen between agencies. Analysis of differences between agencies shows that the Police predominantly adopted a 'why not in-person' approach through both the first and subsequent lockdowns with one Police respondent commenting, 'Meetings with professionals were done virtually. Visits to children/families always in person'. In contrast, Mental Health and Law predominantly adopted an approach which reserved in-person work to the high risk or unknown cases through both the first and subsequent lockdowns. However, a visible shift in approach from 'reserving in-person contact to high or uncertain risk cases' to 'why not in-person' contact can be seen in both Health and Children's Social Care from the first lockdown to subsequent lockdowns. Only Health and Law reported the decision being down to practitioners in any significant way, and only Law were primarily guided by children and families in any significant way (however this was still limited).

The nature of the different approaches used to communicate with children and families, and also the appropriateness of these methods is further explored through reflections by respondents on the appropriate use of in-person, video-link or telephone to facilitate communication with children and families for safeguarding and child protection work. Figure 3.2 shows that majority of respondents thought that use of these communication methods through the course of the pandemic has been about right (73%; 77%; 76%). However, 26% of respondents said that they felt in-person communication should have been used more, and 21% of respondents said that they felt telephone communication should have been used less.

This is consistent with the findings above that indicate a move towards 'why not in-person' communication from the first lockdown to subsequent lockdowns.

Figure 3.2: Attitudes regarding appropriate use of In-person, Video-link and Telephone communication (n=279, n=277, n=287; not answered by Safeguarding Partnerships)



Again some differences were seen by agency in relation to how appropriate respondents thought the use of in-person, Video-link and Telephone communication had been with children and families. Health and Education were more likely to say that they felt in-person communication should have been used more. Health, Law and Education were also more likely to say that telephone communication should have been used less. Health, Education and Law also indicated they wanted to make more use of video link to communicate. The following comments by Health respondents made within the survey further emphasise that health professionals felt strongly about in-person communication/ contact with children, young people and families:

> Huge increased risk due to lack of face-to-face contact with any professional: e.g. Health Visitors not doing home visits or when attending they do not physically examine the baby/child, GPs remote consults/not examining fully if seen, no school face-to-face to detect changes = several cases of life threatening medical and safeguarding problems not detected. Remote working makes it far too easy for the CYP to not be seen or spoken to. – Designated Doctor for Safeguarding, Clinician or Manager for LAC, East Midlands

> Families need face to face support with clear outcomes, so often families have 8 weeks of something remote and then say it hasn't worked. It isn't the courses that help - it is the relationships built with professionals who can empower parents. – Named Nurse for Safeguarding, South East England
>
> We still have to see families and see the children. Remote conversations are not great but better than nothing. doorstep conversations would be better. – Named Doctor, Yorkshire & The Humber
>
> Lack of face to face contact from social workers & health visitors seems to have impacted on families causing additional stress & anxiety to families. – Named Nurse for Safeguarding, East of England

3.1.2 Concerns about remote communication

Due to the frequent concerns raised by our interview participants in stage 1, we asked survey respondents to indicate concerns in relation to remote communication with children and families, which are outlined in Table 3.1 below.

Table 3.1: Level of agreement with common concerns about remote communication

Concern	Proportion who agreed this was a concern to them
Not being able to use all senses to pick up non-verbal cues (n=327)	97%
Not knowing who else is in the room (n=325)	95%
Who it excludes (digital poverty) (n=316)	93%
Rick of misunderstandings (n=322)	85%
Impact on relationship building/rapport (n=326)	84%
Lack of warmth/felt support in communication (n=319)	80%
Lack of reliable online methods of communication (n=323)	69%

Overwhelmingly respondents were concerned not only about the lack of reliable online communication methods available for children and families (which is a recurring theme in this section), but the nature of communication, the impact on assessment skills (such as using all senses to pick up non-verbal cues) and the impact on relationship building when facilitated through an online medium.

Several additional concerns were raised in the 'other' box by respondents in relation to remote communication with children and families. One Law respondent noted that '... remote access has been good, but it is very limited in really getting a feel for a child and their home life', a sentiment echoed by a Health respondent who noted that with remote communication there is a barrier to assessing 'environmental factors.' Both Education and Health respondents also observed that remote communication impacts on professionals actually seeing children and hearing their voices, which was also captured by another survey question discussed

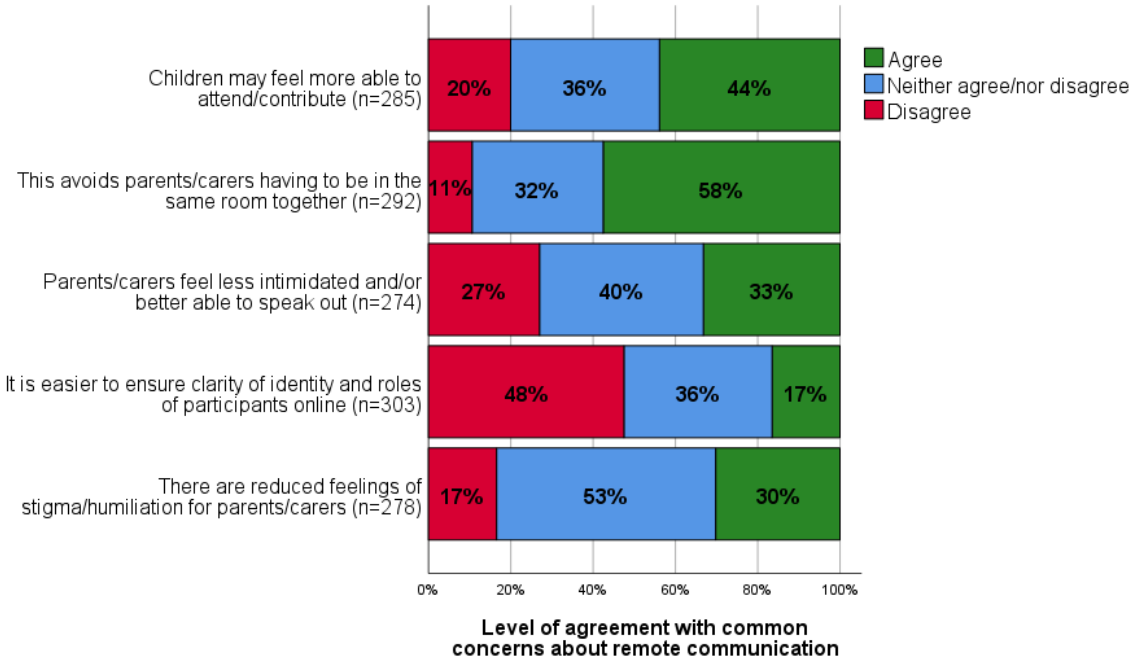
earlier (section 2.7). Health respondents specifically noted that at times children are not present for remote (phone or video) assessments/consultations, which is a considerable issue for detection of safeguarding concerns (e.g. injuries). It was also mentioned that remote communication may not be appropriate for non-verbal children and children with hearing and sight related disabilities.

A few small differences were seen by agency, although there was significant consensus in relation to most of the concerns. Only Law and Children's Social Care were not quite as concerned as everyone else about not knowing who else is in the room; and the police were not quite as concerned as others about not being about to use all senses to pick up on non-verbal cues. Health were a little more concerned than others about the risk of misunderstandings while Law and Education were slightly less concerned than others about lack of warmth/felt support in communication. Education was also slightly less concerned than others about the impact on relationship building/rapport. Finally, Children's Social Care were slightly less concerned than others about the lack of reliable online methods of communication.

3.1.3 Benefits of remote communication

While our interview participants from stage 1 had identified a range of concerns related to online communication with children and families, they also identified several benefits which we also asked survey respondents about. Respondents were also asked to indicate (from a predetermined list) whether they agreed with some potential benefits of remote communication (see Figure 3.3).

Figure 3.3: Perceived benefits of remote communication



The results from these questions indicate quite diverse experiences of remote communication with children and families, with many choosing not to agree or disagree with the statements (potentially because of very mixed experiences). The results do indicate that almost half of respondents did not believe remote communication helped to ensure clarity of identity and role of respondents. However, over half of respondents did indicate that remote communication can help avoid parents/carers being in the same room as each other, as highlighted by an Education respondent: 'It certainly helps when there is a parent who is so aggressive or where the parents are disagreeing.' Approaching a half also considered that children may feel more able to contribute through online communication methods. These data indicate an ambivalence to remote communication with children and families, and that respondents had mixed feelings or contradictory ideas about the benefits for children and families.

Some further examples of benefits of remote communication in relation to children and families were provided by Children's Social Care, Health, Mental Health, Law, and Police respondents in open text boxes. The following reflections highlight that some children may have found remote communication to be a positive experience.

> Families joining a child protection conference from the comfort of their own home. – Children's Social Care, North East England

> Some children in care have been able to lead their meetings more from their position due to the use of online methods when supported and encouraged to do so by IRO's. – Children's Social Care, London

> Some looked after children found online so much better and evidence of being really open … – Designated Nurse for Safeguarding, South West England

> Sometimes children enjoy meeting solicitors remotely. – Children's Panel Solicitor, London

> Engagement particularly with teenagers has increased in some cases due to digital contact. This is something that should be offered alongside face to face discussions going forward. – Mental Health Safeguarding Lead for Children, East of England

> YOT (Youth Offending Team) case of a young man who wasn't attending school and didn't participate well in sessions with YOT worker started to engage better in Zoom calls and then subsequently was coaxed back in to attending school. – Police, North West England

However, a counternarrative from a health respondent provides insight that virtual communication may not be appropriate for specific circumstances and groups of children: 'CAMHS reported some cohorts of children i.e. Eating Disorder /body dysmorphia hated virtual consultations where video was used.' While respondents were more likely to provide

commentary that children and young people enjoy or prefer remote communication, in contrast respondents felt that remote communication may not be beneficial for parents:

> Parents can feel overwhelmed with larger than usual numbers of professionals attending meetings and dealing with the difficult content alone in their own homes. – Children's Social Care, London

> Parents/carers felt more excluded from the process. – Children's Panel Solicitor, Yorkshire and the Humber

These dynamics were explored in further detail through the survey and will be discussed later.

In relation to differences by agency, Mental Health and Children's Social Care were more likely to agree that online methods reduced stigma/humiliation for parents/carers, while Education were more likely to disagree with this. In relation to whether remote communication makes it easier to clarify identity and roles of respondents online, most professionals really disagreed with this, but Children's Social Care and Safeguarding Partnerships disagreed much less. Children's Social Care were much more likely to agree that working remotely made parents/carers less intimidated and/or better able to speak out, and Education, Health and Police were more likely to disagree with this. In relation to remote working making children feel more able to attend/contribute, Education stands out from other agencies in significantly disagreeing with this statement. The multi-agency results show some significant differences in experiences of remote working or perspectives towards its impact (maybe due to the role/use of remote communication).

3.1.4 Access to critical IT resources

Difficulties accessing critical IT resources was another clear theme raised by the interview participants. Respondents were therefore asked to indicate accessibility of critical IT resources required for effective online communication, and the extent to which the lack of, or access to, hardware, software, internet connectivity and digital literacy, was a problem for professionals, and also for children and families (Table 3.2).

Table 3.2: Problems accessing critical IT resources for professionals and for children/families

	Professionals		Children/families	
	Yes	**No**	**Yes**	**No**
Hardware (n=306/n=264)	20%	80%	92%	8%
Software (n=302/n=252)	21%	79%	87%	13%
No internet connectivity (n=289/n=258)	24%	76%	91%	9%
Speed of connectivity (e.g. 4G) (n=299/n=243)	58%	43%	94%	6%
Ability to use/knowledge of technology/digital literacy (n=295/n=254)	42%	58%	84%	16%
Knowledge of safe online practice (n=290/n=231)	24%	76%	91%	9%

Overwhelmingly respondents indicated that many children and families had difficulties in accessing all critical IT resources needed for effective online communication. Particular difficulties were also identified for many professionals in accessing fast internet connection and in their ability to use technology (i.e. digital literacy). Concerns relating to access to IT resources for both families and practitioners were also reflected in commentary provided by respondents:

> Online can be brilliant but many people need helping and formal training on how to manage online services are desperately needed e.g. how to manage your Wi-Fi, how to use zoom etc. Only then do people have the space to be able to reflect. – Designated Doctor for Safeguarding, Yorkshire & The Humber

> Significant improvement is needed in parent access and ability to use tech as well as hardware availability to judges and courts as the workload of LAs has increased significantly to make up for deficits in the court office ability to serve the judiciary. – Local Authority Solicitor, East of England

Interestingly, when asked for 'shining examples' of creative adaptive practice which may represent emerging best practice, two Law respondents highlighted provision of technical resources, and in one case a safe space, to support parental engagement in remote legal proceedings:

> [X] provided 6 laptops for parents to use to access remote hearings which enabled court hearings to proceed even if parents did not have access to IT or internet. This was then mirrored in the other Local Authorities and is now expected practice. – Local Authority Solicitor, South West England

> Provision of remote court access at the civic centre for parents via provision of laptops and a Covid secure environment. – Local Authority Solicitor, London

3.2 Remote operation of child protection processes and procedures

Summary of interview findings

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.

Survey results

While earlier questions in the survey asked about generic experiences of communication with children and families, we asked a set of questions about how specific statutory processes were undertaken and experienced online. The findings below outline the impact of these remote processes on attendance/engagement, meeting efficiency, access, whether they were liked by parents/carers and children/young people, and the overall balance of advantages and disadvantages. Differences between agencies reported here should be treated with caution, due to small numbers in some groups. Only Law were asked questions about remote Directions/Case Management Hearings, and Remote Final Hearings and only those with experience of MASH and core groups answered questions about these processes. Questions about remote emergency hearings were predominantly answered by Law and Children's Social Care. Questions about the remote operation of Looked After Children reviews were only asked to Children's Social Care, Education, Mental Health and Health respondents.

3.2.1 Attendance and engagement

Overall, respondents largely felt that all the remote meetings and statutory processes that we asked about were generally better attended or had resulted in better engagement by those participating, apart from remote Final Hearings, as shown in Table 3.3.

Table 3.3: Generally better attendance/engagement?

	Yes	No
Remote MASH (n=132)	79%	21%
Remote Strategy/section 47 meetings/discussions (n=221)	85%	15%
Remote Case Conferences (n=241)	80%	20%
Remote Core Groups (n=105)	78%	22%
Remote Directions/Case Management Hearings (n=54 – Law only)	75%	24%
Remote Final Hearings (n=45 – Law only)	42%	58%
Remote Looked After Children reviews (n=126)	79%	21%

In relation to any difference by agencies, Mental Health and Education were more likely than the other agencies to disagree that MASH had been better attended. Education and Police were both more likely than the other agencies to disagree that remote core groups had been better attended. Education respondents were also less likely than other agencies to agree that remote strategy/section 47 meetings/discussions, case conferences and also remote Looked After Children reviews had been better attended.

3.2.2 Efficient use of time

Overall, respondents largely felt that all the remote meetings and statutory processes that we asked about resulted in a more efficient use of time (Table 3.4), with very little variation being seen across agencies (i.e. there was a clear consensus about this across all agencies). The exception to this was remote final hearings, where those responding to this question (Law only) were much less likely to believe that the remote nature of these hearings had been a more efficient use of time.

Table 3.4: More efficient use of time

	Yes	No
Remote MASH (n=143)	93%	7%
Remote Strategy/section 47 meetings/discussions (n=235)	95%	5%
Remote Case Conferences (n=273)	93%	7%
Remote Core Groups (n=107)	94%	7%
Remote Emergency Court Hearings (n=105)	88%	12%
Remote Directions/Case Management Hearings (n=58 – Law only)	90%	10%
Remote Final Hearings (n=56 – Law only)	61%	39%
Remote Looked After Children reviews (n=134)	90%	10%

3.2.3 Access challenges

Issues of accessibility of online processes are summarised in Table 3.5 and Table 3.6. Again, we see a clear pattern in relation to all the remote meetings and statutory processes that we asked about where approximately 40% of all respondents felt that access to this meeting/event was difficult for some practitioners (Table 3.5). The exception to this was remote directions/case management hearings, where those responding to this question (Law only) were much less likely to believe that access had been difficult for some practitioners (only 18%).

Table 3.5: Difficult to access for some practitioners

	Yes	No
Remote MASH (n=131)	44%	56%
Remote Strategy/section 47 meetings/discussions (n=215)	41%	59%
Remote Case Conferences (n=247)	39%	61%
Remote Core Groups (n=104)	41%	59%
Remote Emergency Court Hearings (n=105)	41%	59%
Remote Directions/Case Management Hearings (n=55 – Law only)	18%	82%
Remote Final Hearings (n=56 – Law only)	41%	59%
Remote Looked After Children reviews (n=123)	37%	62%

In relation to any difference by agency, Children's Social Care and Police were less likely than the other agencies to state that remote MASH meetings were difficult to access for some practitioners. Safeguarding Partnerships were more likely than the other agencies to state that remote strategy/section 47 meetings/discussions were difficult to access for some practitioners. Safeguarding Partnerships were also more likely than the other agencies to state that remote case conferences were difficult to access for some practitioners with Education much more likely to disagree with this. Children's Social Care were less likely than the other agencies to state that remote core groups were difficult to access for some practitioners with Safeguarding Partnership respondents more likely to agree that access was difficult. Children's Social Care were more likely than Law to state that accessing remote emergency court hearings were difficult for some practitioners. Children's Social Care were less likely than the other agencies to state that Looked After Children reviews were difficult to access for some practitioners.

Overall, respondents largely felt that all the remote meetings and statutory processes that we asked about had been difficult to access for some parents/carers (Table 3.6).

Table 3.6: Difficult to access for some parents/carers

	Yes	No
Remote Case Conferences (n=246)	89%	11%
Remote Core Groups (n=98)	87%	13%
Remote Emergency Court Hearings (n=103)	91%	9%
Remote Directions/Case Management Hearings (n=55 – Law only)	73%	27%
Remote Final Hearings (n=52 – Law only)	90%	10%
Remote Looked After Children reviews (n=119)	65%	35%

In relation to any difference by agency, Children's Social Care were less likely than the other agencies to state that Looked After Children reviews were difficult to access for parents/carers.

3.2.4 Acceptance of remote access by parents/carers and children

Table 3.7 shows answers to a question as to whether remote access to these processes were disliked by parents or carers. It is important to note here that the response rate for this question reduced significantly compared to the other questions in this section, which may have been because respondents were not confident to speak on the behalf of parents/carers, or because they did not know whether the meetings/event asked about were liked or disliked by parents/carers. The data here is also very mixed with the majority of respondents believing that parents/carers disliked remote core groups, Emergency Court Hearings and Final Hearings, while the majority of respondents also felt that remote case conferences, Direction/Case Management Hearings and Looked After Children reviews were not disliked by parents/carers.

Table 3.7: Generally disliked by parents/carers

	Yes	No
Remote Case Conferences (n=97)	34%	66%
Remote Core Groups (n=57)	87%	13%
Remote Emergency Court Hearings (n=55)	56%	44%
Remote Directions/Case Management Hearings (n=34 – Law only)	27%	74%
Remote Final Hearings (n=36 – Law only)	78%	22%
Remote Looked After Children reviews (n=72)	18%	82%

In relation to any difference by agency, Education respondents were more likely than those from the other agencies to state that parents/carers disliked remote case conferences and also remote Looked After Children reviews. Safeguarding Partnership respondents were more likely than those from the other agencies to state that parents/carers disliked remote core groups.

Answers to a similar question in relation to children and young people's views on remote access to these processes are summarised in Table 3.8. It is important to note here that the response rate for this question reduced significantly compared to the other questions in this section, which may have been because respondents were not confident to speak on the behalf of children/young people, or because they did not know whether the meetings/event asked about were liked or disliked by children/young people. Most respondents stated that they did not feel that children/young people disliked the remote events/meetings listed. The exception to this was final hearings, where respondents (Law) were more likely to say they thought children/young people disliked remote final hearings.

Table 3.8: Generally disliked by children/young people

	Yes	No
Remote Case Conferences (n=102)	23%	78%
Remote Emergency Court Hearings (n=35)	20%	80%
Remote Directions/Case Management Hearings (n=22)	9%	91%
Remote Final Hearings (n=18 – Law only)	44%	56%
Remote Looked After Children reviews (n=83)	18%	82%

In relation to any difference by agency, Education respondents were more likely than those from the other agencies to state that children/young people disliked remote case conferences and also remote Looked After Children reviews.

3.2.5 Balance of advantages and disadvantages of remote communication

We also asked for respondents' views on whether overall the apparent advantages of remote communication for these purposes did not outweigh the perceived disadvantages (Table 3.9).

Table 3.9: Any advantages of remote do not outweigh the disadvantages

	Yes	No
Remote MASH (n=112)	44%	56%
Remote Strategy/section 47 meetings/discussions (n=190)	38%	62%
Remote Case conferences (n=185)	37%	63%
Remote Core Groups (n=185)	38%	62%
Remote Emergency Court Hearings (n=96)	44%	56%
Remote Directions/Case Management Hearings (n=56 – Law only)	14%	86%
Remote Final Hearings (n=51 – Law only)	61%	39%
Remote Looked After Children reviews (n=102)	38%	62%

Again, we see a clear pattern in relation to all the remote meetings and statutory processes that we asked about where approximately 40% of all respondents felt that any advantages of holding the meetings/events remotely did not outweigh the disadvantages. These responses indicate quite an ambivalent attitude to the remote dimension of this work (as highlighted earlier). The exception to this was remote final hearings, where those responding to this question (Law only) were much more likely to state that advantages of remote final hearings do not out outweigh the disadvantages (61%) and also Remote Directions/Case Management Hearings where, conversely, only 14% of respondents believed that the advantages did not outweigh the disadvantages.

In relation to any differences by agency, Police and Education were more likely than the other agencies to state that the advantages of remote MASH did not outweigh the disadvantages. Police were also more likely than the other agencies to state that the advantages of strategy/section 47 meetings/discussions did not outweigh the disadvantages. Safeguarding

Partnerships were more likely than the other agencies to state that the advantages of remote case conferences did not outweigh the disadvantages. Children's Social Care were more likely than Law to state that the advantages of remote Emergency Court Hearings did not outweigh the disadvantages. Finally, Education were also more likely than other agencies to state that any advantages of remote Looked After Children reviews do not outweigh the disadvantages.

3.2.6 Use of hybrid meeting formats

Overall, about 65% respondents felt that all the remote meetings and statutory processes that we asked about should be held in a way that allows both in-person and remote attendance, with there being more support for strategy/section 47 meetings discussions and case conferences to remain online and more support for emergency court hearings and Looked After Children reviews to return to in-person (Table 3.10). The exceptions to this were Final Hearings, where no respondents (Law only) said that they felt Final Hearings should continue remotely after the pandemic, and the majority wanting them to return to in-person hearings; and also Direction/Case management Hearings where 60% of respondents wanting them to remain remotely.

Table 3.10: Respondents' view on how these events should be held after the pandemic

	Retain remote	Hybrid	Return to in-person
MASH (n=155)	17%	74%	8%
Strategy/section 47 meetings/discussions (n=263)	24%	68%	8%
Case conferences (n=306)	25%	63%	12%
Core Groups (n=110)	14%	68%	18%
Emergency Court Hearings (n=108)	14%	60%	25%
Directions/Case Management Hearings (Law only) (n=59)	60%	37%	7%
Final Hearings (Law only) (n=59)	0%	44%	56%
Looked After Children reviews (n=175)	6%	67%	27%

In relation to any difference by agencies, Mental Health and Children's Social Care more likely to state they would like MASH to be held in a hybrid manner for most/all practice after the pandemic, and Education more likely to state that they would want MASH to return to in-person meetings. The Police and Safeguarding Partnership respondents were slightly more likely to state that they wanted MASH to remain remote for most practice.

Education and Police were less likely than the other agencies to state they would like strategy/ section 47 meetings/discussions to be held in a hybrid manner for most/all practice after the pandemic, and Education more likely to state that they would want these discussions to return to in-person meetings. The Police were more likely to state that they wanted these discussions to remain remote for most practice.

Education were less likely than the other agencies to state they would like case conferences to be held in a hybrid manner for most/all practice after the pandemic, and Education slightly more likely to state that they would want case conferences to return to in-person meetings. The Police were more likely to state that they wanted case conferences to remain remote for most practice.

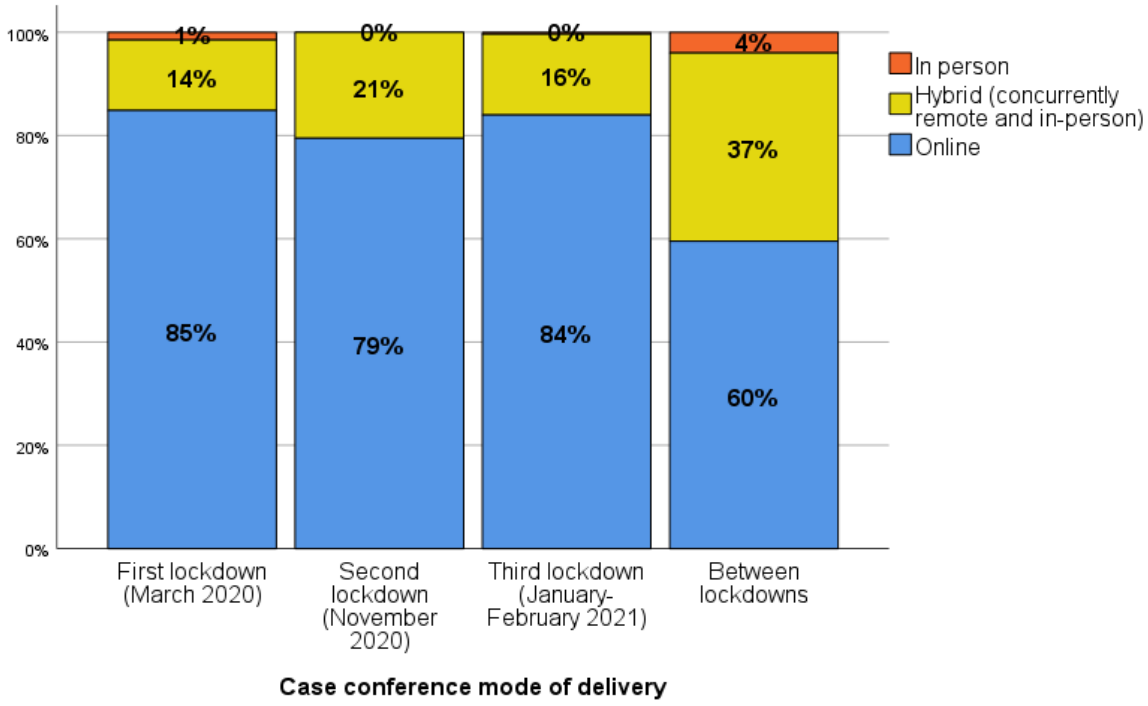
Police were more likely to state they would like core groups to be conducted in hybrid manner after the pandemic, and Education slightly more likely to state that they would want core groups to return to in-person meetings, and also slightly more likely to state that they wanted core groups to remain remote for most practice.

No respondents from Mental Health or Children's Social Care wanted Looked After Children reviews to be held remotely after the pandemic. Education were also slightly more likely to state that they would want Looked After Children reviews to return to in-person meetings, and also slightly more likely to state that they wanted them to remain remote for most practice indicating greater heterogeneity of experiences and practice preferences from Education than the other agencies.

3.2.7 Mode of delivery adopted for case conferences

Many of our interview participants in stage 1 spoke at length about the impact of the pandemic on case conferences, with a lack of consensus in relation to how effective different modes of delivery were. In the survey we asked respondents how their child protection case conferences were held during different lockdowns from March 2020 – February 2021. The data shows that most child protection conferences have been held online during the pandemic until February 2021, with approximately 80% occurring online only through the lockdowns and 60% occurring online only in between lockdowns. A minority of case conferences have been held in a way which has allowed for concurrent in-person and remote attendance (often referred to as a hybrid model), with more being facilitated in this way during the second lockdown in November 2020 and in-between lockdowns. The data indicate that child protection case conferences have rarely been held all in-person during the pandemic up until Feb 2021 (Figure 3.4).

Figure 3.4: Case conference mode of delivery



Recommendations:

9. Continued investment in ensuring vulnerable children and families have access to online services, resources and information, as well as being able to engage through video-link with practitioners. Investment is needed not only in hardware and software, but also in increasing connectivity and equipping vulnerable children and families with IT information and IT support.
10. Continued investment to ensure that practitioners are fully able to engage with vulnerable children and families and carry out their safeguarding duties safely at a distance, with particular attention to increased connectivity for practitioners and increased digital literacy and IT support.
11. Clear evidence-based guidance for practitioners to identify when in-person engagement needs to happen and when digital contact is appropriate or preferable. Guidance needs to take into account both the experiences of practitioners and vulnerable children and families, with attention to the 'why not in-person approach' that has increasingly been used as the pandemic has progressed.
12. When digital communication is used as part of child protection practice, regular reviews of how this medium is being used must be enacted to reduce the risks associated with this form of communication for child protection purposes.
13. Investment in child-friendly and 'safe' technology to aid safeguarding work by all actors, such as the development of apps or social media sites that support protection work.

14. Investment in creating the possibility for more meetings between professionals, including those that involve vulnerable children and families, which enable people to attend online and in-person at the same time (a 'hybrid' approach). This includes making the necessary technology, space and technical knowledge widely available; taking into account the experiences of professionals and children and families; and the development of practice guidelines to enhance use of this hybrid approach.
15. Conversations with vulnerable children and families about their preferred method of communication need to occur as a routine aspect of practice.

3.3 Redeployment

Summary of interview findings

Healthcare services throughout England restructured 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, respondents 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 London 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 Children's Social Care. 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 violence and 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 were made about redeployment during the second and third lockdown periods, suggesting that some of this evaluation was under way.

Survey results

In follow up to the interview data we asked respondents to what extent they agreed with the redeployment of specific professional groups. The strength of feeling regarding the

appropriateness of the redeployment of key universal and safeguarding health professions is clear from the data (Table 3.11). Less than 10% of respondents disagreed with statements that various staff should not be redeployed, and at least 80% or more of the respondents agreed with the statements about various staff not being redeployed.

Table 3.11: Agreement with redeployment

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
Safeguarding midwives should never be redeployed (n=276)	1%	5%	9%	28%	58%
Health visitors should never be redeployed (n=280)	1%	7%	15%	28%	50%
Designated safeguarding doctors and nurses should never be redeployed (n=286)	1%	7%	13%	27%	51%
Named doctors and nurses for safeguarding should never be redeployed (n=287)	1%	7%	12%	26%	54%
Plans for redeployed of universal staff should be made **in conjunction** with **safeguarding leadership in that organisation** (n=288)	0%	1%	7%	40%	52%
Plans for redeployments of **universal health staff** should be **agreed by Safeguarding Partnerships** (n=284)	0%	11%	17%	34%	38%
Plans for redeployment of **safeguarding lead staff** should be **agreed by Safeguarding Partnerships** (n=287)	0%	5%	12%	38%	44%

The only statement which had less support was in relation to whether the redeployment of universal health staff should have been **agreed by Safeguarding Partnerships**, whereas much more support is given to plans for redeployment of universal staff being made **in conjunction with safeguarding leadership** in that organisation and also that the redeployment of safeguarding lead staff should have been agreed by Safeguarding Partnerships. Overall however, it is clear that respondents did not generally agree with the redeployment of universal and specialist health professionals that are key to child safeguarding (such as Safeguarding Midwives, Health Visitors and Designated or Named health professionals). It is important to note that in the interviews most Health respondents did acknowledge the critical need to 'save lives', but also wanted recognition that safeguarding work was also about saving lives, albeit in a less tangible way. It is also clear that more involvement in the decision-making

around redeployment from safeguarding leads or Safeguarding Partnerships was wanted as emphasised by two Health respondents in the following comments:

> Decisions were made regarding redeployment of staff from children to adult services without any consideration of the impact. If Safeguarding Partnerships had been consulted some of the pitfalls might have been recognised and action taken to mitigate the risk. – Designated Nurse for Safeguarding, East of England

> Decisions about redeployment that affect Safeguarding processes should be discussed at the Partnership following consultation with the agency in the first instance.
> – Designated Nurse for Safeguarding, South West England.

Some small differences were seen by agency. Health were more likely than all the other agencies to strongly agree or agree that Safeguarding Midwives, Health Visitors and Designated or Named health professionals should not have been redeployed as indicated by the quote below. This is also seen in Mental Health as well in relation to Safeguarding Midwives and Named Doctors/Nurses.

> Safeguarding leads should not be redeployed. This leads to loss of supervision and loss of an overview of the health landscape. Safeguarding midwifery role is underestimated, as the referrals have increased to the midwifery safeguarding team. Redeployment has led to less supervision and oversight. Health visitors should never be redeployed as newborn babies are at risk and mothers need their input for breast feeding, mental health support, safe sleeping, screening for domestic violence and other advice.
> – Designated Doctor for Safeguarding, Clinician or Manager for LAC, London

Health safeguarding professionals exhibited strong views in relation to redeployment, especially at the start of the pandemic. Respondents cited that the decision was 'reactive' and 'initially a knee jerk reaction' where safeguarding was considered 'unimportant' and 'not prioritised by those in power.' Additionally, one Mental Health respondent noted that as the pandemic worsened 'any protection indicated nationally that safeguarding staff were meant to have, went out of the window.' However, qualitative commentary regarding redeployment of health safeguarding staff provides a somewhat mixed picture as several health professionals noted that staff were either not redeployed in their organisation or redeployment was limited. One participant provided an example of a community trust retaining safeguarding staff, increasing support for staff and the leadership role safeguarding staff took on at the beginning of the pandemic:

> I am aware that some London boroughs redeployed Safeguarding staff. In our community provider Trust we increased Safeguarding supervision, provided a 7 day Safeguarding help line for all staff. Issued clear directions promoting face to face visits to vulnerable children with PPE at a time that social workers were not doing statutory visits to CP children, this was due to effective leadership by our safeguarding director from the early days of Lockdown 1. The 0-19 teams reported our safeguarding team

> had led them through the confusion of the early weeks in staff surveys. – Named Nurse for Safeguarding, London

Respondents also provided a picture of redeployment of safeguarding staff causing 'stress and strain' and increasing workloads for staff not redeployed.

> This was a mistake as this left the few remaining staff overwhelmed due to an increase in the complexity and severity of the cases that were coming to our attention and the relentless emotional strain on staff from the nature of the job in addition to the significant changes in their own personal circumstances and adapting to working at home. – Mental Health Safeguarding Lead for Children, East of England

All agencies other than Health and Mental Health had a slightly higher proportion of 'neither agree nor disagree' which indicates less knowledge or concern about the redeployment of health professionals and the impact on safeguarding. The Police were more likely than the other agencies to disagree with the statements indicating that they found the redeployment of health professionals less problematic than other agencies.

With the pressure of the vaccination programme, Health respondents also highlighted a concern that safeguarding staff are either being redeployed to support vaccination efforts, or 'asked regularly to add hours and contribute.' One Designated Nurse for Safeguarding commented:

> This time we have been asked to support the rollout of the vaccination programme but safeguarding is still considered business critical so only supported when capacity allowed. – East of England

Recommendations:

16. Future decisions around redeployment of a. **health professionals with safeguarding responsibility** and b. **health professionals who are critical for the early identification of safeguarding concerns** (such as midwives and health visitors) should be undertaken in consultation with both safeguarding leadership within health and Safeguarding Partnerships.

3.4 Workforce capacity and wellbeing

Summary of interview findings

For many, particularly young professionals in Children's Social Care and the Police who had previously been 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 Children's Social Care, where recruitment and staff retention are expected to remain an ongoing challenge.

Interviewees 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 barriers 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.

Survey results

3.4.1 Impact on wellbeing

Due to the many concerns raised by the interview participants from stage 1, we asked whether practitioners with responsibility for safeguarding/child protection within respondents' agency/organisation/firm experienced any of a number of key concerns identified in relation to workforce capacity and wellbeing. Table 3.12 shows the huge impact of the pandemic on staff wellbeing across all of the seven agencies included, with the majority of respondents stating that practitioners with responsibility for safeguarding/child protection in their agency had faced increased caring responsibilities, reduced staff and practitioners in their team/organisations, increased workloads, loneliness, mental health concerns, and illness. Bereavement, poor working from home and inadequate resources to do their jobs were also noted by a significant minority. Economic hardships and housing precarity appear to have affected safeguarding/child protection staff the least.

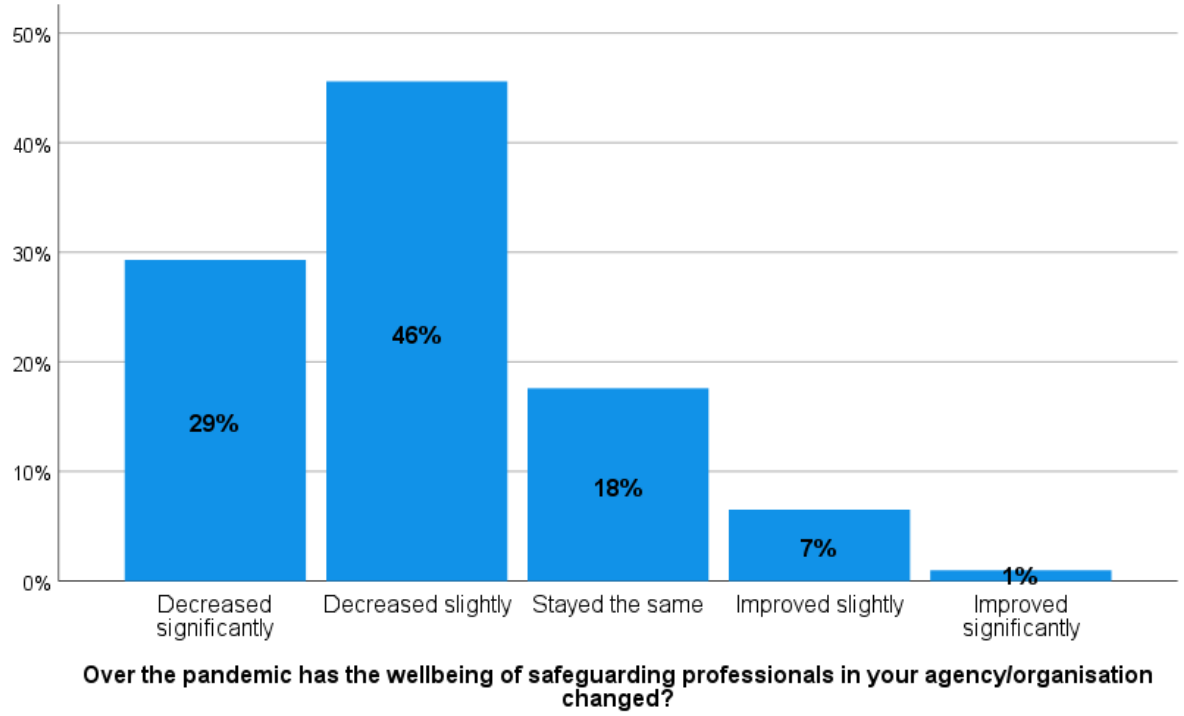
Some small increases in workloads, loneliness, staff mental health concerns, reduced practitioners, staff illness, bereavement, and economic hardship can be seen between the first lockdown and the third lockdown. Some small decreases in increased caring responsibilities (probably because more school places were accessed for critical workers in the third lockdown), poor working from home environment, inadequate access to resources to do their job and redeployment can be seen between the first lockdown and the third lockdown.

Table 3.12: Impact on wellbeing of practitioners with responsibility for safeguarding/child protection during first lockdown and third lockdown (not asked to Safeguarding Partnerships)

	First Lockdown		Third lockdown	
	Yes	**No**	**Yes**	**No**
Increased caring responsibilities (n=267; n=258)	88%	12%	84%	16%
Reduced staff (n=268; n=256)	87%	13%	9%	91%
Increased workload (n=277; n=270)	81%	19%	88%	12%
Loneliness (n=263; n=255)	80%	20%	84%	16%
Staff mental health concerns (n=251; n=243)	75%	25%	79%	21%
Reduced practitioners (e.g. self-isolation/infection) (n=281; n=271)	69%	31%	70%	30%
Staff illness (n=258; n=257)	61%	39%	68%	32%
Bereavement (n=233; n=235)	51%	49%	60%	40%
Poor working from home environment (n=231; n=228)	47%	53%	43%	57%
Inadequate access to resources to do their job (n=262; n=255)	42%	58%	29%	71%
Redeployment (n=258; n=244)	31%	69%	22%	78%
Economic hardships (n=191; n=183)	15%	85%	17%	83%
Housing precarity (n=178; n=170)	9%	92%	8%	92%
Any of the above exacerbated for BAME staff (n=160; n=155)	38%	62%	35%	65%

It is not surprising then that over the course of the pandemic (i.e., since the end of March 2020) 29% of respondents (n=307) said that the wellbeing of safeguarding professions in their organisation had decreased significantly, 46% said that it had decreased slightly, 18% said that it had stayed the same, 7% said that it had improved slightly and 1% said that it had improved significantly overall (Figure 3.5).

Figure 3.5: Change in wellbeing of safeguarding professionals over the course of the pandemic (n=307)



When asked about areas of concern related to the pandemic, qualitative comments concerning staff wellbeing were noted by professionals from all agencies, except Police and Safeguarding Partnerships. The following excerpts provide a varied but concerning picture of wellbeing issues described by respondents:

> The length of time without a likely or known end of this way of living and working and the impact this has on staff where they are not able to have sufficient /direct face to face support including and particularly with peers. – Children's Social Care, North East England

> Professionals working with children and families do well in their work if they feel they are making a meaningful impact in children's lives. This is harder to do in a virtual world and impacts on staff morale. – Children's Social Care, London

> School safeguarding staff missed holidays to cover safeguarding throughout the pandemic and attended all CP, core group, CIN etc meetings whilst social care or health managed to have annual leave. – Education, East Midlands

> I have had to seek out not only safeguarding supervision in my Trust but I have also asked our CAMHS team if they are able to support some reflective practice. Both have said they want to support me as a colleague but do not have capacity even remotely. This has left me feeling quite frustrated, unmotivated and low at some points. There has been pressure from senior management to physically be in an office where we are unable to socially distance and colleagues are not wearing face coverings despite being able to work from home. – Named Nurse for LAC, London

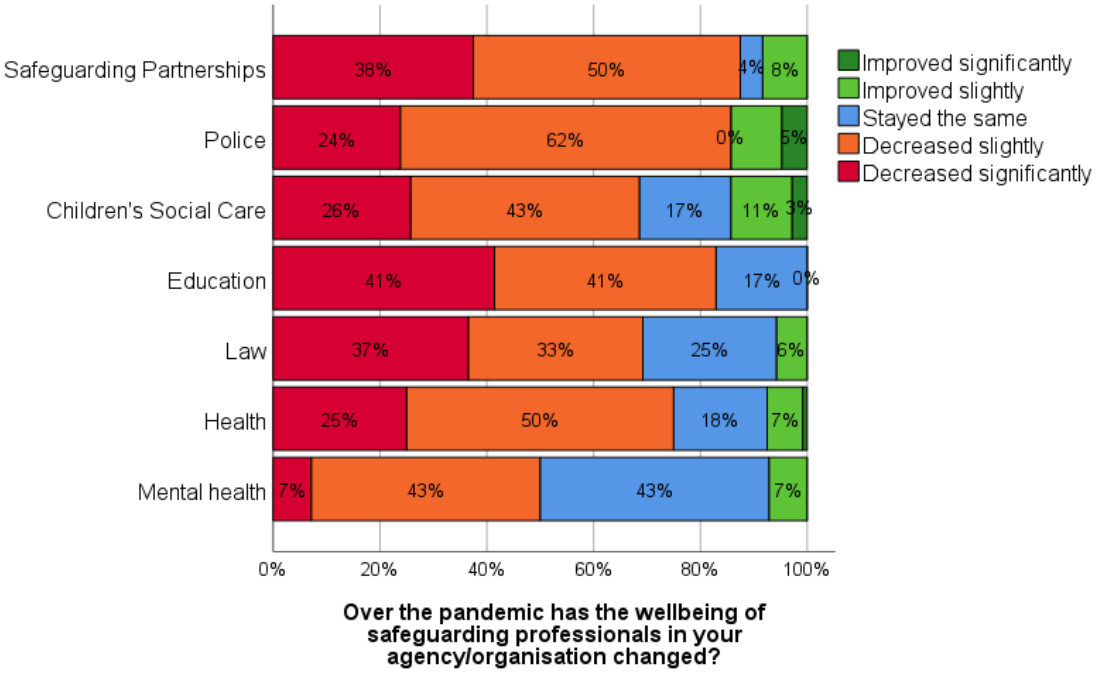
> High levels of sickness and continued anxiety impact on professional practice or professional curiosity. – Named Nurse for Safeguarding, South East England

> The pressure on professionals has been concerning. Hundreds of additional emails are being sent by Lawyers who are sending extra emails rather than travelling to court. Hours is spend sending links for advocates meetings and pre hearing discussions that someone always wants to rearrange, and more hours are spent doing that - it is unsustainable. Lawyers need guidance from the president of the family division about these issues as we are now working longer hours than ever due to all the increased admin / emails and lack of boundaries about the end of the working day / week. – Children's Panel Solicitor, London

> The health of the professionals working within this sector (social workers and Lawyers in my field) has been significantly impacted. Workloads are far higher with little to no respite. Furlough is not an option in the Local Authority. – Local Authority Solicitor, South West England

Figure 3.6 shows that some differences were seen by agency in relation to the change in overall wellbeing of safeguarding professional over the course of the pandemic with Education, Law and Safeguarding Partnerships more likely to state that wellbeing had decreased significantly, and Mental Health more likely to say that wellbeing had stayed the same. Only a few respondents from Health, Children's Social Care and the Police stated that wellbeing had improved significantly. Data from the interviews in stage 1 indicated that some increase in wellbeing was linked to working from home which helped with work-life balance and caring responsibilities.

Figure 3.6: Change in wellbeing of safeguarding professionals over the course of the pandemic by agency



3.4.2 Strategies to address staff wellbeing

As the strain on staff wellbeing was highlighted as a key concern in the qualitative interviews, we also asked about the use of ways to support safeguarding professionals during the pandemic. Table 3.13 shows that various strategies were employed to support different aspects of staff wellbeing, the majority of which were rated as quite or very effective, particularly regular individual supervision, regular contact with managers, ensuring opportunities for informal peer support and regular group supervision. The two strategies which did not seem to be as effective as the others were accessing mental health support/counselling and decreased length of online meetings to allows for breaks – although we do not have any further data to indicate whether the strategies were ineffective because they were difficult to employ or because they were ineffective even when employed well.

Table 3.13: Strategies used to support safeguarding professions during the pandemic (does not include SPs or those that did not use these strategies)

	Very ineffective	Quite ineffective	Neutral	Quite effective	Very effective
Regular individual supervision (n=253)	3%	6%	15%	34%	42%
Individual regular contact with manager (n=264)	2%	4%	15%	30%	50%
Ensure opportunities for informal peer support (n=256)	3%	7%	13%	39%	38%
Regular group supervision (n=229)	4%	3%	22%	34%	37%
Active management of leave (n=231)	2%	6%	23%	47%	23%
Staff for a/discussion groups focused on adaption of practice (n=227)	2%	3%	28%	36%	32%
Create Covid-safe spaces for in-person peer support (n=211)	6%	7%	26%	30%	31%
Access to mental health support/counselling (n=253)	2%	7%	35%	28%	29%
Decreased length of online meetings to allow for breaks (n=211)	11%	16%	28%	26%	20%

The following qualitative comments provide supplementary insight into 'shining' examples of staff support adaptation during the pandemic within Children's Social Care, Education and Health:

> Development of staff wellbeing programme with a mix of resources and activities to help staff to practice in the pandemic environment. – Children's Social Care, North East England

> Mentoring sessions - either face to face or remotely (always 2 members of staff) - just a chance for an informal chat and check in. Even remotely, staff could pick up areas of issues and where they might need to refer on. – Education, East Midlands

> The development of the National Network for Designated Health Professionals (NNDHP): a really positive level of support not just professionally, but also from an emotional wellbeing perspective. – Designated Doctor for Safeguarding, North East England

Further detail is given in relation to contingency plans to address increases in safeguarding/child protection work. Respondents indicated that a limited number of strategies were used to address increases in safeguarding/child protection work, the top two strategies being increased scope and/or delivery of training and revised rotas, as seen by Table 3.14.

Table 3.14: Contingency plans to address increase in safeguarding/child protection work

	Yes	No
Increased scope and/or delivery of training (n=215)	61%	39%
Revised rotas (n=206)	51%	50%
Changed arrangements for leave (n=205)	42%	58%
Staff retention strategies (n=200)	21%	80%
Recruitment of extra staff (n=219)	16%	84%
Redeployment of staff to child protection (n=216)	14%	86%

Recommendations:

17. Recognition of the critical role that safeguarding practitioners from all agencies have played in keeping children and young people safe during the pandemic needs to happen at the highest levels in government.
18. Professional wellbeing must be prioritised in workforce planning decisions made over the coming year: critical areas of staff wellbeing that need urgent attention include the balance of work with increased caring responsibilities, increased workloads, loneliness, poor mental health, staff illness and bereavement.
19. Further investment in strategies to increase practitioner wellbeing, including regular individual supervision and contact with managers; regular opportunities created for

informal peer support (including both in-person and online spaces); regular group supervision and discussion; and active management of leave.

3.5 Safeguarding related training

Summary of interview findings

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 (FLBA) provided valuable input for upskilling in remote platforms and sharing good practice. Respondents 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 wellbeing 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.

Survey results

We asked respondents which of the following areas of training they would prioritise for all relevant professionals as a result of the pandemic (Table 3.15). Four areas of training were identified by over half of all respondents as in their top five training priorities for all relevant professionals as a result of the pandemic. These were: Impact of the pandemic on the mental health of children; Remote safeguarding/protection of children; Child protection during a pandemic; and Domestic violence.

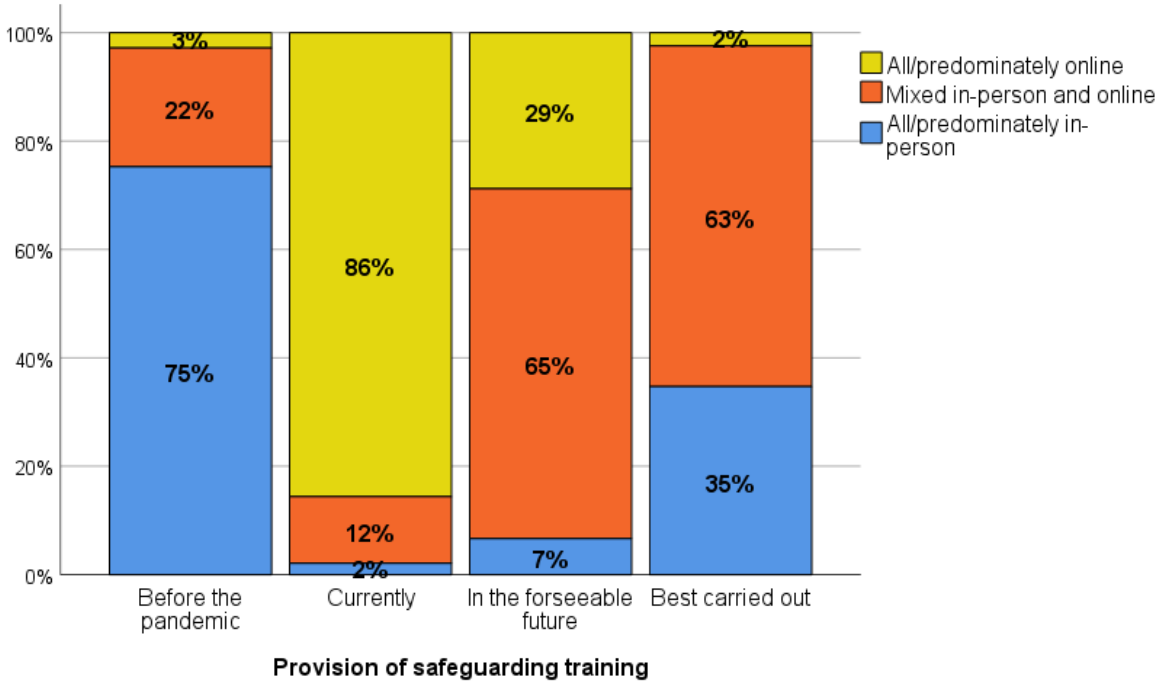
Table 3.15: Aspects of safeguarding training that were in the top 5 of priorities for all relevant professionals as a result of the pandemic

n=320	**In top 5 of priorities for all relevant professionals as a result of the pandemic**
Impact of the pandemic on the mental health of children	74%
Remote safeguarding/protection of children	65%
Child protection during a pandemic	61%
Domestic violence	60%
Trauma informed approach	36%
Impact of the pandemic on the mental health of professionals	34%
Neglect	33%
Online abuse	33%
Impact of poverty on maltreatment	25%
Criminal exploitation/County Lines	17%
Bereavement	15%
Young Carers	13%
Sexual exploitation	8%

Additional qualitative commentary from respondents also highlighted other areas for training as a result of COVID-19, including: 'impact of [the] pandemic on CYP with autism and learning difficulties' (Education) and 'neurodiversity/disability' (Health); 'infants/babies' (Health); 'supervision of school staff' (Education); 'effective virtual consultations' (Health); 'professional curiosity and sharing information' (Safeguarding Partnerships).

We also asked about changes to the mode of safeguarding training before, during and after the pandemic. Unsurprisingly the pandemic has had a huge impact on how safeguarding training is delivered, with only 3% being delivered online before the pandemic, while respondents report that 86% of safeguarding training was currently (January - February 2021) online (Figure 3.7). Respondents also could not see a fast return to in-person training with online only and mixed methods being anticipated for the foreseeable future. However, while online training has been necessary during the pandemic, respondents were not keen for it to remain this way: when asked how safeguarding training is best carried out, only 2% of respondents said that it was best carried out online, with the majority stating in a mixed mode (63%) and a significant minority (33% or one third) stating in-person.

Figure 3.7: Mode of safeguarding before, during and after the pandemic (not answered by Safeguarding Partnerships)



In relation to key differences between agencies, Education and Safeguarding Partnerships were more likely to engage with safeguarding training in a mixed mode than other agencies during the pandemic. Education was also slightly more likely to indicate that training would return to in-person for the foreseeable future, with Children's Social Care more likely to say that training is likely to be in a hybrid form for the foreseeable future, and more likely to state it will be online for the foreseeable future. Education and Mental Health were more likely to state that their preferred mode of safeguarding training is in-person than other agencies.

As part of the qualitative responses given through the survey, Health respondents specifically cited online training during the pandemic as a relatively positive and well evaluated experience by professionals, as illustrated in the following additional qualitative commentary:

> Webinars for training has been excellent. – Named for Nurse for Safeguarding, London

> Delivery of safeguarding training via zoom has enabled greater attendance and the development of a pre course workbook has enabled a shorter more manageable length of training. Feedback has been overwhelmingly positive. – Named Nurse for Safeguarding, South East England

> Level 3 safeguarding training is developed and rolled out via MS teams to include contemporary issues including the impact of Covid on families and children. This is well evaluated and is a good use of time. – Named Nurse for Safeguarding, South East England

> I do a lot of training, well thought out good interactive on line training using all the facilities e.g. whiteboard, polls, works really well and if recorded actually reaches more people. We can now do training across the country. Our courses are full and we have more faculty / trainers as they don't have to travel. – Designated Doctor for Safeguarding, Yorkshire & The Humber

> All training packages were adopted to be delivered virtually and very [well] evaluated by staff attending. – Head of Safeguarding, Yorkshire & The Humber

However, when asked about areas of concern one Health respondent provided a differing view of online training, which suggested that the transition was possibly more difficult, especially in relation to health and multi-agency training. This comment below also highlights the responsibility of health as a leading agency on multi-agency training:

> TRAINING! A challenge for all of us, in terms of moving to largely online training - both within health and also multi-agency. Requires a lot of work to adapt the in-person packages for use online when we are talking about a half day or full day training. Much of the multi-agency training in our area is driven by health and we are all very busy having to adapt and cover other areas at times plus our own internal training. The multi-agency training is definitely a gap over last 10 months and we are trying to get it up and running again but suffering from lack of resource and manpower (our Partnership Lead trainer is on long term sick). – Named Doctor for Safeguarding, Yorkshire & The Humber

Recommendations:

20. Further investment in training programmes which combine in-person and online modes, or which allow both in-person and online engagement at the same time. Despite safeguarding training largely being carried out online throughout the pandemic, participants clearly indicated that safeguarding training is best carried out with all (or some) in-person elements and not all online. Immediate training priorities include the impact of the pandemic on the mental health of children; remote safeguarding protection of children; child protection during a pandemic; and domestic violence.

4. Service Provision

4.1 Complexity and severity of cases

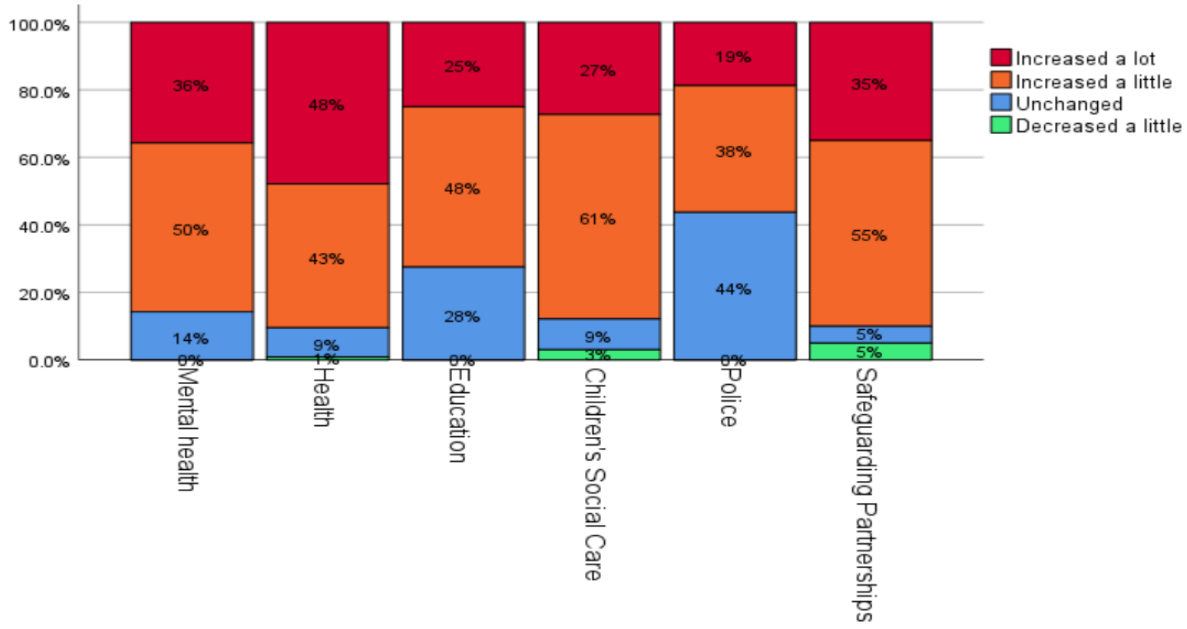
Summary of interview findings

Stage 1 findings indicated that patterns of presentation had changed, and that adversity had increased for children. Adequate staffing was difficult to achieve in all agencies, as described in previous sections, but the nature of safeguarding had changed with the pandemic: it was more time consuming, and there were heightened concerns about the safety of children seen remotely or not seen at all. Referrals to Children's Social Care generally followed the national pattern of an initial fall in numbers (by up to 40% in one borough) followed by recovery as schools started to open more widely in June 2020. One area noted pre-birth concerns did not change, but referrals of babies decreased initially. An important point to note is that interviewees from most London 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) and Pearce and Miller (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 (Coles, 2020) on 19th November 2020. 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).

Survey results

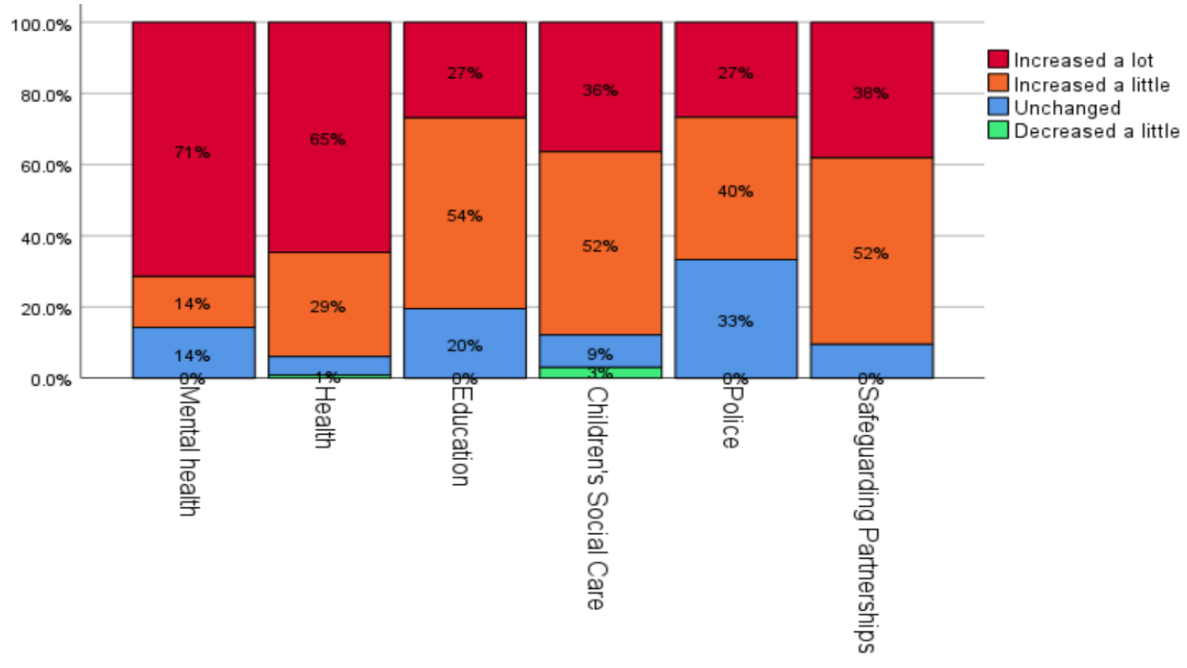
Survey respondents concurred with interviewees that referrals had increased in both severity (84%, n=238) and complexity (88%, n=240) since the onset of the pandemic. This is shown graphically below (Figure 4.1 and Figure 4.2). National data and other reports indicate that there were increased injuries in babies by up to a fifth (Spielman, cited in Launder, 2020) and in children (Masilamani et al., 2021).

Figure 4.1: Changes in severity of referrals (n=238)



A smaller proportion of Police noted changes in referral severity and complexity, which may reflect the very senior level of police participants, who may be more likely to be routinely involved in particularly severe and complex cases. A minority of Children's Social Care and Safeguarding Partnership respondents felt that severity of cases had decreased. 63% of the legal respondents also noted an increased severity, and 68% of them an increased complexity, in cases referred to them (n=53).

Figure 4.2: Changes in complexity of referrals (n=240)



Factors leading to these findings are likely to be related to stress in parenting alongside increased family and economic stress, with schools closed, decreased face-to-face contact by universal and professional services, and decreased support services compounding mental health issues. As outlined by the first stage interviewees, in addition to decreased visibility of children known to be at risk, new children have also become vulnerable with presentations relating to mental health, DVA, and child sexual abuse. Most respondents from all agencies concerned, and Health and Mental Health in particular, noted a particularly increased complexity of referrals and this was reflected in a number of qualitative comments:

> The work has increased in amount and complexity- but with no plan to manage this. Redeployment of any safeguarding staff added to these pressures. – Named Nurse for Safeguarding, South East England

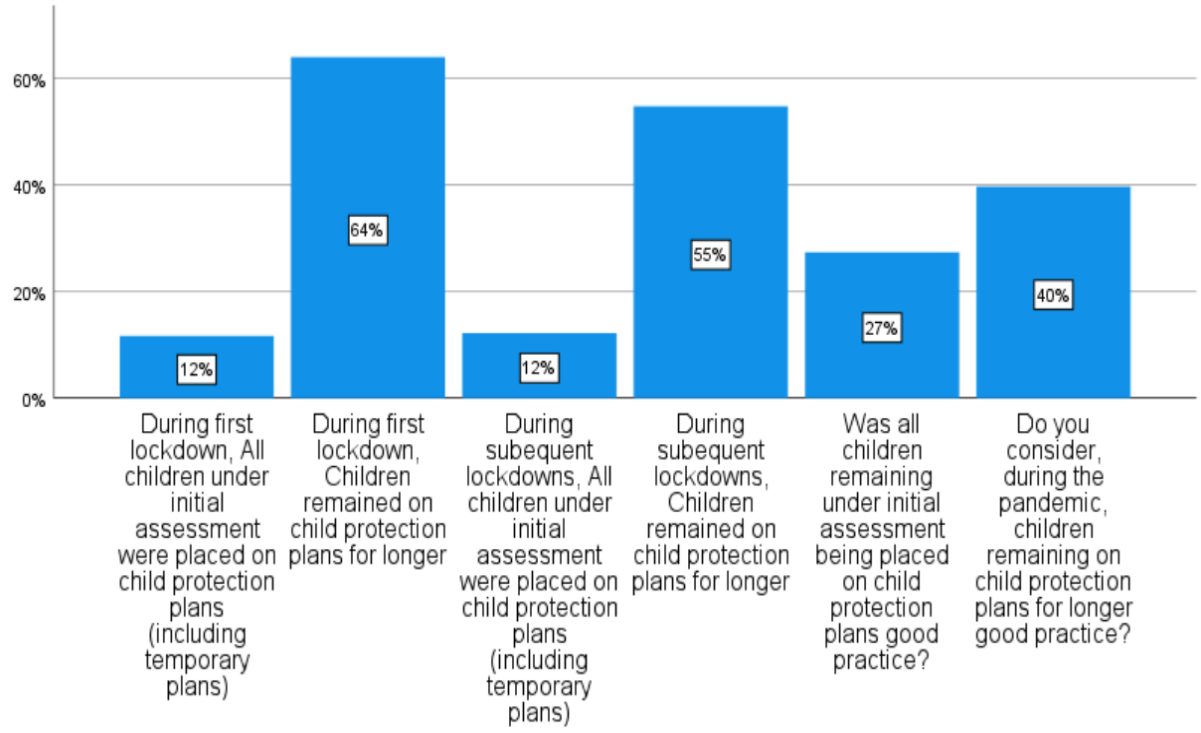
> ...the few remaining staff [were] overwhelmed due to an increase in the complexity and severity of the cases that were coming to our attention and the relentless emotional strain on staff from the nature of the job in addition to the significant changes in their own personal circumstances and adapting to working at home.
> – Mental Health Safeguarding Lead for Children, East of England

One respondent noted that:

> Due to increased complexity of need and presenting much later at a more acute phase I would commit to adequate health (and other agencies) resource in the MASH- multi-agency safeguarding Hubs or similar arrangements in order to understand a child's holistic needs and vulnerabilities for the family. It builds multi-agency relationships to understand roles, challenges decision making thresholds and ultimately helps to keep children safer in a more timely manner. – Designated Nurse for Safeguarding, South East England

Amidst this complexity and uncertainty, Figure 4.3 demonstrates that children generally spent longer on a child protection plan in all lockdowns, but with concern about this. This reflected difficultly in carrying out meaningful work as noted in the interviews, and at least one area put children temporarily on a plan in order not to discriminate against families and relating to concerns about the ability to carry out comprehensive assessment. Health and Education respondents were more likely to say that it was good practice for children to be on a plan for longer.

Figure 4.3: Practice with child protection plans (n=137,136, 131,126,117,126)
% Agreement



Just as in the interviews, many survey responses expressed concerns about needing 'adequate mental health support to deal with the vulnerabilities and issues that have been created and exacerbated by the pandemic' (Named Doctor, Northwest England). Mental health of caregivers was a concern to Education respondents, as was the mental health of pupils and exposure to domestic violence in lockdown. One of the Mental Health survey respondents noted that children and young people were staying for exceptionally long periods of time on children's medical wards in hospital settings and were becoming institutionalised in acute hospitals. Mental health needs across the entire population were of concern and are a significant risk factor relating to safeguarding concerns and vulnerability of children of all ages.

Recommendations:

21. Recognise that services need to spend sufficient time on assessments, with dedicated time for analysis and professional supervision.
22. Multiagency discussion is crucial: services need to be configured in such a way as to ensure availability of appropriately trained staff for strategy and other case discussions, and that robust interagency pathways are in place.
23. Upskill the workforce in identifying and signposting when there are mental health difficulties as well as at-risk settings and behaviours.

24. Ensure that there is a 'think safeguarding' as well as a 'think family approach' to vulnerability and need.

4.2 Early Help

Summary of interview findings

Identified concerns regarding prevention and support work from stage 1 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.

Survey results

Findings from the survey related to current management. As summarised in Figure 4.4, 172/193 (89%) noted increased Early Help needs locally, and the perception of this was similar across the agencies. Of concern, 60/153 (39%) said that Early Help services were cut in favour of statutory services. This was only the case for 3/28 (10%) Children's Social Care respondents and 4/15 (27%) Safeguarding Partnership respondents, but particularly noted by Education 14/22 (64%) (see Figure 4.5). 184/196 (94%) said that provision had shifted online, and only 57/108 (53%) of respondents said that the services online were effective, with differences between professional responses that could reflect the geographical area, professional perception or knowledge. 118/173 (68%) said that there was more onus on families to take the initiative to contact services: this figure was higher for Education and Health (95/119, 80%). 6/12 (50%) of Safeguarding Partnership respondents agreed with this, with similar numbers from Mental Health, but only 7/27 (26%) of Children's Social Care. Even if thresholds for Early Help access have not changed (see below), any dependence on families to take the initiative will further increase the gap in provision for those that are most vulnerable and who may find it difficult to access services at any time, particularly those with learning difficulties, mental health problems or lack of internet access or literacy.

Figure 4.4: Effect of pandemic on Early Help services
% responding yes (n= 193, 153, 173, 196, 108)

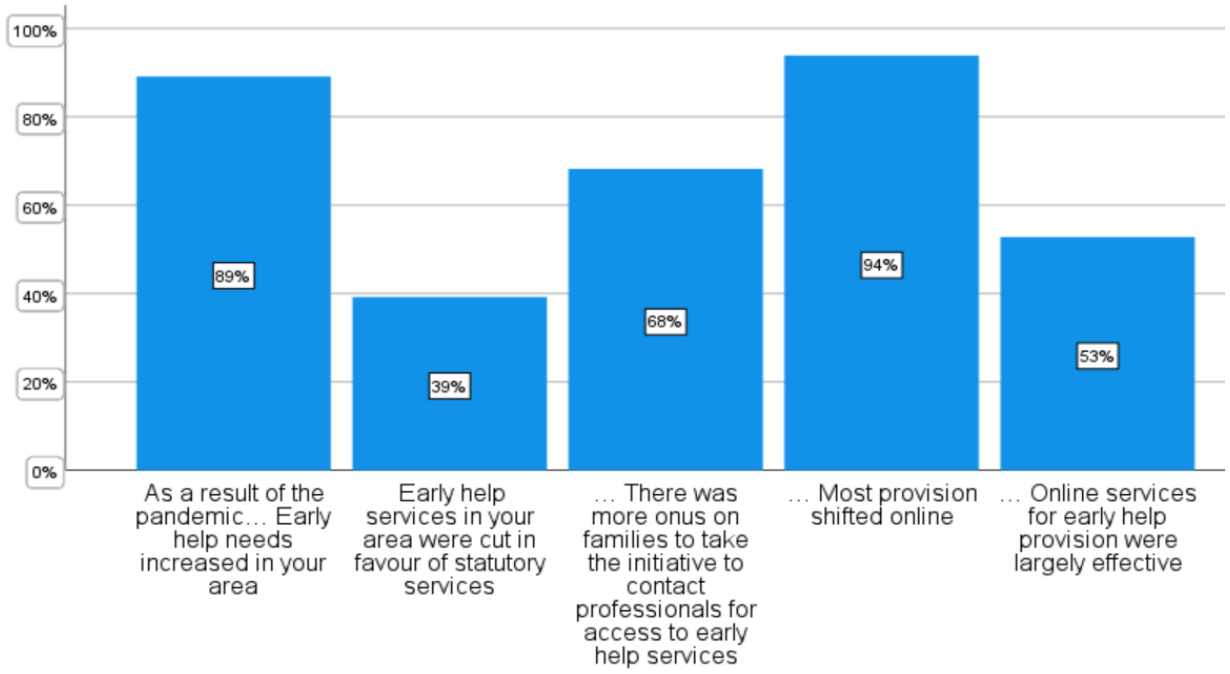
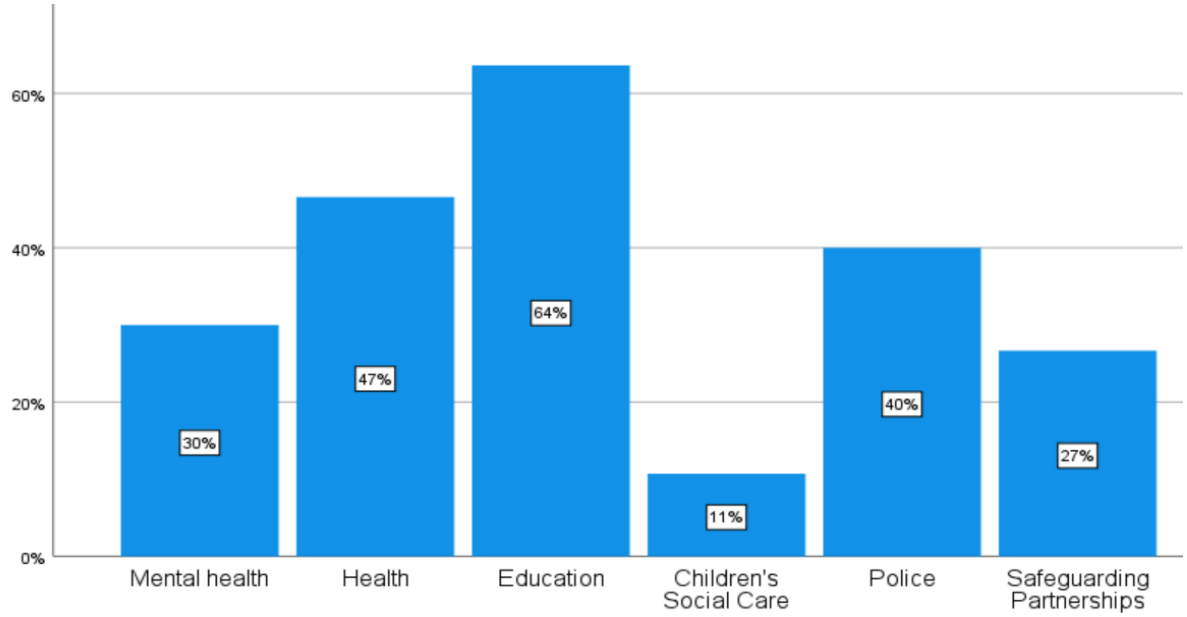
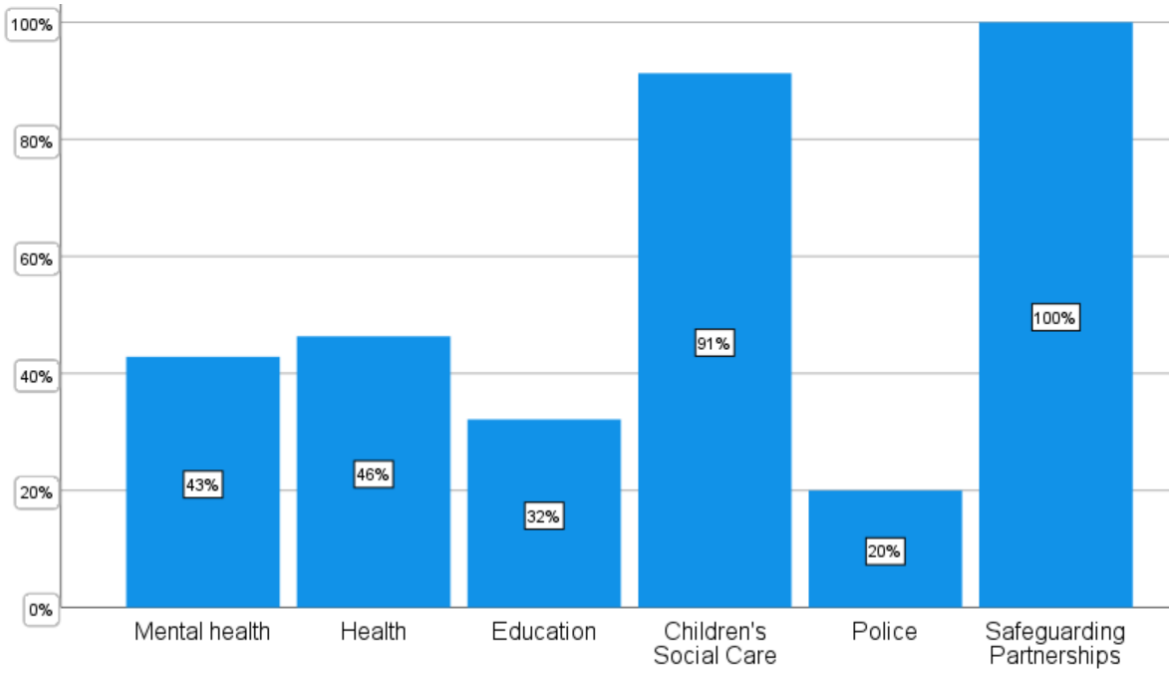


Figure 4.5: Were Early Help services cut for statutory services?
by agency % stating yes (n= 153)



Children's Social Care and Safeguarding Partnership respondents were less likely to consider that services were cut (Figure 4.5) and more likely to consider online provision to be effective than other agencies (Figure 4.6). These discrepancies may reflect responses from different areas, or the experience of services such as Education and Health having a more universal offer to clients and perhaps greater awareness of the day-to-day difficulties for these families and children.

Figure 4.6 Effectiveness of online Early Help services
percentage effective, by agency (n= 108)



Comments about the importance of and the need to resource Early Help came from all the agency respondents and priorities included: 'Early Help provision' (Police, South East England); 'Investment in Early Help and family support and interventions as well as mental health and education' (Children's Panel Solicitor, South East England); 'Invest in Early Help and evidence based practice' (Children's Social Care, North East England).

In open comments, survey respondents referred to the significance of pre-existing and ongoing concerns in relation to early help as well as in the context of the Pandemic and the need for:

> Significant increase in funding for early years/early help intervention - prevention better than cure. Upheaval of benefits package to address poverty directly impacting on families as a result of UC. Reopening of children's centres, more on the ground health visitors, more power to social workers to support families. – Named Nurse for Safeguarding, East Midlands

Thresholds for early help were considered, with roughly equal numbers (15%) of respondents reporting lowered thresholds having been introduced and still in place and reporting higher thresholds (n=144/n=133). Children's Social Care and Safeguarding Partnership respondents were less likely to report raised thresholds and Education more likely than other agencies to do so, but there was some reporting of lowered thresholds by all agencies and of higher thresholds by all except Safeguarding Partnerships. It is of concern in the context of increased complexity and severity of safeguarding cases, that at least a few areas had increased

thresholds in place for Early Help. At the start of the pandemic this sort of triage may have been felt to be inevitable and essential if there were concerns about staffing and capacity to manage new processes to see children.

Many comments related to the need to invest in Early Help, particularly resources to respond to Domestic Violence and Abuse and to prevent children becoming recipients of statutory services. Early Help services were not just considered relating to young children, but in the context of early intervention, for example CAMHS intervention for young people at risk of violent crime. One respondent described needing to be 'very responsive to need and creatively involving children and parents to look at what will work best to support them' (Children's Social Care, North West England).

Enhanced communication of Early Help packages to professionals, young people and families was an adaptation to practice reported by about half of respondents. It is concerning that a significant proportion did not introduce enhanced communication of Early Help packages, as reported or perceived by respondents from all the agencies including Safeguarding Partnerships and Children's Social Care. This would seem to be important to follow up in local areas. One survey participant reiterated the need to 'ensure all families have access to technology and connectivity so that it can be used to see/ speak to the family' (Business Manager, East of England), underlining the importance of considering non-technological communication such as adverts in order to reach people.

Most respondents reported that there had been a creative online offer of Early Help services. One Designated Nurse for safeguarding from North West England described 'creation of one single point multi-agency Early Help website for families seeking advice and support'.

Creation of COVID safe spaces for in-person Early Help support was noted overall by half of respondents, and particularly noted by Children's Social Care and Safeguarding Partnership respondents as well as Health. Interviewees had noted several different options including opening special school playgrounds for families to book a play slot, or social workers meeting with young people in the park.

Concern was also raised by survey participants about access to help in general. As one Police respondent from the West Midlands said 'the whole system is fragmented and disjointed. If I don't know where to go to access mental health support how can a person in crisis?'.

In summary, Early Help provision was one of the highest priorities of respondents and it is of concern that in some areas thresholds have increased, and the onus is often on vulnerable families to take the initiative. Whilst internet options are possible, they are not overwhelmingly thought to be what families and children need and where the offer is available there would seem to be a need to communicate this, particularly to families with

internet poverty and literacy difficulties. Going forward there is a need to invest in Early Help and community services. As one respondent stated: 'There needs to be policy change to improve investment in prevention and supporting families at the very beginning of their journey into parenthood' (Designated Nurse for LAC and Safeguarding Children, Northwest England).

4.3 Children's Centres

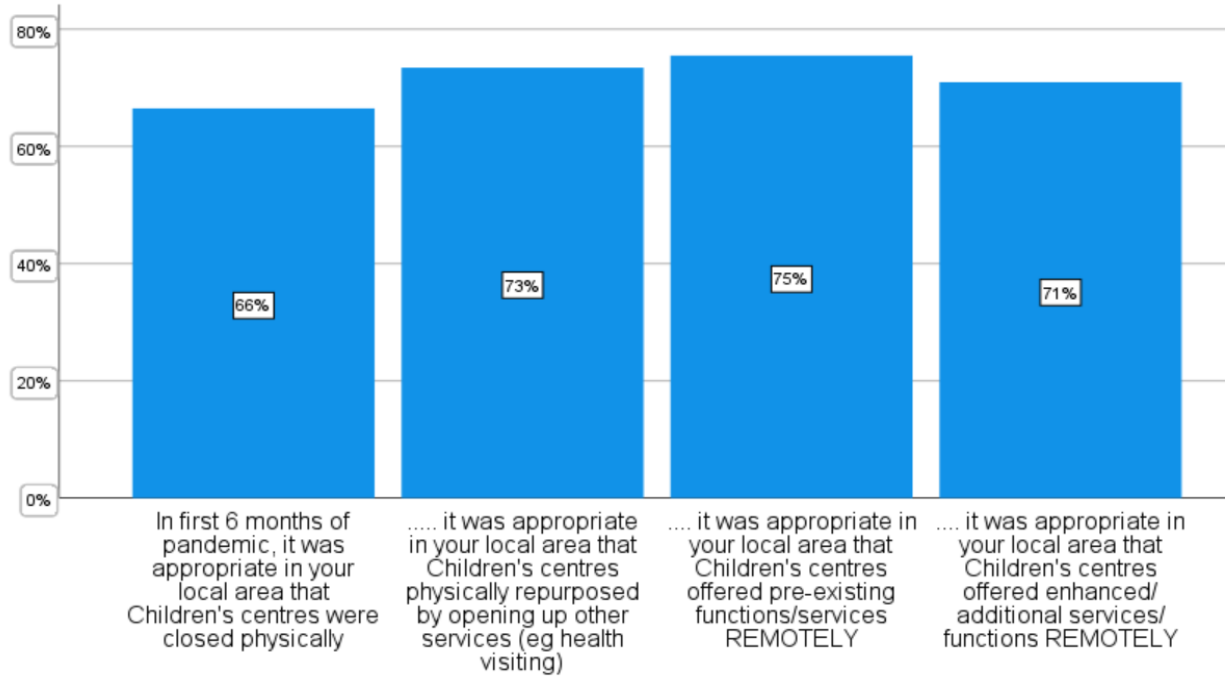
Summary of interview findings

Boroughs took a range of different approaches in relation to children's centres, with some continuing in-person, 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 Violence and 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.

Survey results

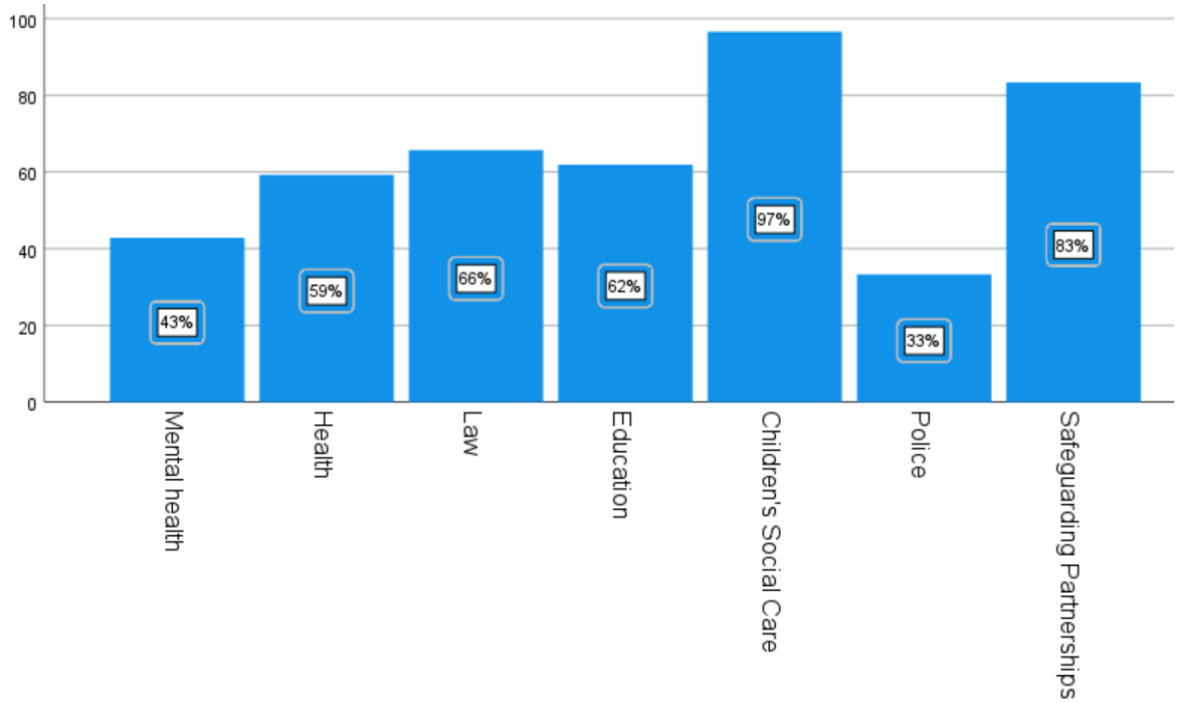
All but 5% of survey respondents reported that **children's centres were closed or partly closed physically** in the first six months: 153/217 (70%) of respondents reported closure, and 54/217 (25%) reported part closure (for Children's Social Care, 27/31 (82%) reported closure or part closure). 67% of total respondents thought that this was an appropriate response to the pandemic as shown in Figure 4.7 below.

Figure 4.7 Appropriateness of closure of children's Centres (total)
% responding 'yes' (n= 191,113,151,124)



There were differences in agreement with closure of Children's Centres as shown graphically below at Figure 4.8, with greatest approval by Children's Social Care and Safeguarding Partnerships as shown by percentage of respondents from each agency.

Figure 4.8: Was physical closure of children's centres appropriate?
Percentage yes by agency (n=191)

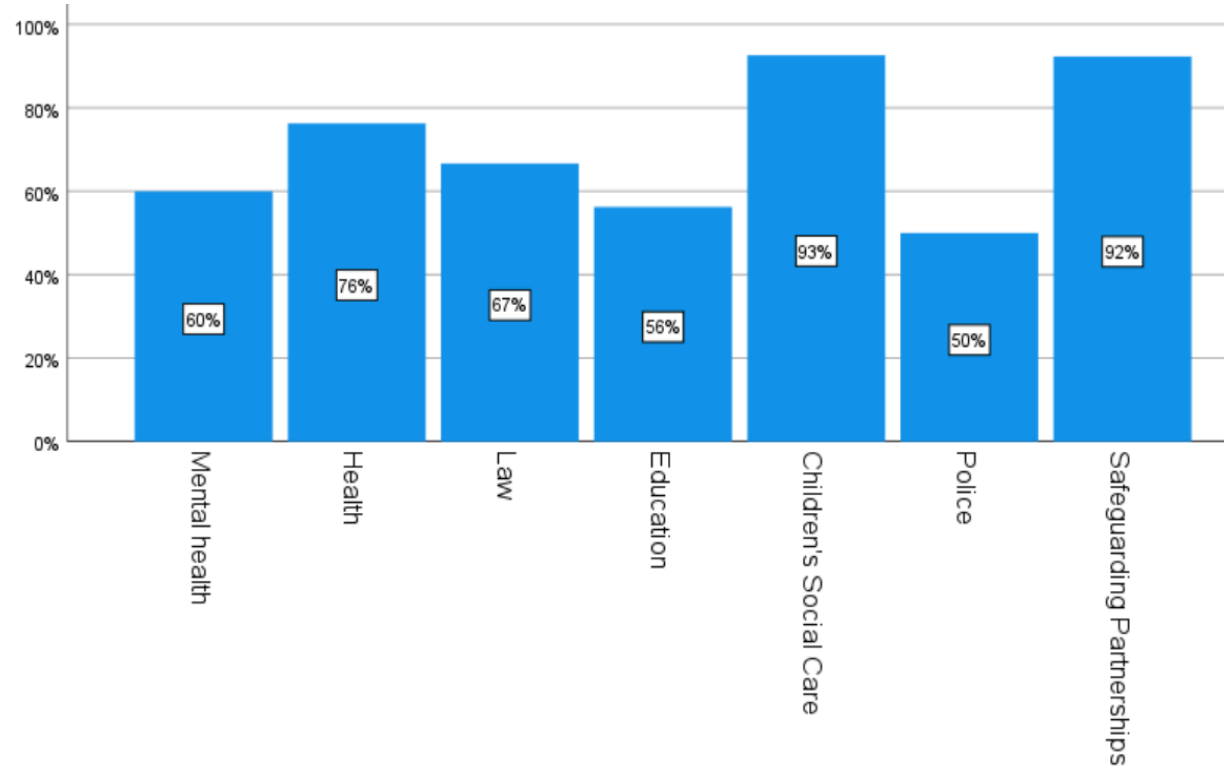


While numbers are small, and regional experiences may differ, these differences between Children's Social Care and other agencies are likely to reflect concern by universal and other services supporting vulnerable families at a distance during the pandemic with the experience and/or concern that families needed Early Help services in person.

56/129 (43%) said that the children's centres were **repurposed** in some way, for example to include health visiting. 74% of respondents thought that repurposing children's centres in this way was appropriate: some further qualitative exploration as to the purpose and worth of doing so would be beneficial.

Most, 129/154 (89%), said that children's centres offered **pre-existing functions remotely**, either in full (n=67) or part of the services (n=62). Only 4/29 (14%) from Children's Social Care said that there was no offer during the pandemic. 114/151 (76%) of respondents agreed that they thought that it would be appropriate to offer pre-existing functions remotely. Children's Social Care and Safeguarding Partnerships were the most comfortable with the online offer as shown below at Figure 4.9.

Figure 4.9: Appropriateness of children's centres functioning remotely
% yes by agency (n=151)



85/125 (68%) of respondents said that some **enhanced or additional functions** were offered by children's centres. 88/124 (71%) thought that this was appropriate.

Differences in agency responses are likely to reflect the tension between anxiety about the pandemic and human cost of infection, as opposed to the increased anxiety about families and children known to universal services that may have had more contact with, and concerns for, children and families known to them to be likely to need more face-to-face work and to be less able to initiate contact themselves. This was expressed clearly by a number of respondents:

> Children's centres closed, leaving vulnerable families with limited aid. I am uncertain how this was allowed to happen. When they reopened, there was little communication to guide how they would operate. This is against a backdrop of falling competencies within Health visiting/ school nursing services as experienced staff left, morale was already low and quality control around preventative work delivered by primary care/mental health staff allowed to decline. – Designated Doctor, East Midlands

4.4 Case planning

Summary of interview findings

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 remote assessments of parenting capacity and of children might be less reliable. 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.

Survey results

Questions about child protection plans were answered by about one third of total survey respondents. In the first lockdown, none of the 30 Children's Social Care respondents put children in their areas on a plan as part of the initial assessment, but this was introduced in one area in a subsequent lockdown based on earlier adverse experience. Other agencies gave a view that this was more commonly introduced, and may have reflected practice in different areas, or less detailed knowledge of the actions of social care. Sixteen of the 30 Children's Social Care respondents stated that children in their area were on plans for longer during the first lockdown, and this was reduced to 13/30 in subsequent lockdowns indicating focussed local work. Other agencies were more likely to respond that the children known to them seemed to be more likely to be longer on a plan in both lockdowns, and this again may reflect children known to their services, or different local areas.

Recommendations:

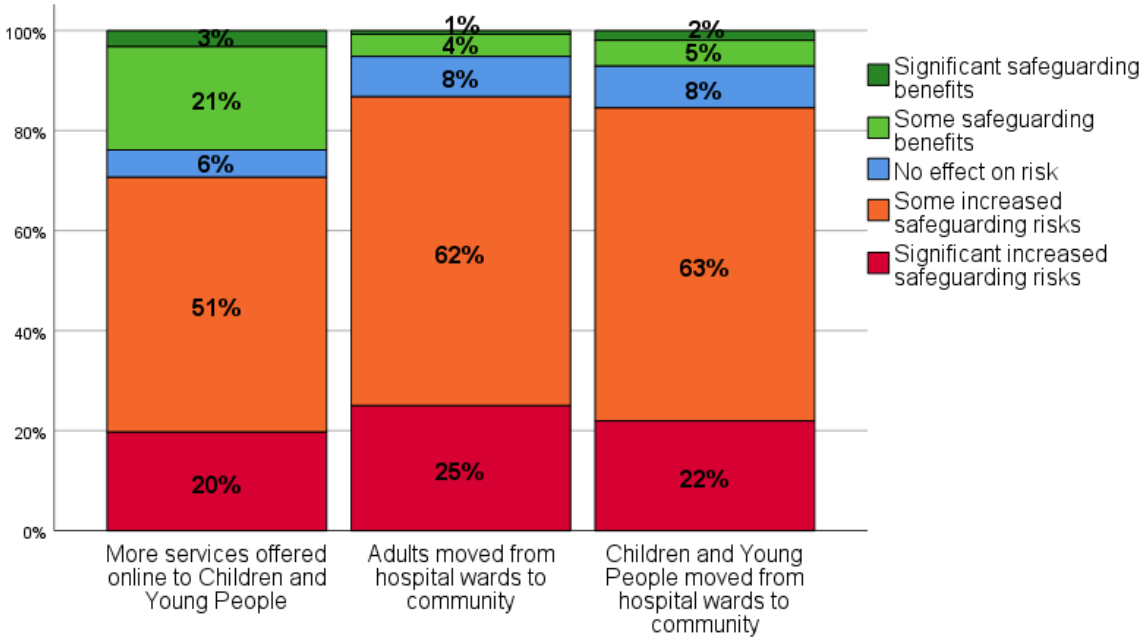
25. Baseline Early Help resourcing needs to be strengthened.
26. Evaluate the effectiveness of online provision of Early Help; assess which groups did not access the services during the pandemic; and formulate take-away lessons from this for a broader reach in the future.
27. Ensure equity of access and detail how support will be offered and provided to families that do not have internet access or may have social/learning vulnerabilities.
28. Enhance local information sharing strategies should further lockdown take place, such that information on health, early intervention, and protection are part of the routine local mail out in addition to local authority information.
29. Plan for future lockdown such that children's centres are accessible and safe.
30. Develop plans for COVID safe spaces for client meetings and family contacts in the longer term.

4.5 Mental health practice

4.5.1 Increased safeguarding risks as a result of changes in Mental Health service delivery

Due to the widespread increase in concern about the mental health of children and young people, and the impact this has on all aspects of the safeguarding continuum and on professional practice, we asked all respondents about the impact of the pandemic on mental health services, and whether they felt this has increased any safeguarding risks. The data show that respondents predominantly felt that all of the main changes to mental health services (moving services offered to children and young people online; moving adults from hospital to the community and moving children and young people from hospital to the community) increased some safeguarding risks to children and young people, although a significant minority of respondents (21%) felt that moving mental health services online for children and young people may have had some safeguarding benefits (Figure 4.10).

Figure 4.10: Increased safeguarding risk as a result of changes in Mental Health Services



Mental Health respondents were both more likely than other respondents to state that the move to online services had some safeguarding benefits to children and young people and also increased some safeguarding risks suggesting a lack of consensus amongst Mental Health respondents. Children's Social Care were also more likely to state that they felt the move online of mental health services to children and young people had increased some additional safeguarding risks. Safeguarding Partnership respondents were more likely than other agencies to state that moving adults from mental health hospital wards had significantly increased safeguarding risks to children and young people.

4.5.2 Importance of actions by mental health services and practitioners in protecting children and young people during the pandemic

Again due to the widespread increase in concern about the mental health of children and young people, and the impact this has on all aspects of the safeguarding continuum and on professional practice, we asked all respondents about the importance of action by mental health services and practitioners in protecting children/young people during the pandemic (table 4.1). All of the actions and interventions by mental health services and practitioners were considered important (i.e. over 90% of respondents say that the action is important or very important), with particular emphasis being placed on keeping specialist services open and involving CAMHS early in planning support for Looked After Children. There were no significant differences by agencies due to the overwhelming support for all these actions.

Table 4.1: Importance of action by mental health services and practitioners in protecting children/young people during the pandemic (not answered by Law, Health or Police)

	Very unimportant	Slightly unimportant	Neutral	Important	Very important
Increased safeguarding supervision in adult MH services (n=82)	2%	0%	4%	28%	66%
Triage young people as to those that can be seen safely online (n=100)	2%	0%	6%	35%	57%
Increasingly frequent contact by MH professionals during lockdown (n=103)	2%	0%	3%	31%	64%
Keep specialist MH services open (n=104)	2%	0%	0%	17%	81%
Involve CAMHS early in planning support for looked after children (n=102)	2%	1%	1%	21%	76%

Additional comments were also made by our respondents about mental health service provision:

> Hubs were created in our borough and it's the most easily accessible that I've experienced CAMHS services to ever have been in the past 20 years. – Designated Doctor for LAC, London

> Mental health services have offered direct referral by education to their CAMHS. – Designated Nurse for Safeguarding, North West England

> There appeared to be an increase in children committing acts of self-harm, making suicide attempts and in a small number of cases taking their own life. I remain concerned about the level of mental health provision to both children and adults. If a child had a broken leg there would be an expectation that the leg would be treated at A&E within a few hours, when they have mental illness there is far too often a significant delay between asking for help and receiving it. – Police, West Midlands

Recommendations:

31. Recognition of the critical role that mental health services and practitioners play in safeguarding children and young people needs to happen at the highest levels in government.
32. Mental health including community interventions need to be adequately resourced: a proportion of government resources allocated to mental health services should be ringfenced for safeguarding leadership and supervision for both child/adolescent and adult mental health practitioners.
33. Future decisions about significant and widespread changes to mental health provision (such as moving to online services or moving from hospital to community care) should be undertaken in consultation with safeguarding leadership within Mental Health and Safeguarding Partnerships.
34. Increased child safeguarding training is needed for all adult mental health practitioners due to increased child safeguarding risks linked to higher levels of mental health problems.

4.6 Looked after Children

Summary of interview findings

Interviewees reported that Looked After numbers appeared stable despite reported increased court hearings but were anticipated to rise in the autumn. Fewer Looked After Children (LAC) 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 in the first lockdown was a reported 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, the question whether there would be sufficient placements was an urgent concern from the outset relating potentially to illness of parents, health vulnerability of carers, increased safeguarding concerns, and carers being afraid to take potentially infected children. Interviewees reported that 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.

Survey results

Up to 100 respondents with Looked After Children (LAC) responsibility responded to these questions, with a predominance of answers from Health and Children's Social Care.

4.6.1 Placements

Several different strategies were used in order to increase placements during COVID as summarised in Figure 4.11 and outlined below.

Most of 38 respondents carried out strategies to educate and provide **pandemic information for carers**. This included 16/19 Children's Social Care, who reported that the strategy resulted in 7/19 successful placements, and 9/19 placements made but with some concern about their success. Perhaps surprisingly, this was overall the most successful strategy both in terms of numbers of placements and the number of successful placements. Information for carers would have helped to give confidence and allay their fears. From the interviews, there was joint working with Children's Social Care and LAC Health leads to provide the most information to promote placements and placement stability.

Recruiting more foster carers: Of Children's Social Care respondents, only 4/19 indicated that it was a successful strategy, and the majority had some concerns about the placement. This was the most widely reported strategy and there would need to be more analysis as to why these placements were not successful, for example relating to the nature of the selection process, or support for carers during the pandemic.

Other strategies included attempts to **return retired carers**: 14/23 Children's Social Care respondents did not use this strategy and of the 9 Children's Social Care respondents that did try to recruit, 5/9 were unsuccessful in increasing placements. This may have related to the reason for retiring from caring, as many were likely to be older and have comorbidities making them more vulnerable to the consequences of COVID–19 infection and therefore reluctant to return to caring work with potential risk to their own health or that of family members.

Increasing numbers per carer: this strategy was used by only 8/23 Children's Social Care respondents. Although reported to be unsuccessful by only one respondent, others expressed some concerns about the placements. This strategy may be of short-term

applicability given the practicalities for carers taking extra children into their homes with satisfactory outcomes for all concerned.

Relaxed matching: It was reported that this strategy was mainly not used. 7/24 Children's Social Care respondents attempted relaxed matching, with some success for six of these in obtaining placements. Responses were similar for Health and Children's Social Care, and there were concerns about the placement once made.

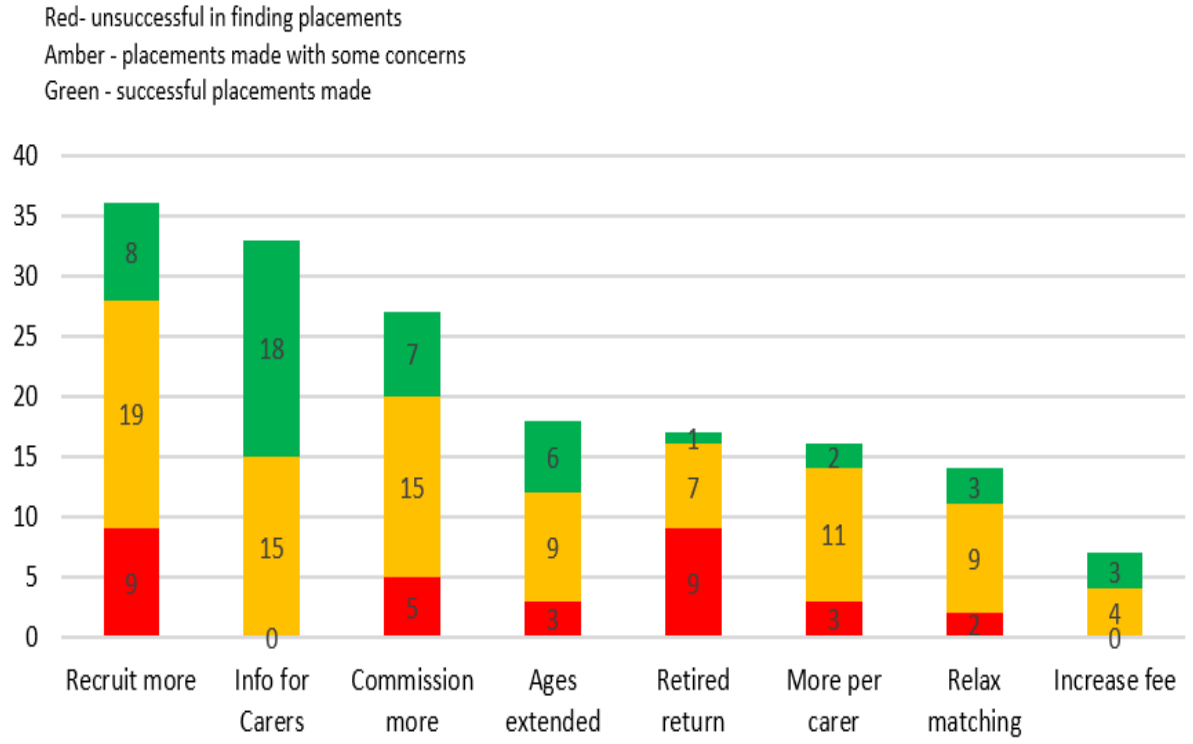
18/34 respondents had experience of **extending the age range of children** placed with foster carers. This resulted in increased placements in 15/18, with confidence in six, and increased numbers placed in a further nine but with some concerns about the success of placements.

Enhancing the fee for emergency placements was only used by 3/23 (13%) Children's Social Care respondents, with success in finding placements reported by those that did so.

Commissioning extra residential placements was attempted by 14/23 (61%) Children's Social Care, successfully in all but two, with some concern about the success of placements in nine.

Results from all respondents are shown in Figure 4.11 below, which summarises responses from all agencies in relation to the success of strategies to increase placements for LAC.

Figure 4.11: Strategies to increase placements (by number of total respondents)



Cross authority collaboration to secure low volume, high risk accommodation was said to be needed by 32/42 (76%) of respondents working with LAC (this included 11/17 (76%) from Children's Social Care). From the interviews, some of these young people did not meet the threshold for different professional groups (Children's Social Care or CAMHS) and could spend a long time in emergency departments awaiting resolution. Whilst this may in part relate to inter-agency protocols, this also relates to those young people with known complex

behavioural and mental health needs that simply could not be housed by available accommodation and specialist support, and this was particularly emphasised by respondents.

> …Cost of residential placements, and sufficiency for complex cases is poor. – North West England

During discussion at the policy lab, cross boundary collaboration for hard to place young people was also stated strongly to be a gap.

4.6.2 Professional work with LAC and carers

Not only have the number of children in care increased nationally, but the pandemic has also made it harder to carry out meaningful work and maintain contact with birth families.

All 27 Children's Social Care respondents said that they had provided **laptops for LAC**, with almost all (26/27 (96%)) continuing this provision at the time of the survey. 44/67 (66%) respondents were providing **food parcels** for LAC, and 42 reported that this was continuing at the time of responding to the survey. These were often given by schools according to some interviewees and survey responses and also formed part of strategies to develop supportive relationships.

Online resources were provided for foster carers by 24/25 (96%) Children's Social Care respondents, noted by 7/11 Education respondents and 52/58 (90%) of respondents overall; this was introduced in some areas by joint working with Health (interview with Designated Doctor).

Placement stability and relationships

Early in the pandemic, interviewees responded that placement stability had improved, and interviewees speculated that this was perhaps because relationships were built, or because there was no pressure on young people to attend school, as well as decreased pressure to be involved in local gangs as the lockdown allowed them to be at home. The survey enabled this to be re-examined after a period of time. Even later in the pandemic, the majority (59/87 (68%)) felt that placement stability had stayed the same or improved during the pandemic, and 63/77 (82%) said that relationships with carers had improved or stayed the same (only 18% felt that relationships had worsened with carers). However, of significant concern is that 37/67 (55%) felt that relationships with parents had deteriorated during the pandemic (8/22 (36%) of Children's Social Care respondents). Given that many young people return home from care, there is recovery work needed in supporting parents and strengthening professional relationships with parents as well as with young people and their families.

Increased remote contact with Social Worker/Personal Adviser/ Independent Reviewing Officer (IRO) was noted to be put in place by 26/27 (96%) of Children's Social Care

respondents and given the repeated lockdowns it was unsurprising that this has been maintained by 25/27 (93%) of them. 62/72 (86%) of total respondents noted that remote contact increased.

24/26 (92%) of Children's Social Care respondents reported that the Local Authority introduced in-person **contact with LAC in alternative placements**, and this was continued in 23 of them at the time of the survey and was said to be ongoing by 42/66 (64%) of the total respondents. This was encouraging given the concerns about isolation of LAC but would also be more likely for children placed in area.

Professionals were concerned about aspects of professional work: for example, a Health survey respondent stated that children were not having physical initial health assessments, that there was a waiting list, and that LAC were not getting interventions other than these assessments. Another respondent was concerned that access to CAMHS services remained problematic for children placed out of area. National guidance recommended in-person initial health assessments, and this should already be included in recovery planning (RCPCH/RCN, 2020). Remote access is of concern given the issues raised in this research about safety and appropriateness of remote contact for young people requiring safeguarding services, although it needs to also be recognised that some young people, including those with autism and some teenagers, found it easier to engage with professionals remotely.

Educational engagement and Looked After Children

Although more than a third overall (29/81 (36%)) reported worsened educational engagement during the pandemic, only 10% of the Education respondents felt that it had worsened and this is in keeping with extensive work to 'keep in touch', reported by interviewees in stage 1 of this study. This finding from Education may also reflect the motivation of participants of the study and intensive work carried out by Education participants.

31/52 (60%) respondents including 15/22 (68%) Children's Social Care noted that their area introduced **peer support**, with the majority continuing peer support at the time of the survey (29/52 (56%) of the total). The outcomes of peer support will be useful to analyse in the future as something that may help young people on an ongoing basis and in terms of the safety provisions required and how peer support can benefit minority groups of young people such as those with English as a second language.

Virtual activities for LAC such as yoga or art were reported to be set up by 18/22 (82%) of Children's Social Care respondents and reported by 34/54 (63%) of all respondents. This would appear to be an area for development in conjunction with Education as not all areas appeared to have introduced virtual activities.

Concerns for specific groups of children in care

Interviews raised the plight of young people in care, and elicited particular concern for disabled children, unaccompanied minors, and LAC in detention, as well as care leavers during the pandemic.

For **Disabled children** in care, it was felt that support had overall worsened during the pandemic. Interviewees raised concern about contact with family members and others that they would usually need to see in-person rather than remotely. One interviewee noted that children from residential homes were sent home, raising concern about risk and support. 30/65 (40%) of survey respondents felt that support had worsened during the pandemic, and more than a 1/3 of survey respondents from a social care perspective agreed with this.

22/55 (40%) of total respondents felt that support for **Unaccompanied Minors** (UASC) was worse during the pandemic based on their experience. Education and Children's Social Care were much more positive about the picture for unaccompanied minors, with only 10-20% responding with concern, probably reflecting increased contact and outreach by these agencies. However, 67% of Health respondents had experienced worsening support for UASC. Interviewees raised concern about out of borough/area placements. Issues are likely to include: prior trauma, isolation, fear, future uncertainty, and communication difficulties. The pandemic raised challenges in carrying out health assessments remotely with an interpreter. Lack of meaningful normalising activity would also be detrimental for these young people.

LAC in detention have been reported to be particularly vulnerable, with existing mental health, language, learning and behavioural needs (BMA, 2018). Most of Health, Law and Children's Social Care respondents (27/44 (61%)) reported that support had worsened during the pandemic. This concurs with the literature and information given by interviewees in the first stage of the study with increased effective solitary confinement.

4.6.3 Care Leavers

From interviews and the policy lab, it is clear that care leavers and in particular those that had recently left care were felt to be particularly vulnerable during the pandemic. 59/70 (84%) of respondents considered that care leavers had become more isolated during the pandemic, including 21/24 (88%) of respondents from Children's Social Care. 33/75 (44%) felt that transition planning had been negatively affected. Delayed transition out of care was noted by 19/24 (79%) Children's Social Care respondents and was an ongoing concern for 17/24 (71%) of Children's Social Care and 27/43 (63%) of total respondents. It was also considered by 27/70 (38%) of respondents that professional support had declined for care leavers. Given the cycles of deprivation, homelessness, and vulnerability known to be linked to young people in care, it would seem to be essential to optimise this care, and to continue to maintain and

develop relationships between care leavers and professionals that can support them longer term and be part of building resilience.

Recommendations:

35. Ensure that alternative and skilled provision is available should a children's home need to close.
36. Explore the impact of the pandemic on the carer experience, including trends in placement stability following rapid induction during COVID-19, develop strategies to strengthen support to current carers and review carer training and suitability.
37. Consider whether the increased severity and complexity of cases has translated into more complex placements to maintain and in this context assess the provisions, as well as the training and support needs of social workers and carers.
38. Develop further contact centres that can also cater for separated mother and babies in a pandemic safe way as part of the planning requirement.

5. Conclusions and Reflections

5.1 Introduction

Our research provides a unique perspective on the challenges facing the safeguarding and child protection workforce during the COVID-19 pandemic and the adaptations to professional practice made in response to the social distancing and lockdown measures in two important respects. First, inclusion of a full range of disciplines enabled us to examine commonalities and differences in the key challenges encountered and solutions implemented, and to investigate the impact of changes in one part of the system on other areas and on inter- and multi-agency working. Second, our methodological approach ensured that questions and response options included in the national-level survey drew on the key issues and responses identified by expert senior practitioners in the interview stage. Although the study does not conform to the 'true' Delphi method in a number of respects, deviations have arguably strengthened the findings. We widened the remit of the survey from London to England-wide in response to professional feedback that London is in some respects a special case and that findings in that context may not translate to other regions. As a consequence, we also deviated from limiting the second stage to the same pool of participants as the first, although interviewees were invited to respond to the survey, and we were therefore able to capture data from a much larger group of respondents. The Delphi method also assumes that participants in later stages of a study are commenting on the same problem identified at the outset of the study, whereas in reality much had changed for our respondents from the first to the third lockdown as adaptations to practice evolved rapidly when the pandemic raged on for longer than initially expected. We therefore have some insight into developments over time as professionals sought to restore what they regarded as the most important aspects of established ways of working or find alternative means of assuring the safety of vulnerable children and young people.

This report has focused on the findings from the survey stage of the report, comprising 417 responses from senior safeguarding leaders. These data are enriched by the more than 1,000 comments made in response to open questions. The open comments, in conjunction with insights from the interviews, provided valuable perceptions to support interpretation of some patterns in the data, such as what might at first sight be regarded as contradictory data about the shift to a tripartite model of local safeguarding leadership or ambivalent attitudes towards the use of remote communications methods. At the end of our study in April 2021 we held a policy lab with our expert partners, expert reference group, representatives of our four partner organisations, policymakers, voluntary sector organisations and professional leaders. This elicited feedback on key priorities for policy and practice and centred our findings in the broader context of professional concerns around vulnerable children. The policy lab also provided valuable reflection on the extent to which key concerns are new as a result of the pandemic as compared with the many issues that were pre-existing concerns that have been significantly exacerbated during the pandemic. In this section of the report we have reordered

the consideration of issues to reflect those that appeared to be of greatest priority for our policy lab attendees.

5.2 Hearing the voice of the child

Given the extensive disruption to fundamental pathways for the disclosure and identification of safeguarding and child protection concerns effected by the social distancing and lockdown measures, it is unsurprising that our survey respondents considered that the voice of the child has been less readily heard during the pandemic notwithstanding a plethora of initiatives. Delegates at the policy lab picked up on the importance of the research in exposing the need to access the child's voice and the significance of the constraints on hearing children. It is clear that these constraints span the entire safeguarding continuum, from concerns about population mental health and hidden harms to children in families who were not known to services, to worries about child carers and the isolation of care leavers. Policy lab attendees echoed our interviewees in highlighting the importance of in-person contact for non-verbal and very young children as well as children involved in court proceedings, and high levels of concern for particular groups, such as babies, children with disabilities and those in custody or detention. It is important to note however the likelihood that children and families will have different perspectives and experiences than practitioners, who were our target group. The importance of understanding the experiences and views of children and families in order to best meet their needs and enable them to make safe choices and seek support was a strong focus of research participants, endorsed by policy lab attendees.

The pandemic has served to exacerbate pre-existing inequalities and draw attention to the impact of digital poverty in the identification and response to child protection concerns as well as deepening educational inequalities. The need for a more systematic approach to ensuring that all children's voices are heard and that children's perspectives are central and not regarded as an 'add-on' was highlighted at the Policy Lab, with suggestions such as outcome measures that take children's perspectives into account and further investment in digital resources and training. Consideration might be given to using Lundy's model of participation rights (Lundy, 2007) to analyse the impact of conditions imposed by the pandemic on children's ability to be heard effectively: this would require ensuring children have 'space' (safe opportunities to express their feelings and experiences); 'voice' (facilitation of that expression, through appropriate communication methods taking in account age and any particular needs); 'audience' (including professional opportunities and skills to pick up and respond to safeguarding concerns) and 'influence' (mechanisms and capacity to facilitate appropriate action in response to communication by children). More work is needed on the effectiveness of virtual monitoring of vulnerable children and on engaging children in remote communication methods, including clear guidance on good practice.

Non-attendance at school by vulnerable children was thought to be most commonly due to concern about the child or carer's health and/or a response to the national message to stay at home, but 85% of respondents cited families taking advantage of the opportunity to disengage from professionals as a contributory factor. Our research has consolidated existing evidence of professional anxiety over the safety of children and young people who are home educated. Policy lab commentary endorsed our respondents' views that Elective Home Education (EHE) is likely to increase significantly as a result of the pandemic as well as their calls for greater monitoring. The surprisingly high level of support by our survey respondents for mandatory school attendance for 'vulnerable' children without clinical risk factors during the pandemic evidences the critical role of schools as the only service with daily contact with (almost) all children from 4-18.

5.3 Remote communication

The study highlights the different approaches to, and appetite for, in-person work, both between and within disciplines in the early stages of the pandemic. While the balance of risk in individual circumstances must be an important consideration, our survey findings suggest that decision-making as to mode of communication was rarely left to the discretion of practitioners, although this increased over time, and even less likely to be guided by the preferences of children and families. Our interviews during the first lockdown suggest some confusion over what was required or advised in a context of rapidly changing guidance or instructions and decision making at different levels. Respondents in Health and Education were particularly likely to consider that more in-person contact should have been used: this again increased between the first and subsequent lockdowns as access to equipment, testing and vaccinations increased. Professionals exhibited high levels of anxiety about the extent to which remote communication methods inhibited robust assessment of risk as well as building of rapport and felt support.

It is clear that there are many potential benefits to be gained from remote communication in the operation of statutory meetings, conferences and court hearings, particularly in terms of the efficient use of professionals' time and in facilitating 'attendance' at meetings which might otherwise require significant time taken up in travelling. But while most professionals were able to access essential IT resources and skills, there was some indication of a digital skills deficiency among some practitioners. Additionally, very high proportions of our respondents reported that digital poverty and digital literacy problems could pose technical barriers to access for children and families, and there were additional concerns over engagement, understanding and felt support. While there is much ambivalence among professionals in relation to remote communication, there is a clear desire for meetings and statutory processes to be conducted where possible and appropriate in a way which allows

both in-person and remote attendance ('hybrid' arrangements). There is also clear scope for greater use of online or hybrid delivery of safeguarding training.

There is also a mixed picture in relation to children and young people's engagement through remote communication methods, with some groups appearing to enjoy online contact at times. Potential benefits include increased contact with Looked After Children who are placed out of area. From interviews, some groups of children with mental health difficulties were more comfortable with remote contact. However, while there may be benefits for some young people in accessing mental health services remotely, the weight of opinion is of increased safeguarding concerns. Policy Lab attendees highlighted the need to acknowledge that virtual meetings cannot replace in-person contact but may supplement it and the importance of recognising where virtual communication is not appropriate. More guidance for practitioners in this area is needed.

5.4 Multi-agency working

It appears that the pandemic has helped to embed Safeguarding Partnerships arrangements through increased activity and communication in response to the crisis. Most survey respondents agreed that the shift to a tripartite leadership arrangement had been successfully achieved in their local area, although challenges were noted in achieving a truly tripartite accountability and leadership. Almost half of respondents were neutral as to whether the change of structure itself improved inter-agency collaboration, with some noting the significance of strong pre-existing relationships. Individual inter-agency working was generally considered to have either been maintained or improved, with the notable exception of Education respondents, a considerable minority of whom reported deterioration in inter-agency collaboration, in particular in relation to Children's Social Care. The greater responsibility for safeguarding devolved onto schools during the pandemic reignites a pre-existing debate as to the appropriate status of school representation within Safeguarding Partnership arrangements. Policy Lab attendees endorsed the importance of reconsideration of how to ensure meaningful engagement of the schools sector in Safeguarding Partnerships at a time when publication of the Wood report was imminent. There was exceptionally strong support from our survey respondents for greater representation on and involvement in the work of local Safeguarding Partnerships by education and health providers, CAMHS and housing and surprisingly high support for representation of those agencies on the Executive Board, despite the statutory accountability arrangements. These figures likely reflect concerns expressed in interviews around potential loss of the wider partnership with the shift to Safeguarding Partnerships and as to whether operational input was strong enough. We thought that the strength of feeling that we gleaned from the interviews as to the absence of the representation of health providers might be a problem particular to London where the health estate is particularly fragmented, but the survey results suggest it is a nationwide issue.

The question arises as to what the implications might be of the transition to Integrated Care Systems under the Health and Social Care White Paper *Integrating Care.* There were also concerns expressed at the Policy Lab as to the divergent development of Safeguarding Partnerships as well as comments echoing those from our interviewees about the importance of strategic thinking and multi-agency consultation in decision-making that impacts on safeguarding, such as redeployment.

Support for a shared database of pre-agreed information to support child safeguarding was also exceptionally high and would appear to reflect heightened anxiety around identification of child protection concerns and significant work to promote information sharing to that end during the pandemic, including broadening the eligibility criteria for consideration of children's circumstances through Multi-Agency Safeguarding Hubs. A 'digital record so the child/young person doesn't have to keep repeating their story' was also suggested at the Policy Lab. Consideration should be given to further expansion of the Child Protection – Information Sharing project (CP-IS), which was extended to school nurses and health visitors during the pandemic but currently only covers children on a child protection plan or looked after and operates between health and social care.

5.5 Service Provision

A backdrop of redeployment of safeguarding staff and closure of universal and support services in the community, together with increased risk factors for many children underlie evidence of increased complexity and severity of referrals. Of particular concern, and building on pre-existing weaknesses, are reports of increased Early Help needs coupled with perceived reductions in Early Help services by some agencies and/or challenges in communication of and access to services and suggestions that carers were required to be more proactive, likely increasing the gap for those that are less able to take the initiative to seek support.

Risk reassessment processes in the light of children's new circumstances were largely regarded as effective and this appeared to be particularly the case when carried out at an interagency level or coordinated by Safeguarding Partnerships. Some commentary suggests that schools' knowledge of children and families was not taken full advantage of in this exercise, which is particularly pertinent given strong agreement that schools took on greater safeguarding responsibility during periods of school closure. 'Keep in touch' strategies by schools were extensive, and generally felt to build lasting supportive relationships with families. The most common strategy to improve school attendance, and the one regarded as most successful, capitalised on relationships with Designated Safeguarding Leads or other school staff known to families. However, while respondents broadly supported maintaining the enhanced role of schools, most acknowledged that it would require investment to do so, while the majority of schools respondents considered that it was only appropriate if most

children were not in school or that it was not appropriate for schools to continue with this greater engagement.

Provision of placements for Looked After Children is another area where pre-existing challenges were intensified as a result of the crisis. A variety of approaches were used to increase availability of placements. The most successful included providing pandemic information for carers, increasing the fee, extending the eligible age range of children in a foster placement, commissioning more placements, and relaxation of matching criteria. The least successful included attempts to recruit more carers, placing more children per carer, and returning retired carers. While placement stability stayed the same or improved for most children, a decline in good relationships with birth parents will require remedial work as social restrictions are eased. Respondents endorsed concerns of reduced support for four particularly vulnerable groups: children with disabilities; unaccompanied minors; those in detention; and care leavers, and the anxiety around the wellbeing of babies and infants and child and parental mental health concerns expressed in interviews.

5.6 Workforce wellbeing and capacity

The safeguarding workforce was felt to be exhausted, and under increased pressure with more complex workloads of increased severity, and new ways of working in safeguarding, amidst staff shortages for reasons of health or redeployment. Redeployment of universal and safeguarding professionals was opposed by most respondents, and there was support for proposals for local safeguarding leads to have an oversight on redeployment decisions. Ongoing staff problems included caring responsibilities, loneliness and bereavement with most respondents noting a decrease in wellbeing. Peer initiatives, supervision, counselling and breaks were said to be helpful, and of concern, there were reported challenges in staff retention and recruitment that need to be addressed urgently. Consideration needs to be given to restoring staff expertise and confidence through training and supervision.

5.7 Concluding thoughts

The global climate change crisis has drawn attention to the notion of intergenerational justice, a concept which is of value also in addressing the way in which the measures taken to combat an adult public health crisis have disproportionately affected the safety, wellbeing and opportunities of the young. The pandemic came at a time when changes in demographics have resulted in adult social care attracting the priority attention of policymakers. Children's services such as CAMHS and the health visiting workforce as well as children's social care services were severely under-resourced before the pandemic struck and little progress had been made on critical social policy issues such as child obesity, infant mortality and mental health. Notwithstanding all the efforts reported here and elsewhere to address barriers to

disclosure or identification of child protection concerns caused by the measures introduced to combat the pandemic, CAFCASS statistics (2021) show a reduction in public law cases received in the year April 2020 – March 2021 compared with the preceding year, suggesting that a surge in public law applications may be yet to come. Coordinated cross-government attention and investment is needed to address the complexity of inter- and multi-agency information sharing, assessment and service delivery to safeguard children and young people. As focus is directed to the importance of tackling the education deficits affecting the children of lockdown, we must not lose sight of the need to reconsider the central role of schools in safeguarding and child protection; the implications of the pandemic for the mental health of children and families; and the wellbeing of professionals.

6. Recommendations

1. Ongoing evaluation as to the effectiveness of Safeguarding Partnerships in coordinating local areas' safeguarding children services and providing strategic leadership. In particular, consideration as to how best to ensure that all relevant agencies, including schools, health providers, and mental health providers, are fully engaged in the work of Safeguarding Partnerships in the light of the critical role played by schools during periods of lockdown and the forthcoming Integrated Care legislation.
2. Arrangements for multi-agency collaboration and cooperation for the protection of children become of heightened importance during periods of lockdown: robust safeguarding contingency plans should be prepared in advance of any future crises with full input from Safeguarding Partnerships, including in relation to redeployment of any staff with safeguarding responsibilities.
3. Consideration to building on some of the initiatives for joint risk assessments and enhanced scrutiny and/or sharing of data and trends to enhance risk management in the future. In particular, thought should be given to extension of the NHS Child Protection-Information Sharing Programme to a wider range of agencies.
4. Attention to processes and mechanisms through which hearing the voices of all children can be adequately assured in any future incidents in which universal services are closed, with attention to particular/special needs of children and families and barriers such as digital poverty.
5. Concerted intervention by both education and safeguarding professionals to reengage 'vulnerable' children not attending school during the pandemic, to limit numbers of children who do not return to mainstream schooling.
6. Legislation to improve monitoring and regulation of Elective Home Education.
7. A review of the role of schools and school staff in safeguarding, including specialist provision within schools, staff training, and the appropriateness and burden of early help work, and monitoring and evaluation of recent investment in mental health support in schools.
8. Consideration of how to ensure that schools' knowledge of children and families is fully respected in multi-agency discussions and taken into consideration in individual safeguarding / child protection cases.
9. Continued investment to ensure that practitioners are fully able to engage with vulnerable children and families and carry out their safeguarding duties safely at a distance, with particular attention to increased connectivity for practitioners and increased digital literacy and IT support.

10. Continued investment to ensure that practitioners are fully able to engage with vulnerable children and families and carry out their safeguarding duties safely at a distance, with particular attention to increased connectivity for practitioners and increased digital literacy and IT support.
11. Clear evidence-based guidance for practitioners to identify when in-person engagement needs to happen and when digital contact is appropriate or preferable. Guidance needs to take into account both the experiences of practitioners and vulnerable children and families, with attention to the 'why not in-person approach' that has increasingly been used as the pandemic has progressed.
12. When digital communication is used as part of child protection practice, regular reviews of how this medium is being used must be enacted to reduce the risks associated with this form of communication for child protection purposes.
13. Investment in child-friendly and 'safe' technology to aid safeguarding work by all actors, such as the development of apps or social media sites that support protection work.
14. Investment in creating the possibility for more meetings between professionals, including those that involve vulnerable children and families, which enable people to attend online and in-person at the same time (a 'hybrid' approach). This includes making the necessary technology, space and technical knowledge widely available; taking into account the experiences of professionals and children and families; and the development of practice guidelines to enhance use of this hybrid approach.
15. Conversations with vulnerable children and families about their preferred method of communication need to occur as a routine aspect of practice.
16. Future decisions around redeployment of a. **health professionals with safeguarding responsibility** and b. **health professionals who are critical for the early identification of safeguarding concerns** (such as midwives and health visitors) should be undertaken in consultation with both safeguarding leadership within health and Safeguarding Partnerships.
17. Recognition of the critical role that safeguarding practitioners from all agencies have played in keeping children and young people safe during the pandemic needs to happen at the highest levels in government.
18. Professional wellbeing must be prioritised in workforce planning decisions made over the coming year: critical areas of staff wellbeing that need urgent attention include the balance of work with increased caring responsibilities, increased workloads, loneliness, poor mental health, staff illness and bereavement.
19. Further investment in strategies to increase practitioner wellbeing, including regular individual supervision and contact with managers; regular opportunities created for informal peer support (including both in-person and online spaces); regular group supervision and discussion; and active management of leave.

20. Further investment in training programmes which combine in-person and online modes, or which allow both in-person and online engagement at the same time. Despite safeguarding training largely being carried out online throughout the pandemic, participants clearly indicated that safeguarding training is best carried out with all (or some) in-person elements and not all online. Immediate training priorities include the impact of the pandemic on the mental health of children; remote safeguarding protection of children; child protection during a pandemic; and domestic violence.
21. Recognise that services need to spend sufficient time on assessments, with dedicated time for analysis and professional supervision.
22. Multiagency discussion is crucial: services need to be configured in such a way as to ensure availability of appropriately trained staff for strategy and other case discussions, and that robust interagency pathways are in place.
23. Upskill the workforce in identifying and signposting when there are mental health difficulties as well as at-risk settings and behaviours.
24. Ensure that there is a 'think safeguarding' as well as a 'think family approach' to vulnerability and need.
25. Baseline Early Help resourcing needs to be strengthened.
26. Evaluate the effectiveness of online provision of Early Help; assess which groups did not access the services during the pandemic; and formulate take-away lessons from this for a broader reach in the future.
27. Ensure equity of access and detail how support will be offered and provided to families that do not have internet access or may have social/learning vulnerabilities.
28. Enhance local information sharing strategies should further lockdown take place, such that information on health, early intervention, and protection are part of the routine local mail out in addition to local authority information.
29. Plan for future lockdown such that children's centres are accessible and safe.
30. Develop plans for COVID safe spaces for client meetings in the longer term.
31. Recognition of the critical role that mental health services and practitioners play in safeguarding children and young people needs to happen at the highest levels in government.
32. Mental health including community interventions need to be adequately resourced: a proportion of government resources allocated to mental health services should be ringfenced for safeguarding leadership and supervision for both child/adolescent and adult mental health practitioners.

33. Future decisions about significant and widespread changes to mental health provision (such as moving to online services or moving from hospital to community care) should be undertaken in consultation with safeguarding leadership within Mental Health and Safeguarding Partnerships.
34. Increased child safeguarding training is needed for all adult mental health practitioners due to increased child safeguarding risks linked to higher levels of mental health problems.
35. Ensure that alternative and skilled provision is available should a children's home need to close.
36. Explore the impact of the pandemic on the carer experience, including trends in placement stability following rapid induction during COVID-19, develop strategies to strengthen support to current carers and review carer training and suitability.
37. Consider whether the increased severity and complexity of cases has translated into more complex placements to maintain and in this context assess the provision, as well as training and support needs of social workers and carers.
38. Develop further contact centres that can also cater for separated mother and babies in a pandemic safe way as part of the planning requirement.

References:

Adams, C., 2020. *Is A Secondary Pandemic On Its Way?*. [online] Institute of Health Visiting. Available at: https://ihv.org.uk/news-and-views/voices/is-a-secondary-pandemic-on-its-way/.

Baginsky, M., Driscoll, J., Purcell, C., Hickman, B. and Manthorpe, J. (forthcoming) *Schools and Multi-agency Working for the Protection and Safeguarding of Children*. Bristol: Policy Press.

Baginsky, M. and Manthorpe, J., 2020. *Managing through COVID-19: the experiences of children's social care in 15 English local authorities*. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. Available at: https://kclpure.kcl.ac.uk/portal/files/131392323/Baginsky_and_Manthorpe_2020_Managing_through_COVID_19_Report.pdf.

British Medical Association (BMA), 2018. *Joint Position Statement on Solitary Confinement of Children and Young People*. [online] Available at: https://www.bma.org.uk/media/1859/bma-solitary-confinement-in-youth-detention-joint-statement-2018.pdf. [Accessed 27 May 2021].

Buzzi, P. and Megele, C., 2020. *The PCFSW Best Practice Guide For Risk Assessment And Prioritising Children And Families' Needs During Pandemic: April 2020 Update*. [online] The Principal Children and Families Social Worker Network (PCFSW). Available at: https://www.skillsforcare.org.uk/Documents/Learning-and-development/social-work/psw/PSW-best-practice-guide-for-risk-assessing-children-and-families-needs-and-risks.pdf.

Cabinet Office/Department for Education, 2021. *Guidance: Children of critical workers and vulnerable children who can access schools or educational settings.* [online] Available at: https://www.gov.uk/government/publications/coronavirus-covid-19-maintaining-educational-provision/guidance-for-schools-colleges-and-local-authorities-on-maintaining-educational-provision [Accessed 27 May 2021].

CAFCASS, 2021. *Public law data: Number of public law cases received.* [online] Available at: https://www.cafcass.gov.uk/about-cafcass/research-and-data/public-law-data/ [Accessed 27 May 2021].

The Child Safeguarding Practice Review Panel, 2021. *Annual Report 2020: Patterns in practice, key messages and 2021 work programme*. [online] The Child Safeguarding Practice Review Panel. Available at: https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2020.

Coles, J., 2020. *Comment on mothers visiting babies in care*. [online] ADCS.org.uk. Available at: https://adcs.org.uk/general-subject/article/comment-on-mothers-visiting-babies-in-care.

Conti, G. and Dow, A., 2020. *The Impacts Of Covid-19 On Health Visiting In England*. First results. [online] London: UCL. Available at: https://www.dropbox.com/s/ib1c25imf5318ob/Conti_Dow_The%20impacts%20of%20COVID-19%20on%20Health%20Visiting%20in%20the%20UK-POSTED.pdf?dl=0.

Department for Education (DfE), 2020. *Supporting Vulnerable Children and Young People During the Coronavirus (covid-19) Outbreak – Actions for Educational Providers and Other Partners.* [online] Available at: https://www.gov.uk/government/publications/coronavirus-covid-19-guidance-on-vulnerable-children-and-young-people/coronavirus-covid-19-guidance-on-vulnerable-children-and-young-people [Accessed: 27th May 2021; withdrawn 4th August 2020].

Department for Education, 2021. *Safe working in education, childcare and children's social care settings, including the use of personal protective equipment (PPE)*. (Updated 1 March 2021). [online] GOV.UK. Available at: https://www.gov.uk/government/publications/safe-working-in-education-childcare-and-childrens-social-care/safe-working-in-education-childcare-and-childrens-social-care-settings-including-the-use-of-personal-protective-equipment-ppe [Accessed 27 May 2021].

Evans, N., 2020. *COVID-19: How Redeployment Is Affecting Children's Services*. [online] Nursing Children & Young People. Available at: https://rcni.com/nursing-children-and-young-people/newsroom/analysis/covid-19-how-redeployment-affecting-childrens-services-159971.

Ferguson, H., Kelly, L. and Pink, S., 2020. *Research Briefing Two: Disruption And Renewal Of Social Work And Child Protection During COVID-19 And Beyond*. [online] University of Birmingham. Available at: https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/research-briefing-2-child-protection-disruption-renewal-accessible.pdf.

Gov.UK Explore Education Statistics, 2021. *Attendance In Education And Early Years Settings During The Coronavirus (COVID-19) Outbreak, Week 10 2021* (Published 9 March 2021). [online]. Available at: https://explore-education-statistics.service.gov.uk/find-statistics/attendance-in-education-and-early-years-settings-during-the-coronavirus-covid-19-outbreak/2021-week-10 [Accessed 27 May 2021].

Hackett, S., Masson, H. and Phillips, S., 2006. Exploring Consensus in Practice with Youth Who Are Sexually Abusive: Findings from a Delphi Study of Practitioner Views in the United Kingdom and the Republic of Ireland. *Child Maltreatment*, 11(2), pp.146-156.

HM Government, 2018. *Working Together To Safeguard Children: A Guide To Inter-Agency Working To Safeguard And Promote The Welfare Of Children*. [online]. HM Government. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2.

Institute of Health Visiting (IHV), 2020. *Health Visiting During COVID-19: An iHV Report*. [online] Institute of Health Visiting. [online]. Available at: https://ihv.org.uk/our-work/publications-reports/health-visiting-during-covid-19-an-ihv-report/.

Iqbal, S. and Pipon-Young, L., 2009. The Delphi Method. *The Psychologist*, [online] (22), pp.598-601. Available at: https://thepsychologist.bps.org.uk/volume-22/edition-7/delphi-method.

Launder, M., 2020. *Abuse of babies increased by a fifth during Covid, Ofsted says*. [online] Nursing in Practice. Available at: https://www.nursinginpractice.com/clinical/paediatrics/baby-care/abuse-of-babies-increased-by-a-fifth-during-covid-ofsted-says/.

Lundy, L., 2007. 'Voice' is not enough: conceptualising Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal*, 33(6), pp.927-942.

Masilamani, K., Lo, W., Basnet, A., Powell, J., Rodrigues, D., Tremlett, W., Jyothish, D. and Debelle, G., 2021. Safeguarding in the COVID-19 pandemic: a UK tertiary children's hospital experience. *Archives of Disease in Childhood*, 106(4), p.1.

Munro, E., 2011. *The Munro Review Of Child Protection - Interim Report: The Child's Journey*. [online] Department for Education. Available at: https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system.

NHS England and NHS Improvement, 2020. *Integrating care: Next steps to building strong and effective integrated care systems across England.* [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf.

Nicolas, J., 2015. *Why Do Home Visits Matter In Child Protection?*. [online] Community Care. Available at: https://www.communitycare.co.uk/2015/09/02/home-visits-matter-child-protection/.

Pearce, J. and Miller, C., 2020. Safeguarding children under Covid-19: What are we learning?. *Journal of Children's Services*, 15(4), pp.287-293.

RCPCH/RCN, 2020. *Looked After Children services in COVID-19 pandemic recovery plans - statement*. [online] Available at: https://www.rcpch.ac.uk/sites/default/files/generated-pdf/document/Looked-After-Children-services-in-COVID-19-pandemic-recovery-plans---statement.pdf. [Accessed 27 May 2021].

Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Harrison, E., Retzer, A. and Sorenson, P., 2016. *Pathways To Harm, Pathways To Protection: A Triennial Analysis Of Serious Case Reviews 2011 To 2014*. [online] Department for Education. Available at:

https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014.

Talbot, A., 2020. *What Is Socially Distanced Child Protection And Can It Work?*. [online] Children's Commissioner. Available at: https://www.childrenscommissioner.gov.uk/2020/04/16/what-is-socially-distanced-child-protection-and-can-it-work/.

Wood, A., 2021. *Wood Report: Sector expert review of new multi-agency safeguarding arrangements*. [online] Department for Education. Available at: https://www.gov.uk/government/publications/wood-review-of-multi-agency-safeguarding-arrangements.

Cases

R (on the application of Article 39) v *Secretary of State for Education* [2020] EWCA 1577. Available at: https://www.judiciary.uk/judgments/r-article-39-v-secretary-of-state-for-education/ November 24 2020.

Study resources:

Protecting Children at a Distance Project Page:
https://www.kcl.ac.uk/research/protecting-children-at-a-distance

Summary of findings stage 1:
https://www.kcl.ac.uk/ecs/assets/projects/protecting-children-at-a-distance-executive-summary-of-stage-1-findings.pdf

Summary of findings stage 2:
https://www.kcl.ac.uk/ecs/assets/projects/protecting-children-at-a-distance-executive-summary-of-stage-2-findings-summary-and-conclusions.pdf

Protecting Children at a Distance Survey (PDF):
http://bit.ly/KCLSurvey

Appendix 1: Survey respondents' recommendations for central government

If you had one recommendation for Central Government in order to safeguard children going forwards, what would it be?

1) Children, Family and Community
    a. Child-centred/voice of child (15)
    b. Poverty & inequality, including digital poverty (12)
    c. Family and Community (5)
2) Central coherence and stability of the system (27)
3) Resourcing
    a. General (20)
    b. Early help/early years (20)
    c. Mental health (10)
    d. Schools/located services (5)
    e. Other (2)
4) Access to schools and services (13)
5) Listen to leaders and professionals (7)
6) Support for staff (11)
7) Other (3)

1) CHILDREN, FAMILY AND COMMUNITY

Keeping the child central

'**Think about children in everything that you plan**, from car parks and town development to new services roles and legislation. If there is a gap in your provision that means a child can 'fall through or be exploited, it will happen.' – Designated Nurse for Safeguarding, South West England

'**Seek views of children so much more actively**.' – Designated Nurse for Safeguarding, North West England

'Vulnerability of a child should not be defined by a specific group. It should be down to the professionals working with the child and family. Although there was a caveat to this effect in the guidance it was not always heard and responded to clearly in individual cases.' – Mental Health Lead for Safeguarding Children, East of England

'Keep trying to find innovative ways to hear various children's voices.' – Designated Nurse for Safeguarding, London

'**Never redeploy colleagues who work directly with children and families**.' – Head of Safeguarding, Yorkshire & The Humber

'More focus on our forgotten children.' –Education, London

'Recognise that CYP are our future and therefore need to be invested in meaningfully.' – Designated Nurse for Safeguarding, Designated Nurse for LAC, South East England

'Have children at focus, CMO etc are adult medics, need paeds... where was the President of the RCPCH.' – Designated Doctor for Safeguarding, South East England

‘Change the ofsted inspection to a more focussed wellbeing approach. The schools have the best interests of their pupils at heart.’ – Police, North West England

‘Children's welfare has to be considered not just media friendly headline grabbers.’ – Designated Doctor for Safeguarding, London

‘Make it easier for professionals working with resistant and challenging families to make parents engage with adult mental health services maybe by making it mandatory for all families working at any level of involvement from Early offer to S47 level to undertake a formal mental health assessment as this is the biggest barrier to change and working with families when parents won't acknowledge their own poor mental health and address it and understand the impact this has on the child.’ – Mental Health Lead for Safeguarding Children, East of England

‘Further investment - actually tackling the issue of gangs, sexual exploitation and County Lines gangs, none of, which is being prioritised or dealt with to the extent that there is now a Modern Slavery Unit that has now been set up because these children are being utilised as drug mules and we live in a society where this is being allowed to happen. Central Government does not want to deal with these difficult conundrums - there is something to be said for the fact that if it was a lot of young white boys or girls being stabbed to death, there would be more action from Central Government and that is a shocking thing to be saying, but it remains true. The clear and unedifying message is that these children's lives are expendable - no-one should be able to say that in a first world country in the 21st Century.’ – LA Solicitor, East of England

‘Listen to the voice of the child and make funds available for children to access services both statutory and more targeted support such as counselling and therapeutic interventions.’ – E, East Midlands

‘**Elective Home Education guidance** re seeing the child and sharing information more readily to access the child.’ – Business Manager, London

‘**Go back to face to face visits, meetings and monitoring**.’ – South East England

<u>Poverty (including digital poverty)</u>

‘Tackle the root causes: inequality and poverty.’ – Mental Health Safeguarding Lead for Children, North East England

‘Address child poverty and inequality - that hasn't changed in the 23 years I have been practising paediatrics!’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Review poverty assessments and "a day in the life of a child".’ – Designated Nurse for Safeguarding, South West England

‘Serious look at poverty prevention and alleviation during the economic downturn.’ – Designated Doctor for Safeguarding, South East England

‘Support troubled families - multifactorial (including poverty)’ – Designated Doctor for Safeguarding, South East England

‘Social Policy needs to be reviewed, children living in relative poverty, increase in provision and funding for early help.’ – Named Nurse for Safeguarding, North West England

'**Investment in IT** for all school pupils.' – LA Solicitor, East of England

'Provision of IT / broadband for all who are unable to access it.' – LA Solicitor, South West England

'Ensure all families have access to technology and connectivity, so it can be used to see

/ speak to the family.' – Business Manager, East of England

'To ensure that all families had access to on-line support with provision of suitable equipment.' – Named Midwife for Safeguarding Children, North West England

'Better mental health services and investment in IT for all school pupils.' – LA Solicitor, East of England

'Housing, poverty impact on children not having access to remote working devices.' – Mental Health Lead for Safeguarding Children, London

Family and Community

'More support for vulnerable families.' – Named Nurse for Safeguarding, South East England

'Stop spending millions on signposting nonsense and community projects. **Build safe, clean bright homes** for families to leave hideous private landlords and abusive males. Enable flourishing not simply surviving. Most environments are totally hostile to those needing help.' –E, West Midlands

'Don't stop school or the community support for families. as these families are already not coping and this adds further immense pressure.' – Named Doctor for Safeguarding, North West England

'Increase resource to communities- staff, physical spaces- that allow communities to work together to improve life chances for all and understand where the risks lie.' – Named GP for Safeguarding Children, North West England

'There needs to be policy change to improve **investment in prevention and supporting families at the very beginning of their journey into parenthood**.' – Designated Nurse for LA, Deputy Designated Nurse for Safeguarding Children, North West England

2) CENTRAL COHERENCE AND STABILITY OF THE SYSTEM

'**Please do not engage in a further re-structure of the system for at least a couple of years** - there has been so much restructuring across all agencies that attention is sometimes effectively diverted from the task in hand.' – Designated Nurse for Safeguarding, North West England

'A **nation-wide approach to safeguarding rather than differing levels of need across local authorities**.' – Education, North West England

'To have a **clearly articulated, joined up vision from all government departments that allows partners to align and work together not just because it's a good idea, but because processes and systems actively promotes and allows it**.' – Designated Nurse, East Midlands

'**Improve inspection services to ensure that there is a more joined up approach**. EG, Ofsted shouldn't just visit school or social services without visiting primary or secondary health care services. CQC should do the same.' – Named Nurse for Safeguarding, South West England

'**Changes in commissioning of health services to reflect integration and shared outcomes for children**, improved accountability of health services in safeguarding children and their responsibilities as corporate parents for looked after children.' – Designated Nurse for Safeguarding, North West England

'Not to reduce the statutory safeguards.' – Children's Panel Solicitor, Yorkshire & The Humber

'Stop sector specific guidance being issued that are not legally compliant, can be misinterpreted locally, or used to pull away from Safeguarding Partnership/Community Safety meetings/activity.' – Business Manager, West Midlands

'Regulations could be reduced dramatically.' –Business Manager, South East England

'The whole system is fragmented and disjointed. If I don't know where to go to access mental health support how can a person in crisis. Is it not time to **consider a national 'Public Service' under which sits the police, children's services etc so we all use the same IT equipment, work to the same policies and procedures** etc. At the moment it seems we are wasting large sums of money working in local/regional silos.' – Police, West Midlands

'Resolve sufficiency of placements issues and the ability for providers to charge and make LAs compete for placements.' – Children's Social Care, London

'**Regulate the use of MASH in local authority areas**.' – Police, East Midlands

'Enforce the **equity of financial responsibility for safeguarding across the three statutory agencies**.' – Safeguarding Partnerships, North West England

'Ensure the duty to cooperate is named in legislation for all, it was changed in Working Together.' – Children's Social Care, North West England

'Make better use of multi-agency monitoring and create a system where this has to take place to prevent serious case reviews.' – Education, London

'Make multi agency working mandatory and hold people to account.' – Education, East Midlands

'Meaningful Communication, observation, swift action when needed.' – Education, London

'Continue to monitor the consistency of approach across local authority safeguarding boards.' –Education, North East England

'Stop focusing on executive requirements to act and do, empower them to know and understand what those with specialist knowledge are doing.' – Designated Nurse for Safeguarding, South East England

'Build on safeguarding principles for all service designs in health instead of believing that safeguarding practice is an add on.' – Designated Nurse for Safeguarding, North West England

'Have **one standard threshold document**.' – Health, London

'I have been in this field for almost 25 years. I have seen things go full circle and it feels as if we have gone back 30 years in some areas. A single health rep which is a manager DOES NOT WORK.' – Designated Doctor for Safeguarding, North West England

'Move the safeguarding resource at designate level for the front/provider level to really make a difference.' – Named Nurse for Safeguarding, South East England

'Ensure an impact assessment is undertaken in respect to safeguarding at every decision-making point.' – Designated Nurse for LAC, North West England

'Greater working collaboratively with services so that there can be a more joined up approach.' – Named Midwife Acute, London

'To have a **central IT system for information sharing**.' – Named Nurse for LAC, London

'Don't make unilateral decisions about the work of certain agencies that then impact on the whole safeguarding system - e.g. certain health roles.' – Business Manager, South West England

'Recognise the reality that **the Wood reforms made engagement with non lead agencies much more difficult including reducing funding**.' – Yorkshire & The Humber

3) RESOURCING

General

'Re-provide all the resources that austerity has stripped away.' – Children's Social Care, North East England

'Review of systems approach to ensure effectiveness in pre-and during covid pandemic crisis with commitment adequate resourcing both human, economic, where the burden of care and dynamics shift.' – Education, London

'**Commit to resourcing and supporting multi-agency safeguarding hubs**- with national best practice guidance updated. For when children are referred due to safeguarding concerns - a holistic risk assessment of immediate concerns should include analysis of their health and development needs, as well as social care history, police, education in any safeguarding decisions and actions.' – Designated Nurse for Safeguarding, South East England

'**Increase of workforce to safeguard children from universal services through to court proceedings**.' – Deputy Designated Nurse for Safeguarding, East of England

'As above, more investment in resources, leadership, training and support.' – Safeguarding Lead, London

'**Investment for public health** and to sit with the NHS rather than the Local Authorities.' – Named Nurse for Safeguarding, North East England

'There should be no cut in services.' – Children's Panel Solicitor, London

'Appropriately resource the relevant services and prioritise children and young people's welfare.' – Designated Nurse for Safeguarding, Yorkshire & The Humber

'To provide more financial and ring-fenced support to all agencies to increase the staffing numbers involved in child safeguarding and investigation. Agencies can then employ

sufficient staff to carry reasonable and realistic workloads so to be able to effectively deal with child protection incidents.' – Yorkshire & The Humber

'Fund it properly. Please actually try to safeguard children instead of making local authorities have to decide who they can and can't support.' – Business Manager, Yorkshire & The Humber

'Better funding of services.' – Business Manager, London

'More resources please.' – LA Solicitor, East of England

'Increase funding for the system generally - Local Authority safeguarding services and family courts in particular.' – LA Solicitor, East of England

'More money!! More access the therapy and parenting work.' – Children's Panel

Solicitor, LA Solicitor, London

'Allow adequate funding.' – LA Solicitor, East of England

'Stop cutting services to vulnerable families.' – LA, London

'**Funding formula on child population and IDACI indicator profiles** and introduced some services / interventions on a national basis as at present children and the profession are subject to a postcode lottery due to local issues and local government vulnerabilities.' – Children's Social Care, London

'Sufficient long-term resourcing of children's services.' – Children's Social Care, North East England

'Enhance resources across all agencies with safeguarding responsibilities the system needs investment to be able to respond effectively, short term funding is not impactful for providing structured and impactful change. new 'burdens' should be funded appropriately not expected to be subsumed in business as usual.' – Children's Social Care, East Midlands

'Increase funding in early intervention and statutory services to ensure that local authorities can provide services which fully respond to local need. More statutory powers to enable authorities to access families. Less focus on bureaucratic processes to allow for more innovative practice.' – Children's Social Care, London

<u>Early Help and Early Years</u>

'Invest in **midwifery services**, stop focusing on labour and birth and be honest about how difficult and wonderful parenting is, there is no longer any meaningful antenatal education, babies need to be nurtured and supported and not medicalised.' – Named Nurse for Safeguarding, South East England

'Allocated resources.' – Named Midwife for Safeguarding Children, West Midlands

'More resources to ensure assessments are carried out properly in timescales.' – Named Midwife for Safeguarding Children, South East England

'**Sufficient funding for early help and impose as statutory function on all partners**.' – Children's Social Care, North West England

‘Invest in early help particularly resources to respond to Domestic abuse.’ – Children’s Social Care, East Midlands

‘Invest in early help and evidence based practice.’ – Children’s Social Care, North East England

‘Raise the profile of safeguarding families by investing in early years and children's services.’ – Named Nurse for Safeguarding, North West England

‘**Increase the number of 0 - 19 health practitioners** and have clear guidance on Early Help. Move services to universal provision to support families earlier in their journey.’ – Designated Nurse for Safeguarding, East Midlands

‘Review and properly fund services Early intervention evidenced based to reduce health inequality.’ – Designated Nurse for Safeguarding, East Midlands

‘Invest more funding to universal services, move funding back from public health or ring fence it. The cost of responding to adolescent needs (crime, exploitation, mental health) will far out way any investment to early years health now.’ – Named Nurse for Safeguarding, South East England

‘As above: Revert the health visiting role back to what it used to be with adequate funding, manageable caseloads and respect for what they do. We need this more than ever now with so many children & young people having MH and self; not just for safeguarding but proactive preventative work.’ – Designated Nurse, Yorkshire & The Humber

‘Provide support early in cases and in child’s life.’ – Named Doctor for Safeguarding, East Midlands

‘Significant increase in funding for early years/early help intervention - prevention better than cure. Upheaval of benefits package to address poverty directly impacting on families as a result of UC. Reopening of children's centres, more on the ground health visitors, more power to social workers to support families.’ – Named Nurse for Safeguarding, East Midlands

‘Put more money into the 0-19 service so that Health Visitors can support families for longer- they have a good service until they are 5 and then it just stops. Families go on needing that support. Listen to what parents and children need and don't rely heavily on courses that don't appear to work.’ – Named Nurse for Safeguarding, South East England

‘Improve funding to the preventative services and Early Help like children's centres and Health Visiting.’ – Named Nurse for Safeguarding, South West England

‘Health Visiting needs to be given its old priority for pre school children. Proper resources put in place to help the vulnerable families.’ – LA Solicitor, Yorkshire & The Humber

‘Increased funding of early intervention services.’ – LA Solicitor, London

‘Increase funding for early support services.’ – Business Manager, South West England

‘Early Help provision.’ – Police, South East England

‘Investment in early help and family support and interventions as well as mental health and education.’ – Children’s Panel Solicitor, South East England

Mental health and therapeutic services

'CYP mental health specifically for those admitted and staying for exceptionally long periods of time on children's medical wards in hospital settings. There are no community services, tier 4 isn't appropriate and they are becoming institutionalised in acute hospitals. It's like going back 20-30 years when children's length of stay was excessive. It's no wonder we are seeing previous LAC in CSE. CCE stats.' – Named Nurse for Safeguarding, North West England

'Invest in expert services for emotional and behavioural concerns in CYP.' – Designated Doctor for Safeguarding, East Midlands

'More money to safeguarding to spend on **therapy for the most harmed** by events and processes...in for the long term stop changing with changes of government have a jointly agreed proceed for long term investment.' – Designated Nurse for Safeguarding, South West England

'Improved resources, improved resources for CYP to access CAMHS. **Improved investment in CAMHS**.' – Education, West Midlands

'Adequate mental health support to deal with the vulnerabilities and issues that have been created and exacerbated by the pandemic.' – Named Doctor for Safeguarding, Yorkshire & The Humber

'Fund children's services nationally and replace CAMHS with an appropriately funded and run organisation.' – Law, West Midlands

'More investment in professional early help services, especially CAMHS for young teenagers at risk of serious violent crime.' – Safeguarding lead, London

'Increase the resource for community mental health services.' – Mental Health Safeguarding Lead for Children, Yorkshire & The Humber

'Resources.' – Mental Health Safeguarding lead for Children and Adults, London

Schools /located services

'Invest in family safeguarding and pastoral support in schools.' – Children's Social Care, South East England

'If schools are expected to be so instrumental in safeguarding we have to be resourced to do it. We need more protection from abuse and complaints We need to not be so exposed as professionals. We need mental health support on site for staff and children and for it to be better. Children should not have to wait years. Staff should not be daily facing such difficult conversations/challenges and not be able to make reasonable demands of parents to parent their children. We need to change the culture of looking for an excuse for their child in SEN or in the growing expectation that everyone else is responsible for their child and their child's problems. We need to be able to challenge parents without fear. This has been a huge change in the last few years as school accountability has grown and we are expected to serve our customer- parents- rather than actually challenge. We need to be able to focus on the child and be able to expect parents to be responsible.' – Education, South West England

'Financial allocation to schools to employ dedicated counsellor/ mental health support worker.' – Education, South East England

'Fund schools with their own Social Workers.' –Education, London

'Fund support in school for young people.' – Mental Health Safeguarding lead for Children, London

Other

'Less rhetoric. More investment in health support for Care Leavers.' – Designated Nurse for LAC, London

'Do not save money by taking away admin from health!' – Designated Doctor for Safeguarding, London

4) ACCESS TO SCHOOLS AND SERVICES

'To insist unless health problems all vulnerable children attend school.' –Education, East Midlands

'Keep children and young people in education.' – Named Nurse for Safeguarding, London

'Ensure all services remain accessible and open not just social care.' – Children's Social Care, Yorkshire & The Humber

'Closing schools has had a very negative impact on children and should be prevented at all costs in the future.' – Children's Social Care, North West England

'Again, open schools. The long term benefit of opening schools far outweighs the possible short term consequences.' – Education, South East England

'Prioritise safe restoration of universal services (education / HV).' – Named Doctor for Safeguarding, London

'Do everything possible to keep schools open. Vaccinate school staff. School is many children's Safe place and they need their peer group.' – Named Nurse for Safeguarding, London

'Children must attend school in person.' – Designated Doctor for Safeguarding, London

'Keep schools open and promote face to face contacts for all statutory agencies where children are involved.' – Designated Nurse for Safeguarding, Yorkshire & The Humber

'To ensure schools remain open. I think the fact they remained closed till the end of the last academic year increased the vulnerability of large swathes of our CYP population.' – Designated Doctor for LAC, London

'Much higher emphasis on alternative provision for children to be seen by a professional if schools have to remain closed to ensure there is not such a drop in referrals.' – LA Solicitor, London

'School aged CYP who are subject to statutory services and or vulnerable should be in School and the Government need to have a good track and trace system as opposed to

a reactive response to opening and closing schools.' – Designated Nurse for Safeguarding, London

'It should be mandatory that remote learning for children should predominately be livetime virtual classrooms as opposed to remote home-work style learning with individual 1 to 1 tutor sessions with pupils periodically to address welfare/safeguarding/individual concerns.' –Police, Yorkshire & The Humber

5) LISTEN TO LEADERS AND PROFESSIONALS

'Allow the Safeguarding Partnership to have the flexibility to modify safeguarding arrangements based on learning from the pandemic so we can make best use of the innovation that has emerged. And take good care of this country's social workers - through public recognition, celebration and whatever rewards are available. Social workers have been the unsung heroes in this pandemic, visiting families and safeguarding children in the most challenging of circumstances.' – Children's Social Care, London

'Ensure that child (and adult) safeguarding professionals are part of strategic decision making during the pandemic, and in all planning for future serious incidents, including any decisions around significant redeployment of health staff from their usual roles.' – Designated Doctor for Safeguarding, London

'Listen to professionals working in front line' – Designated Doctor for LAC, London

'Start listening to what front line professionals and partnerships need - don't just change the system!' – Designated Doctor for Safeguarding, North East England

'To ensure that expert voice of designated professionals and safeguarding are considered in the new legislation when we move to an ICS and it remains a statutory function.' – Designated Nurse for Safeguarding, North West England

'**Listen more to the front line**.' – Mental Health Lead for Safeguarding Children and Adults, West Midlands

'Safeguarding children in a true sense isn't just policy, but policy in action and listening to the team that have to embed policy. Consideration to how policy can be influenced (by staff on the ground) to empower staff and children and young people to remain safe.' – Mental Health Safeguarding Lead for Children, London

6) SUPPORT FOR STAFF

'**Increase the value of frontline child protection social workers**.' – Children's Social Care, North East England

'Comms campaign on social work profession to improve numbers of people going into the profession as well as whole community responsibility to protect children.' – Children's Social Care, London

'Schools are to educate children and while teachers have a role in detecting. noticing and referring safeguarding concerns, **teaching staff are NOT social workers**. We are not

qualified in this area, we are already too busy to keep taking on this role and we are certainly not paid enough.' –Education, North West England

'Ensure that **training** is a priority.' – Education, East Midlands
'**Show the same respect for school staff that you do for NHS. Stop the deliberate scapegoating of our profession by govt and press**.' – Education, North West England

'Provide **more resources/technology for front line workers**.' – Law, South East England

'**Recognition of all the work that frontline practitioners in the police, social services, health service, voluntary sector and schools etc are doing to keep the most vulnerable children safe at this challenging time**.' – Independent Chair/Scrutineer, East of England

'In the North East, where I practice there is deprivation on a staggering scale, more resources and training are needed to **ensure that the best people are in the jobs and, that they are retained** in those positions to ensure the best outcomes for children.' – Law, North East England

'Provide more support to lawyers and professionals in public children's law inc. addressing the issue re the hours we are working due to bad practice.' – Children's Panel Solicitor, London

'Review the enormous weight of safeguarding training expected in education. I am not suggesting that the current training isn't necessary but it is not manageable alongside teaching staff's own professional development in teaching and learning. There needs to be materials provided to support DSLs plan the delivery of training eg: What knowledge is expected of each different topic?' – Education, London

'More funding to maintain services and improve, also need more supervision training and supervision to allow staff retention.' – Designated Doctor for Safeguarding, London

7) OTHER

'**Better regulation of online content** to protect the exposure of children and other vulnerable people to information that is not age-appropriate or suitable and also to protect them from access by inappropriate persons. Is this neglectful of parents not to be taking an interest in what their child is doing online and taking some responsibility for what they are accessing remotely?' – Education, East Midlands

'Would have to think about it once the pandemic is over as **things will never return to how they were**.' – Children's Social Care, East of England

'To have an **accurate Test and Trace system** in place and to **close the borders** so that the COVID-19 rates did not necessitate three national lockdowns and school closures.' – LA Solicitor, London

Appendix 2: Survey respondents' recommendations for improved outcomes

If you could improve one aspect of safeguarding/child protection process or practice in order to improve outcomes, what would it be?

1) Joint working
    a. Communication/Information sharing (24)
    b. Strengthening inter-agency collaboration (17)
    c. Mutual respect (5)
    d. Safeguarding Partnerships (4)
2) Child-centred practice/Visibility/voice of child
    a. In-person work (13)
    b. Voice of the child (9)
    c. School attendance (5)
    d. Virtual contact (4)
3) Professional capacity/Resourcing (15)
4) Thresholds and Referrals (10)
5) Early intervention (7)
6) Specific issues
    a. Mental health (6)
    b. Domestic violence/abuse (2)
7) Other

1) JOINT WORKING

Communication/Information sharing

'Key partner agencies couldn't arbitrarily just end/radically adjust their service provision without conversation...' – Children's Social Care, South East England

'Better inter-agency and multi professional linkage. There is a lot of anxiety around data protection which can hinder and delay processes and sharing of information.' – Children's Social Care, London

'Create more space for practitioners to build relationships and support sustainable change. Use of technology in the right circumstances may well support this.' – Children's Social Care, North East England

'We are a small Local Authority, so increased communication between agencies to respond to improvements as issues arise.' – Safeguarding Partnerships, London

'Better communication and quicker.' – Education, South East England

'Improved multi agency vulnerability lists of not juts CP but SEND children too to be shared more easily across services so that we work more effectively and triangulate the work to

better support families and for housing departments to be more engaged as many families have struggled.' – Named Nurse for Safeguarding, London

'Shared IT systems.' – Designated Doctor for Safeguarding, South East England

'That the Skype link sent by the LA for child protection conferences actually works and professionals do not always have to dial into the meeting. Why send a link if it does not work? On this note, perhaps universal means of holding meetings eg. Microsoft Teams.' – Education, East Midlands

'For social workers and MASH to communicate in a timely manner with schools. At present we have to spend hours chasing outcomes and social workers.' – Education, East Midlands

'Better multi agency data analysis.' – Police, East Midlands

'Keep virtual spaces for talking through issues and problems across professional boundaries and organisation.' – Designated Nurse, South East England

'Maintain access to safeguarding records for professions (delayed access has caused investigation delays).' – Police, Yorkshire & The Humber

'Communication and timeliness of action.' – Designated Doctor for Safeguarding, Named Doctor for Safeguarding, London

'Better frontline communication between health and social care.' – Designated Doctor for Safeguarding, London

'Improved working together through consistent effective information sharing and communication.' – Designated Nurse, Yorkshire & The Humber

'For ALL agencies in the partnership to have a single electronic information sharing system.' – Designated Doctor for Safeguarding, East Midlands

'IT - one system, nationally that can be accessed via health, education and social care which has all the up to date information included on it to allow professionals to have an holistic view of the family's experience and professional input.' – Named Nurse for Safeguarding, East Midlands

'Information sharing becomes standardised and expected/ routine. Appropriate feedback from agencies to the referrer.' – Named GP for Safeguarding Children, North West England

'More joined up IT systems to promote information sharing.' – Mental Health Safeguarding Lead for Children, North East England

'Better IT kit/connectivity for remote meetings supported by good practice guidance.' – Safeguarding Partnerships, Yorkshire & The Humber

‘Elective Home Education information sharing.’ – Business Manager, London

‘Improve documentation around CP medical reports.’ – Named Midwife for Safeguarding Children, North West England

‘Assure that we had admin and data collection service support in health to help with data collection.’ – Designated Doctor for Safeguarding, London

Strengthening inter-agency collaboration

‘Due to increased complexity of need and presenting much later at a more acute phase I would commit to adequate health (and other agencies) resource in the MASH- multi-agency safeguarding Hubs or similar arrangements in order to understand a child's holistic needs and vulnerabilities for the family. It builds multi-agency relationships to understand roles, challenges decision making thresholds and ultimately helps to keep children safer in a more timely manner.’ – Designated Nurse for Safeguarding, South East England

‘Closer working between agencies- joint supervision on complex cases.’ – Designated Nurse for Safeguarding, South West England

‘It would be lovely to do some multi-agency reflective supervision (even virtually).’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Standardised risk assessments and vulnerability.’ – Head of Safeguarding, Yorkshire & The Humber

‘Review of systems approach to ensure effectiveness in pre-and during covid pandemic crisis.’ –Education, London

‘Meaningful and joined up thoughts and actions.’ – Education, London

‘Have children's social workers based on site in hospital to ensure good communication that offers effective early help and progresses the sect 17 or 47 concerns quickly. this helps protect children but also raises awareness and learning for hospital staff.’ – Named Nurse for Safeguarding, South West England

‘Trauma informed practice across the partnership and shared accountability for mutual outcomes across the partnership.’ – Designated Nurse for Safeguarding, North West England

‘Learning from past mistakes. We are seeing a perceived increase in non-accidental injury and death where the same failures are identified - practitioners too easily misled by carers, not insisting on seeing the child and insufficiently robust inter-agency liaison.’ – Law, West Midlands

‘Less fragmented intervention. In a lot of care cases there is a chronology of missed opportunities to intervene more effectively in the families lives because there is a lots of assessments and no joined up thinking.’ – LA Solicitor, Yorkshire & The Humber

‘More multi-agency work to ensure families are well supported.’ – Children’s Panel Solicitor, LA Solicitor, London

‘Enhanced multi-agency capacity/responsibility to respond to safeguarding concerns.’ – Children’s Social Care, East Midlands

‘Inter-agency coordination of Early Help’ – Police, South East England

‘More family safeguarding - adult services support.’ – Children’s Social Care, South East England

‘SMART plans developed in conjunction with families, effectively monitored and progressed through multi agency working.’ – Children’s Social Care, North East England

‘Hold all agencies to account for their roles in the plans - again, often additional support is withdrawn once a child moves into AP.’ – Education, East Midlands

‘A single plan - owned by all agencies and only includes areas that will make a difference for children. (it what should happen but there are often multiple plans that are unfocused and not making a difference for children).’ – Business Manager, South East England

Mutual respect

‘Recognition of professional judgement and respect between multiagency professionals.’ – Named Nurse for Safeguarding, North West England

‘Other agencies make good use [of] expertise within schools especially special schools.’ – Education, London

‘Better liaison with health regarding the strategy discussion and listen if they say child needs a medical.’ – Named Doctor, Yorkshire & The Humber

‘For the acute and community trust to work together rather than against each other in the provision of CP medical examinations.’– Designated Doctor for LAC, London

‘Ensuring health are always considered in decision making.’ – Designated nurse for safeguarding, North West England

Statutory Partnerships

'Include education in the safeguarding partnership with LA, Health, and Police,' – Education, North West England

'The tri-part equal partnership LA, Police and CCGs is a concern - progress is being made at a strategic level but health is much wider than CCGs and they are under review currently with move to ICSs - who will be the statutory partner when there are no CCGs?' – Designated Nurse, Yorkshire & The Humber

'Keep the collaboration with CSC/Police' – Designated Doctor

'Mental health around the table early. Housing and providers to be included in Executive strategic meetings at an early stage along with Designates, and police and social care leads.' – Designated Doctor for Safeguarding, London

2) CHILD-CENTRED PRACTICE

In-person work

'For Social Workers to be able to interact with a child 1-1 in a safe environment.' – Education, East Midlands

'Contact arrangements for hard to reach families.' – Education, South East England

'Mandatory to attend school if on SEND list or Child Protection/Child in Need/Early Support.' – Education, London

'Support social care staff in face-to-face visits wherever possible for complex patients.' – Named Doctor for Safeguarding, London

'All agencies need to commit to in person work. Schools did this right the way through, but were constantly being told by other services that they ' weren't allowed to attend assessments or work in person. Health service professionals/ ep service / family support were worse culprits. Totally frustrating for school staff who have been with children and families in need every single day. Don't we count? Why are we safe to work with. Child with complex needs on a 1-1 basis, whilst supporting mum with home visits to check welfare, providing food etc, but no other agency prepared to do anything but make phone calls.' – Education, North West England

'Keep all staff in the 0-19 services and safeguarding and not redeploy to enable them to contact families and offer face to face contact safely if needed.' – Named Nurse, North West England

‘Avoid redeployment and maintain as many face to face visits as possible.’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘Face to face case conferences.’ – Named Midwife for Safeguarding, London

‘CAFCASS allowed to do direct visits.’ – Children’s Panel Solicitor, London

‘Increase assertive contact with children and families.’ – Mental Health Safeguarding Lead, West Midlands

‘It is so important that vulnerable children are seen face to face and that community services are enhanced during the pandemic to identify the increasing numbers of children at risk of harm and abuse.’ – Independent Chair/Scrutineer, East of England

‘Social Workers to take responsibility for safeguarding children. Social Workers and Family Intervention workers should lead on all cases - not schools. Social Care need to do thorough assessments regardless of us being in lockdown. To my knowledge all social workers in Tameside are working from home and not visiting families and still they are being vaccinated while teaching staff take on more of their role.’ – Education, North West England

‘Families need face to face support with clear outcomes, so often families have 8 weeks of something remote and then say it hasn't worked. It isn't the courses that help- it is the relationships built with professionals who can empower parents.’ – Named Nurse for Safeguarding, South East England

Voice of the child

‘Strengthen all methods to hear the voice of the child and impact on outcomes.’ – Children’s Social Care, North West England

‘Obtaining the lived experiences of the children.’ – Named Nurse for Safeguarding, North East England

‘Keep trying to find innovative ways to hear various children’s voices.’ – Designated Nurse for Safeguarding, London

‘Establish the lived experience of CYP.’ – Designated Nurse, South East England

‘Ask children more about their wishes and views.’ – Designated Nurse for Safeguarding, South East England

‘Proper focus on the child's voice.’ – Designated Doctor for Safeguarding, Designated Doctor for Child Death

‘Listen to the voices of young people and families about what helps. Especially the voice of the Looked After Child.’ – NHS England, London

‘Voice of the child.’ – Designated Nurse for LAC, North West England

‘Get the views of the children / young people on how they want to be approached. my sons have given me often very unexpected feedback on how to approach training. We never ask the children how they want to be approached . many actually prefer it online and I have many children whose psychosomatic symptoms have improved as they don't have to go to school.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

Virtual contact

‘We need more online access to children, that's where children gather now; Instagram, Snap chat, Tic Toc.’ – Named Nurse for Safeguarding, London

‘A relaxation of the regulations around IHAs for children looked after to allow for them to continue to be done virtually if this is the preference of the young person and safe to do so.’ – Designated Nurse, Yorkshire & The Humber

‘Learn from some of the better ways of working we found during the pandemic - the mixture of remote and face to face processes.’ – Designated Doctor for Safeguarding, North East England

‘Significant improvement is needed in parent access and ability to use tech as well as hardware availability to judges and courts as the work load of LAs has increased significantly to make up for deficits in the court office ability to serve the judiciary.’ LA Solicitor, East of England

School attendance

‘Children must attend school in person.’ – Designated Doctor, London

‘Keep vulnerable CYP at school. SW's, HV, School nurses arrange to visit CYP on CP plan and CIN at more regular intervals. Keep Primary care open for CYP.’ –Designated Nurse for Safeguarding, East of England

‘Get schools up and running as normal again, pre-covid normal that is.’ – Education, South East England

‘Ban EHE for vulnerable children. govn intervention re the sufficiency of placements for children across the country Introduce again National Transfer protocol for UACS, some areas are overwhelmed.’ – Children’s Social Care, London

‘Review the use of and monitoring of home elective education.’ – LA Solicitor, London

3) PROFESSIONAL CAPACITY / RESOURCING

‘Lower caseloads for social workers so they have time to build relationships and skills...’ – Children’s Social Care, London

‘Govt recognise the continued under funding on children services.’ – Children’s Social Care, North West England

‘Re-provide all the resources that austerity has stripped away.’ – Children’s Social Care, North East England

‘Consistency in practice across an area. Increased numbers of social workers that deal with a family until that family is removed from support.’ – Education, North East England

‘Organisational priority of safeguarding work allowing staff the time to undertake this.’ – Named Nurse for Safeguarding, South East England

‘Smaller caseloads for LAC Nurses – Designated Nurse, East Midlands

‘Employ enough staff to meet need. Universal services and safeguarding nurses.’ – Named Nurse for Safeguarding, South East England

‘Improved resourcing within provider organisations and less resourcing at the designated level. eg professional and specialist roles at the front line and of services eg CP medicals, Hospital IDVA Provider organisations are well able to provide meaningful contribution to the strategic safeguarding level and know what they need but the feeling is the designated level are not listening or ineffective of facilitating positive change. There are too many designate safeguarding practitioners which does not facilitate strategy and is not a good use of finite resources. There can be a disconnect between the designated level and provider/named level.’ – Named Nurse for Safeguarding, South East England

‘Appropriately resourced.’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘More investment into resources within safeguarding teams.’ –Head of Safeguarding, London

‘An increase in staff including SW front line staff.’ – Children’s Panel Solicitor, London

‘Greater resources allocated to all stages of the process.’ – Children’s Panel Solicitor, Yorkshire & The Humber

‘Ensure it is properly resourced.’ – Police, West Midlands

‘Stop reducing postnatal care to timed appointments in a surgery and stop reducing the remit of midwives visiting to between 5 and 9 days, risk start to appear after a sustained period of sleep deprivation and anxiety.’ – Named Nurse for Safeguarding, South East England

‘The whole sector needs more money to employ staff so thresholds would not have to be so high and children could actually be supported to live safe successful lives. This applies across social care, early intervention, mental health services and therapeutic support. Poverty, austerity, trauma and now the impact of COVID is having lasting effects on our population which is resulting in adults who need safeguarding, who are perpetrators, who are repeating the cycle with their own children, and who will, in fact, end up costing a lot more.’ – Business Manager, Yorkshire & The Humber

4) THRESHOLDS AND REFERRALS

‘Stop the postcode lottery. Thresholds need to be the same. If a case meets threshold for S47 in one borough it shouldn't be closed by another for not meeting "high" thresholds.’ – Health, London

‘Clarity regarding thresholds.’ – Mental Health Safeguarding Lead for Children and Adults, London

‘Lower threshold for help. Change mindset of ‘let’s close this case.’ – Education, West Midlands

‘Keeping families on plans for longer to ensure they can maintain the outcomes set over a period of time - all too often the plan closes and within a couple of month you are referring them again.’ – Education, North West England

‘To not be so hard to reach threshold for children. To have family support to actually challenge parents to step up rather and focus on the children rather than be focused on the adult. To not be so vulnerable to parents anger in that we can't walk away or disengage.’ – Education, South West England

‘Concern that some families narrowly miss MASH threshold and offered Early Help choose not to engage/ accept.’ – Education, South East England

‘Have a conversation rather than a strict threshold to support practitioners who have concerns.’ – Designated Nurse for Safeguarding, South West England

‘Streamline the referral process for practitioners as it is more suited to social care and sometime does not take into account of working practice in the acute services.’ – Named Midwife Acute, London

'CAMHS to be more of MASH decision making process when dealing with a sexual abuse disclosure..' – Mental Health Safeguarding Lead for Children, London

'Better communication and collaboration between health and Mash, at the point of referral.' – Mental Health Safeguarding Lead for Children and Adults, London

5) EARLY INTERVENTION/HELP

'Increase evidenced based early interventions through schools and health services.' – Children's Social Care, London

'Early intervention.' – Designated Nurse for Safeguarding, South West England

'More early help/ intervention in the early years.' – Named Doctor for Safeguarding, East Midlands

'Identifying vulnerable families and providing support before they meet threshold for social care intervention.' – Named Doctor for Safeguarding, Yorkshire & The Humber

'Provide more support to families who may be struggling.' – Law, South East England

'Early intervention in life of troubled young persons. Programmes to turn things around/ break cycles of familial neglect and trauma / support for young/ first time parents.' – LA Solicitor, East of England

'Early support.' – Business Manager, South West England

6) SPECIFIC ISSUES

Mental Health

'More contact with mental health services.' – Children's Social Care, East of England

'Professionals with relevant experience of send and mental health.' – Education, London

'Mental health training for early help and social workers.' – Education, London

'Mental Health support for abused children.' – Designated Doctor for Safeguarding, South East England

'children get interventions to support their physical and mental health in all cases especially UASC, 16+, Residential homes.' – Designated Nurse, East Midlands

'A shared understanding of blockers in finding appropriate placements for young people in Tier 4 settings, whose mental health presentation has been resolved. But awaiting

appropriate social care placement.' – Mental Health Safeguarding Lead for Children, London

Domestic Violence/Abuse

'Create a national framework to support innovation in Domestic abuse practice. If we could crack DA we would have a lot less statutory work and if we could intervene earlier less children would experience the harm that DA can inflict - it is requires an innovative and public health approach.' – Children's Social Care, East Midlands

'Address the issue of domestic abuse once and for all.' – Children's Social Care, North East England

7) OTHER

'Return to regular whole staff training.' – Education, East Midlands

'More family conferencing and more frank and mature conversations with families.' – Designated Nurse for Safeguarding, Designated Nurse for LAC, Deputy Chief Nurse, East Midlands

'Less red tape.' – Law, South East England

'In the geographical area where I practice, I would say look at a problem, look at the positive aspects and try to find a way to make it work by being innovative, rather than the easy option of at the moment blaming Covid.' – Law, North East England

'Regrettably, the Court service has ground to such a halt that children are waiting for longer in the system before they reach their forever homes or have decisions made for their long term future. Further means of conducting hearings is required to enable cases to be progressed.' – LA Solicitor, East of England

'Joint Child Exploitation response team (out of hours).' – Police, West Midlands

'Child Neglect - to improve the knowledge, experience and skill set of professionals in identifying ongoing neglect and implementing measures to deal with this in a more positive and proactive way, placing more responsibility on parents/carers to improve conditions or face sanctions. Not allowing cases of this nature to drift.' – Police, Yorkshire & The Humber

'Make the curriculum inspections more about child wellbeing and less about educational achievement.' – Police, North West England

Appendix 3: Survey respondents' recommendations for professional practice

If you had one recommendation for your profession in order to safeguard children in the future, what would it be? (132)

CHILDREN'S SOCIAL CARE

'Acknowledge the sacrifice social workers have made.' – Yorkshire & The Humber

'Government guidance made clearer about Social Workers being frontline and the need to be clear that SW intervention outweighs infection risk.' – London

'Build relationships to understand the underlying challenges for children and families rather than process and compliance based approaches.' – North East England

'Take time to build relationships with both children and their carers and be creative in doing so - virtually or in person. This is the key to making a difference in a child's life.' – London

'Develop nationally agreed interventions and approaches that all SWs are trained in to an advanced level so there is consistency within the profession and equality of service offer for families.' – London

'Always be curious alert and take responsibility.' – East Midlands

EDUCATION

'Carry on sticking your neck out. Get used to the extra workload and lack of other agency understanding and impact. Do not expect anything useful from CAMHS. Do it yourself.' – North West England

'To have more resources. We can't leave children in any situation which is damaging so we have to get involved. This means we are doing things we aren't trained or paid for. I wish we had access to a resource which meant this didn't happen. That other services focused on the children's every day experience and impact on lives rather than adults and the fact there is no alternative rather than it isn't good enough. If we have to do this- it has to be resourced. We need mental health support on site and to be better. Children should not have to wait years.' – South West England

'Be prepared to professionally challenge other services and refuse to be excluded from meetings. make sure all paperwork is provided for you. Make sure there is supervision available for all.' – North East England

'Not to lose focus on vulnerable families who are not identified by DfE.' – North East England

'Significant time allocation dedicated to DSL role. Sharing of workload amongst more than one staff member.' – South East England

'Do something yourself.' – West Midlands

'Look, listen and act.' – East Midlands

'Mandatory attendance at updates/courses that reflect the current real time needs of the local area.' – North West England

‘Extend encompass incidents to any police incident involving children not just DA.’ – North West England

‘Adequate resourcing both human, economic, where the burden of care shifts.’ – London

‘A higher level of safeguarding training for all staff.’ – East Midlands

‘Have clear plans and procedures in place and that everyone knows their role in safeguarding each child through clear, and regular, communication so that no child can be overlooked/ missed.’ – East Midlands

‘Be flexible and listen to what your community needs.’ – London

‘Always try to seek and be open to engagement.’ – South East England

HEALTH

‘Mental health of children to be a priority.’ – Designated Doctor for Safeguarding, South East England

‘Realise the impact of mental health through the lens/lived experience of children.’ – Designated Nurse for Safeguarding, North West England

‘Always take into account the history of the family, and parenting history in light of any adversity, when assessing risk to an individual child within a family. Do not assess children in a sibling group as a whole. Each has their own needs and own relationship with each caregiver/parent.’ – Designated Nurse for Safeguarding, South East England

‘Use your supervision time to discuss and have a restorative approach.’ – Designated Nurse for Safeguarding, South West England

‘Better staffing levels so that caseloads can be managed safely.’ – Named Nurse

‘Not to stop seeing them. we kept seeing a significant number of children in our clinics but many places stopped completely.’ – Named Doctor, Yorkshire & The Humber

‘Remember Health is our business, you have PPE go out to see these families at home.’ – Named Nurse for Safeguarding, London

‘Partnership to listen to staff on the ground to find out needs, bottom up approach.’ – Named Nurse for Safeguarding, South East England

‘Revert the health visiting role back to what it used to be with adequate funding, manageable caseloads and respect for what they do. We need this more than ever now with so many children & young people having MH and self; not just for safeguarding but proactive preventative work.’ – Designated Nurse, Yorkshire & The Humber

‘Adequate joined up less fragmented health services for children and families and resources to provide safe and effective services to children and families.’ – Named Nurse for Safeguarding, South East England

‘Maintain/enhance services for vulnerable women.’ – Named Midwife for Safeguarding, London

‘To reflect on their internal thresholds for "good enough" to see neglect, to hear, listen to and act on the voice of the child. To work collaboratively with partners in localities to find

local solutions in families and communities to safeguard the most vulnerable.' – Designated Nurse, East Midlands

'A return to a more holistic universal health service for children, particularly pre-school children, which effectively supports parents, as opposed to the much reduced mandatory contacts which do not facilitate ongoing assessment and support.' – Designated Nurse, Yorkshire & The Humber

'Appropriately allocated time to promote safeguarding - not reactive safeguarding.' – Named Midwife for Safeguarding Children, West Midlands

'Encourage practitioners to learn more about their own resilience.' – Named Midwife for Safeguarding Children, North West England

'See children more frequently, listen to them and make every contact count.' – Named Nurse for Safeguarding, South East England

'Be open minded and think of other option.' – Named Nurse for Safeguarding, Yorkshire & The Humber

'Be proactive and constructive and do not assume that your voice will not be heard. Continue to be an advocate for best practice and a place on the executive, and find colleagues that you can work with in order to get important issues shared and discussed appropriately. Always listen, and build relationships, even if what you say might at times be construed to be a challenge; that is part of the job. Remember to keep the child as the central focus, and that we may only see part of the picture. Build on the strength of local relationships; these are what make the difference between advice given centrally, and advice given by a Designated practitioner who understands the depth and breadth of issues in the borough and between agencies. The main recommendation would therefore be; For the CCG to maintain local Designate expertise working across local health providers and local interagency relationships rather than change this into an overarching role covering a large geographical area, as this loses the local knowledge and communication, and is less effective in coming to appropriate solutions.' – Designated Doctor, London

'Continue to attend multi-agency meetings.' – Designated Doctor, South East England

'We need to be more inquisitive, ask more questions not just accept what families are telling us.' – Named Midwife for Safeguarding Children, South East England

'Use a Strengths based approach to child protection and safeguarding. Always be curious.' – NHS England, London

'Don't reduce services for under one's, stop medicalising babies when parents often just need reassurance that its ok if they are finding it hard.' – Named Nurse for Safeguarding, South East England

'Children social worker should consider being acute based.' – Named Midwife Acute, London

'Keep Going, children rely on us! And any 'gut feelings' of safeguarding ...discuss with your safeguarding leads.' – Named Nurse for Safeguarding, South West England

'Maintain a healthy cynicism.' – Designated Doctor for Safeguarding, North East England

‘As above, more investment in resources, leadership, training, and support.’ – Safeguarding Lead, London

‘Having capacity to safeguard the children. Psychological support for staff health and wellbeing.’ – Named Nurse for Safeguarding, North East England

‘Investment in prevention and early help services that are evidenced to make a difference. Investment in 0-19 public health nurses.’ – Designated Nurse, Yorkshire & The Humber

LAW

‘A better understanding or 'risk management' to try to achieve a situation where children are not being hastily removed from parents before proper intervention is tried. Less risk adverse practice.’ – Children’s Panel Solicitor, London

‘Invest in staff. Look after those staff and ensure mental health/ training and support forums available.’ – LA Solicitor, East of England

‘Better understanding and intention to support parents in proceedings - they are the reason we are there and we should be listening to them about to improve the experience for them. Listen and advocate for them in their interests - better training for parents reps re mental health and capacity. Better training for child solicitors - how to talk to YPs.’ – LA Solicitor, East of England

‘Focus on the child/ren who are the subject of the proceedings and their need for welfare decisions to be made and not pander to the excuses of parents as to why they cannot attend /participate in urgent hearings.’ – LA Solicitor, East of England

‘To focus on the child and achieving an early outcome for them at the soonest opportunity. as Lawyers, regrettably, there has been a tendency to create a wealth of authorities for preserving the rights of the parents and to ensure their right to a fair Trial (which is not wrong) but is increasingly at the expense of children waiting in the system. There is a tendency amongst the judiciary to worry so much about a pending appeal, that children are being allowed to wait 52 plus weeks, when professionals have already identified that there is no prospect of a parent being able to resume care of the child. Whilst it is appreciated that everyone has a right to a fair trial, this is increasingly being bandied about as a way of buying a client some more time. Judges are reticent to be robust and likewise to think creatively to ensure that these children are prioritised, rather than the adults who have often already failed these children dismally. This has been an ongoing issue for years and it is only worsening. I fully appreciate due process but when you have parents who have long-term and chronic drug misuse and are still using and yet their right to a Trial (at all costs) is being advanced at the expense of a child, whose window of opportunity for adoption may well be lost; it is not entirely "right." ‘ – LA Solicitor, East of England

‘To look at the "cumulative" picture in respect of a child's experiences when considering whether threshold for proceedings and/or removal is met.’ – LA Solicitor, London

‘Ensure high standards are maintained despite the practical difficulties in a system under immense pressure.’ – Children’s Panel Solicitor, Yorkshire & The Humber

MENTAL HEALTH

'Adequate funding of support for young people in distress.' – Mental Health Safeguarding Lead for Children, London

'Smaller focussed case loads on high risk children.' – Mental Health Safeguarding Lead for Children and Adults, West Midlands

'Show curiosity in all situations and never take information and situations at face value.' – Mental Health Safeguarding Lead for Children, East of England

'Better communication and relationship between CAMHS and CSC.' – Mental Health Safeguarding Lead for Children, London

POLICE

'We need to work harder to prevent officers normalising what they see in order that they deal with each child protection incidents as if it is their first.' – West Midlands

'Train all workforce in trauma informed practice.' – North West England

'More staff.' – East Midlands

'Ensure effective professional curiosity.' – Yorkshire & The Humber

INTER-AGENCY/GENERAL

Inter-agency collaboration

'True multi-agency working not just in the sense of attending meetings through the partnership. But a shared understanding of roles including frustrations.' – Mental Health Safeguarding Lead for Children, London

'Improved multi agency working.' – Education, East Midlands

'Stronger multi agency working relationships that share a vision and work with families towards solutions.' – Designated Nurse for Safeguarding, Designated Nurse for LAC, Deputy Chief Nurse, Yorkshire & The Humber

'A shared vision across all professionals who work for children.' – Education London

'Ensure agencies are talking to each other about any potential concerns and not leaving it too late.' – Designated Nurse for Safeguarding, Yorkshire & The Humber

'Co-located with other partner agencies to understand each others roles and make decisions more effectively.' – Named Nurse for LAC, London

'Stop and think meeting joint reflection on progress.' – Designated Nurse for Safeguarding, South West England

'Better mapping and triangulation of services for vulnerable families.' – Named Nurse for Safeguarding, London

'Think safeguarding and contribute small pieces to wider jigsaw puzzle.' – Designated Doctor for LAC, London

‘Flexibility in delivery of services. More multi agency decision making rather than organisations working in silos.’ – Named Nurse for Safeguarding, South East England

‘Embrace more integrated working across social care and health.’ – Named Nurse for Safeguarding, South West England

‘Collaborative working and communication.’ – Designated Nurse for Safeguarding, North West England

‘Multi agency working, communication and always trying to improve their service.’ – Designated Nurse for Safeguarding, London

‘More integrated working for children on the edge of care so adequate wrap around support that is outcome focused can be provided for families.’ – Designated Nurse for Safeguarding, North West England

Communication & information-sharing

‘Re-introduce contact point, a national data sharing system that was ready to go before and then turned.’ – Children’s Social Care, North West England

‘Review of documentation and referral processes - one IT system that is accessible to all those working within safeguarding arena.’ – Named Nurse for Safeguarding, East Midlands

‘Consider Systems that can be used, aligned across Health and Social care, primary care to maintain oversight of vulnerable families.’ – Designated Nurse for Safeguarding, East of England

‘Always consider why you would not share information/ concerns rather than consider why you should.’ – Named GP for Safeguarding Children, North West England

‘Ensure all professionals share information.’ – Children’s Social Care, East of England

‘Cross agency information sharing and decision making to support children in Early Help space- especially in contextual safeguarding.’ – Police, South East England

‘Information sharing is key (effective).’ – Named Nurse for Safeguarding, North West England

‘Improved communication between professionals is essential - nothing will improve without it’ – Education, London

‘Ensure links and lines of communication across agencies and families stay open.’ – Education, South East England

‘Talk to each other in your teams and the wider teams around the child.’ – Designated Nurse for Safeguarding, South West England

‘Communication, communication, communication.’ – Designated Doctor for Safeguarding, London

‘Keep talking to each other and sharing involvement so a holistic understanding is created.’ – Designated Nurse for Safeguarding, North West England

‘Better communication’ – Law, South East England

Voice of the child/child-centred

‘Don’t forget to keep the child at the centre.’ – Health, London

‘Listen to the voice of the child.’ – Education, East Midlands

‘Maintain the focus on the child and their experiences.’ – Children’s Social Care, North East England

‘Communicate with the children as much as the parents.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘Always put the child/young person at the centre of all you do.’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘Keep eyes and ears open and take every opportunity to stand in a child's shoes.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Keep trying to find innovative ways to hear various children’s voices.’ – Designated Nurse for Safeguarding, London

‘Listen to more CYP.’ – Designated Nurse, South East England

‘Keep schools open.’ – Designated Doctor for Child Death, Yorkshire & The Humber

‘All vulnerable children must attend school in lockdown so they are seen by professionals.’ – Children’s Panel Lawyer, London

In-person/remote contact

‘Universal services to continue face to face meetings with children and parents as much as possible.’ – Designated Doctor for Safeguarding, South East England

‘Face to face contact is important and needs to be sustain for the most vulnerable children.’ – Children’s Social Care, London

‘Face to Face must be the default for contact with CYP.’ – Designated Doctor for Safeguarding, East Midlands

‘Children must be seen at all costs.’ – Children’s Panel Solicitor, London

‘Maintain the flexibility that virtual working has brought us to enhance our meetings and create a mixed approach to visits and multi-agency working.’ – Children’s Social Care, East Midlands

‘More face to face to continue if any further pandemic.’ – Designated Doctor for Safeguarding, London

‘Ensure that you have the ability to work remotely with families even if you aren't in a pandemic. A lot of the remote working has been good for professionals and families and is worth holding on to.’ – Children’s Social Care, London

‘Learn from this experience, particularly listening to children's experiences.’ – Designated Nurse for LAC, North West England

Early intervention

‘Early Intervention based on evidence bring back Sure Start.’ – Designated Nurse for Safeguarding, Designated Nurse for LAC, East Midlands

‘Provide support early.’ – Named Doctor for Safeguarding, East Midlands

Other

‘Be proactive and exercise professional curiosity.’ – Children’s Social Care, London

‘Commitment to invest and expand MASH and Child Exploitation coordination and investigative capacity in conjunction with safeguarding partners.’ – Police, West Midlands

‘Train all workforce in trauma informed practice.’ – Police, North West England

‘More staff.’ – Police, East Midlands

‘Child Neglect - to improve the knowledge, experience and skill set of professionals in identifying ongoing neglect and implementing measures to deal with this in a more positive and proactive way, placing more responsibility on parents/carers to improve conditions or face sanctions. Not allowing cases of this nature to drift.’ – Police, Yorkshire & The Humber

‘Quicker processes.’ – Education, South East England

‘Remember the impact of the pandemic and make allowances in the future.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

When child in need plan or child protection plan has a target - ensure that it met.’ – Law, West Midlands

‘As a family lawyer who frequently represents children as well as other members of the family, I would say continue to "Fight the good fight" to try to secure the best outcomes for the children.’ – Law, North East England

‘There is no magic bullet. Child Protection requires good communication between agencies; observation, assessment and reflection and if necessary decisive action.’ – LA Solicitor, Yorkshire & The Humber

‘Keep advocating at local and national level.’ – Designated Doctor for Safeguarding, London

‘Meet the needs of parents while remaining vigilant.’ – Children’s Social Care, South East England

‘Improve the retention of child protection professionals.’ – Children’s Social Care, North East England

‘Vote for a different government.’ – Children’s Social Care, North East England

Appendix 4: Support for children's mental health in schools

Many areas have put in place additional arrangements in schools to support children's mental health. Please provide any views you have on what has worked well and any other comments here. (61 –don't knows removed)

CHILDREN'S SOCIAL CARE

'Improved communication has been put in place with regular bulletins shared with all schools - this has meant good pathways into schools with information about resources - training has continued virtually and this has meant good access to these events.' – East Midlands

'Mental Health Teams in Schools (MHTS)' – South East England

'Mental health week recently was very positive. the pandemic has enabled opportunity to talk.' – South East England

'Some online opportunities could have been effective but it is difficult to quantify or judge at this current time.' – East Midlands

'MH services liaising directly with schools.' – London

'Don't know as not heard what schools have put in place.' – East of England

'Remote access, in and outside of school hours has enabled children to use a range of platforms for engagement with mental health practitioners, good publicity (door to door leaflet drops, bus stop campaigns) professional signposting all supported use and engagement.' – London

'Able to have access to the child via remote means i.e. they do not have to go into school to be spoken to. Increase in communication with early intervention services to co-ordinate care and response to children with mental health difficulties.' – London

'Social and Emotional Mental Health pathway very effective.' – London

EDUCATION

'They are all quite ineffective for the children (parents' minds seem to be put at ease more often knowing their child(ren) have consulted with a professional), because engagement with social workers is not the same and not nearly as effective as real social integration, with kids their age, at school.' – East of England

'Absolute lack of anything for pupils with PMLD. All mainstream focus.' – London

'Access is patchy.' – London

'Area has put nothing in place – individual schools are doing their own thing.' – North West England

'Daily class virtual gatherings (registration and setting up the day).' –East of England

‘Headstart sessions- use of Google classroom to allow children to talk to each other.’ – South West England

‘Regular check ins, mentoring sessions, face to face walks outside, creative activities such as signing or art based activities - face to face or remote.’ – East Midlands

‘Re-focusing on curriculum, including time for 'recovery curriculum' activities/accessibility of staff to respond to voices of young people/families. More holistic approach to building trust/relationship with young people/families.’ – London

‘We have an Emotional Literacy practitioner in school who, alongside our whole staff, support our children’s mental health.’ – London

‘We have 2 learning mentors in school and a vast pastoral team to support YP and families.’ – East Midlands

‘Identification of children struggling with their mental health before lockdown has enabled calls to be made several times a week by the well being mentor and resources gained from the school nurse quickly.’ – East Midlands

‘Daily student support emails with reminders and advice as where to access support - including apps, school nurse, chathealth provision, use of the website, Twitter and sharing information with parents too. This has been much increased and should continue going forward.’ – East Midlands

‘A care team of known staff members to provide immediate support for children worked better than referring and waiting for counselling professionals. Where the need was identified as being in need of a clinician with specific knowledge and skills, the care team was an initial response only.’ – North East England

‘Deployment of ELSA Further training of all staff ahead of full opening to be aware, approachable, curious and to adopt appropriate strategies when dealing with a child.’ – South East England

‘Signposting to self help online services’ – North East England

‘Recovery curriculum focus on PSHE and wellbeing. Additional timetabled time.’ – South East England

‘There has been a huge amount of information and resources passed onto schools and it has been very challenging to filter the information. It seems like many agencies, in trying to be supportive, have actually caused additional work and the resources are of very varying quality. Professionals working with children want to be open to any support/advice to improve the service however the information has flooded in without any quality control.’ – London

‘Employ a Mindfulness Teacher. Mindfulness Community on DB Primary. Fitness daily sessions with PE team. Tables on the playground for colouring and reading which is away from the other games.’ – London

HEALTH

‘Zoom meetings for young carers help lines advertised through twitter and other forums.’ – Named Nurse for Safeguarding, London

‘Don’t forget the 16+ age group, who were in year 11 at the beginning of this pandemic. Endings are important, and they did not get to 'finish' school in the usual way- this impacts on known vulnerable for ill mental health AND wider population’ – Designated Nurse for Safeguarding, South East England

‘Not aware of such.’ – Named Nurse for Safeguarding, West Midlands

‘Not known.’ – Specialist Nurse Safeguarding

‘Extending access to resources to support mental health, mental health workers in schools or linked to schools.’ – Designated Nurse, East Midlands

‘Very variable. Some schools very clear they need to interact and support children.’ -– Named Doctor, Yorkshire & The Humber

‘Our area have self referral routes, NHS 111 access to CAMHs teams, all has worked well.’ – Named Nurse for Safeguarding, London

‘Some schools have worked well with health agencies to assess needs of vulnerable children at home especially those with additional needs.’ – Named Nurse for Safeguarding, South East England

‘MHST. Voluntary and 3rd sector. Take 5 resilience training for children primary educational settings.’ – Designated Nurse, Yorkshire & The Humber

‘I am not aware of any measures put in place.’ – Designated Doctor for Safeguarding, East Midlands

‘Unable to comment – too early to tell.’ – Named Nurse for Safeguarding, South East England

‘The use of a 'worry button' on google classrooms that goes directly to a member of the teaching staff.’ – Named Midwife for Safeguarding, London

‘Mental health champions supported by CCG Mental health Team.’ – Designated Nurse for Safeguarding, East of England

‘National mental health campaigns, limited local schemes.’ – Safeguarding lead, London

‘Yes schools have identified young people with known MH issues to make sure they are contacted regularly.’ – Designated Nurse for Safeguarding, North West England

‘Access to on line counselling; resources made available to staff and children to use.’ – Designated Doctor for LAC

‘Use of "Place 2 Be", promoting well being in assemblies and general primary teaching, better access to pastoral support.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Hubs were created in our borough and it's the most easily accessible that I've experienced CAMHS services to ever have been in the past 20 years.’ – Designated Doctor for LAC, London

‘As a Trust we have mental health liaison nurses who have supported young people both in and out of hospital and staff.’ – Named Nurse for Safeguarding, South East England

‘In reach offer form community mental health team either though school nurse or directly is in place and regularly reviewed.’ – Designated Nurse, South East England

‘Outreach and wrap around services.’ – Designated Nurse for Safeguarding, London

‘MHSTs, online support.’ – Designated Nurse for LAC, Yorkshire & The Humber

‘Phone line 24/7 school nursing wellbeing sessions.’ – Designated Nurse for Safeguarding, South East England

‘Mental health services have offered direct referral by education to their CAMHS.’ – Designated Nurse for Safeguarding, North West England

‘Some Education staff have been trained to recognise mental health issues in children and were appropriate provide early help/intervention.’ – Designated Nurse, North West England

MENTAL HEALTH

‘This needs to be done in conjunction with local CAMHS and schools to avoid repetition and counterproductive working. Schools also need to get better at understanding thresholds of harm and sharing identified concerns earlier rather than cataloguing them before making a referral later down the line.’ – Mental Health Safeguarding Lead for Children, East of England

‘Closer working relationship with CAMHS.’ – Mental Health Safeguarding Lead for Children, London

SAFEGUARDING PARTNERSHIPS

‘Services offered virtually to children, which has been working well.’ – London

‘Online spaces, use of Winston’s Wish.’ – Business Manager, London

‘During the first lockdown it appeared that mental health improved and this was attributed to reduction of peer stress at schools. However it has surged during subsequent lockdowns and hospitals are feeling overwhelmed.’ – Business Manager, South East England

‘Well being resources shared; well being websites; opportunities for 1-1 catch up with tutor/pastoral leads; face to face meetings where identified.’ – Business Manager, South West England

Appendix 5: Support for disclosure in schools

Many areas have put in place additional arrangements in schools to support children to disclose maltreatment. Please provide any views you have on what has worked well in supporting disclosure and any other comments here. (54 –don't knows removed)

CHILDREN'S SOCIAL CARE

'DSL training has moved online and our school effectiveness team have built strong relationships with schools - they have targeted those children missing from education or those out of touch with schools and communicated well with CSC.' – CSC, East Midlands

'Our arrangements for linking services with schools helped schools to have confidence in making referrals and good liaison with families.' – South East England

'Promoting online access (childline)' – South East England

'Weekly virtual meetings with DSLs and CSC Simple info sharing systems' – London

'Not enough has been done to enable children safely talk about what life is like at home during the pandemic.' – CSC, London

'Online support to school's from social care.' – London

'Training for school staff, focus on well being when they return, comms campaign for the community when schools are closed to pupils.' – London

EDUCATION

'The intention for help is there but it's been difficult to stay within the rules and guidelines given by the government.' – South East England

'We have put measures in place as a school for Deaf children, I am not aware of measures put in place by CSC - it was difficult to SW support as SW could not sign and did not understand the importance of this. They took information at face value.' – London

'Good pastoral team support in school.' – South East England

'Nothing put in place as an area, as a school we have constantly posted the available reporting routes for children - this is mostly visible to those with online access and those whose parents collect work. The true vulnerable have no reminders to what is available - there should be a big upturn on tv advertising to alert children to what to do.' – North West England

'Dedicated email address for DSLs.' – East of England

'Trained Headstart practitioners running online sessions and virtual meetings. Live lessons and communication with families- getting children into school where we have any concern.' – South West England

'Regular contact with a variety of different school staff. Live lessons and mentoring sessions online.' – East Midlands

'Increased frequency of contact with young people/families/ empowerment of staff.' – London

'Free school meal vouchers and regular COVID communication with families and seeing the children online learning.' – East Midlands

'Google Classroom platform has allowed children to communicate online. It has also allowed teachers to post mental health and safeguarding information at the top of their classrooms, so therefore seen everyday.' – East Midlands

'A student support email has been put in place, but this has not been used. students hanging back at the end of a lesson have spoken to a chose teacher, this appears to have been the most successful unformalized method..' – East Midlands

'Deployment of ELSA Further training of all staff ahead of full opening to be aware, approachable, curious and to adopt appropriate strategies when dealing with a disclosure.' – South East England

'Links supplied for online / remote reporting was made available through welfare links.' – North East England

'Change in TA role to provide additional time to support individuals and groups well-being needs and provide 'time to talk' – South East England

'Teachers speaking with the pupils daily. Having online referral forms for staff and pupils. Having a section on our DB Primary page for support e.g. Childline' – London

HEALTH

'Chat lines; Kooth; every mind matters info.' – Named Nurse for Safeguarding, London

'Giving permission, that its okay to feel ...., worried, scared...but if they are and they want to talk about it they should go to... and LISTEN, BELIEVE.' – Designated Nurse for Safeguarding, South East England

'Communications about social care being open for referrals, planned links in online learning that children can access support.' – Designated Nurse, East Midlands

'High school pastoral team in touch with students. this is v variable from school to school.' – Named Doctor, Yorkshire & The Humber

'Smaller class sizes when at school has increased the ability of CYP to feel safe and supported and to build relationships with staff.' – Designated Doctor for Safeguarding, East Midlands

'Unable to comment – too early to tell.' – Named Nurse for Safeguarding, South East England

‘The use of a 'worry button' on google classrooms that goes directly to a member of the teaching staff’ – Named Midwife for Safeguarding, London

‘NSPCC See it Report it’ – Designated Doctor, South East England

‘National helplines, limited local schemes.’ – Safeguarding lead, London

‘Teachers have been amazingly proactive in contacting students/ children regularly - phoning / on line contact, chasing up on concerns and even visiting children at home. they have gone way beyond their remit, in schools which have reduced pastoral care due to cuts.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘Not sure this has been done in our area.’ – Designated Nurse for Safeguarding, North West England

‘Tutor group meeting daily, access to pastoral staff.’ – Designated Nurse for Safeguarding

‘From a personal perspective, my son is in year 7 and home schooling at the moment. His school do a welfare phone call to me or my husband every Thursday and always ask to speak to my son directly. They are doing this for every single pupil in school. Children at home can contact their form teacher directly through email but not sure re arrangements for those actually attending school during this 3rd lockdown.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Social care has developed a team who are working in the most deprived schools in the borough.’ – Designated Doctor for LAC, London

‘As a hospital trust we liaise with schools and colleges and have continued information sharing when identify risk or are worried about risk.’ – Named Nurse for Safeguarding, South East England

‘Regular safeguarding case review forums in place for education to work with locality based mental health, social care and community.’ – Designated Nurse for Safeguarding, Designated Nurse for LAC, South East England

‘Children being in classes with teachers they know and trust School teachers making regular contact with vulnerable families and offering a listening ear to parents I do worry labelling families as "vulnerable" can put off parents from sending their child(ren) to school.’ – Safeguarding Specialist Nurse, South East England

‘Investment by headteachers and teachers in maintaining contact with children and young people’ – Designated Doctor for Safeguarding, North East England

’24 hour child CRISIS Line.’ – Designated Nurse for Safeguarding, London

‘Having access to schools over a weekend period.’ – Designated Nurse, North West England

MENTAL HEALTH

‘This needs to be undertaken across the full age range and include pre-school but with the consideration that children especially the younger ones may not disclose abuse if to them it is seen as normal behaviour and that there needs to be more education around children

understanding what is adverse behaviour to be able to understand what is not acceptable to make a disclosure.' – Mental Health Safeguarding Lead for Children, East of England

'As children not visible in school unknown if any physical injuries picked up. Some schools insist cameras are off so can't see child online.' – Mental Health Safeguarding Lead for Children, London

SAFEGUARDING PARTNERSHIPS

'Publicising concept of reachable moments.' – Business Manager, London

'All schools asked to complete a Covid-19 Safeguarding Impact Review - what else could they do to improve visibility of children; contact by DSLs; doorstep visits for children not engaging/seen.' – Business Manager, South West England

Appendix 6: Safeguarding Partnerships

If you would like to provide any additional comments to your responses above about Safeguarding Partnerships, please do so here. (82 responses)

CHILDREN'S SOCIAL CARE

'We have embedded regular meetings across all tiers of working within the safeguarding partnership from the start of the lockdown which are additional meetings outside business as usual. The use of virtual meetings has made this sort of engagement across agencies easier reducing time taken to get together. Good communication has meant that front line practitioners have been aware of any changes to processes caused by redeployment or increased demand using these meetings.' – East Midlands

'The Partnership was strong before but the legislation and pandemic have also helped.' – South East England

'The shift from a Board to a Partnership was perhaps poorly understood and perhaps the scrutineer role has/had become blurred with exceptions of 'this is still a Board' – Yorkshire & The Humber

'Weekly 'covid' response meetings proved valuable for cohesion, support and synergy.' – South East England

'Whilst we have easier accessibility to partner agency professionals through virtual means actual partnership engagement with a focus on the needs of children has been impaired during the COVID period, professional/service need has in my view at times impaired a child centred approach to meeting the needs of families during these challenging times.' – East Midlands

'The smaller Safeguarding Partnership has improved the work and collaboration with Statutory partners, with the Pandemic have lost some traction with the VCS' – North West England

'I would argue that the LA still have to lead the partnership Heath and police poor at consultation re changes that impact on practice' – North West England

'Virtual meetings have enabled more professionals to attend because of reduction in travelling to a venue. I think that virtual meetings should continue in the future - more accessible for professionals with time constraints.' – South East England

'The challenge for safeguarding partnerships is achieving equity in responsibility as the local authority generally has the lead duty. The pandemic has widened some of the accountability gap with autonomous leadership directives on practice expectations for schools, police and health staff. Children's Social Care staff have been left carrying multi-agency responsibility for all partners at times during this pandemic.' – London

‘I'm an independent Conference Chair, so not directly involved in what the partnership does’ – North East England

‘Whilst have the three strategic safeguarding partners in place has ensured that there is focused leadership and decision making, so more timely and purposeful. We have lost the strength of the wider partners who saw themselves as 'statutory member / partner'. CAFCAS and Probation has both withdrawn funding so far as don't see it as a responsibility to contribute both finally and in group meetings.’ – London

‘Information sharing and partnership working at a local level has been improved by the response to the pandemic and in particular more flexible ways of working and technology. Challenges have mainly been created by decision that are outside of local control particular in the health sector created by the tension caused by NHS national command and control culture.’ – North East England

EDUCATION

‘Perhaps a little too early to evaluate the impact that the change has had.’ – London

In many instances schools are not listened to or updated effectively.’ – East Midlands

‘Massive lack of communication between social service and schools and pressure to close cases at beginning of pandemic.’ – East of England

‘The working relationships between Social Care, Police & schools has been very difficult with resources stretched to breaking point.’ – East of England

‘Multi-agency working was already strong in my area. For frontline practitioners the change in arrangements has, therefore, made little difference.’ – South East England

‘It is just not enough to meet the needs. There has been improvements but Encompass is still not working well in our area for highlighting domestic abuse and social workers are not doing physical home visits, so very limited.’ – London

HEALTH

‘I feel a lot of good work stopped a lot of time spent on reshaping.’ – Designated Nurse for Safeguarding, South West England

‘Remote meetings using MS Teams has facilitated people getting together and discussing more.’ – Named GP for Safeguarding, London

‘In my area we worked very closely across all agencies when we were safeguarding boards so safeguarding partnerships didn't improve that as it was already in place. I do feel we have less communication at that level now regardless of covid.’ – Named nurse, North West England

‘We have a weekly meeting with heads of safeguarding across health, including acute health CCG and providers, social care, probation, voluntary organisations, police, the safeguarding partnership boards, this has raised issues quickly and the meeting feeds into the Children and Young Peoples Covid Group.’ – Designated Nurse, East Midlands

‘The partnership was working well pre pandemic. some changes have been positive and helpful in the pandemic eg children not being admitted for CP medicals if not medically unwell. the significant drop if referrals for CP medicals even though social care continued to get some referrals is v concerning. the health input into strategy discussions was not heard at times even if a CP medical was suggested. or if a referral to a SARC was suggested. the lack of professionals seeing children esp the young ones is a real concern with no support for high risk families.’ – Named Doctor, North East England

‘Health contributions, leadership seems dependant on individual leadership skills. I don’t feel that the partnership is reaching out to relevant health providers to support development but remains within the CCG. It does not feel that we are listened to and feels all about money not the needs of our population. A top down approach. Covid is not a reason for this as remote working is successful , however again these meetings need good leadership.’ – Named Nurse for Safeguarding, South East England

‘We were involved on changes but had no say as they were going ahead anyway despite Health's concerns eg reduction of MAT teams and introduction of Early Help’ – Named Doctor for Safeguarding, East Midlands

‘It’s still early days but anecdotal evidence suggests a more collaborative culture of trust, shared learning and working together is being developed.’ – Named Nurse for Safeguarding, South East England

‘Partnership made aware of changes rather than being consulted.’ – Designated nurse for LAC

‘Reduction in resources for safeguarding.’ – Named Nurse for LAC, London

‘My organisation has had limited contact with the SG partnership during the last 10 months. Health appears to be the poor relation in the tripartite partnership.’ – Named Nurse for Safeguarding, Named Nurse for LAC, South East England

‘The working relationships across the three statutory partners has been extremely strong and this has not changed during the pandemic. What has changed is the frequency with which we meet as strategic leaders which has enabled us to identify actual or potential problems and develop fast-time responses to these.’ – Designated Nurse, Yorkshire & the Humber

‘It’s a shame Education are not a partner, as they see Children for the largest period of time.’ – Named Nurse for Safeguarding, Yorkshire & The Humber

‘Education, Mental Health and the provider safeguarding lead attending the partnership executive added to the breadth of understanding by the executive and subgroups.’ – Designated Doctor for Safeguarding, London

‘I meet with Directors of Children’s services Op lead and Police Inspector in charge of safeguarding command on a weekly basis. My Deputy for LAC meets her counterparts.’ – Designated Nurse, East of England

‘Although collaboration has improved, there is still predominantly single agency decision making.’ – NHS England, London

‘Easier access due to virtual; meeting platform.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Our social care also failed across this period and we have had a stream of changes in leadership.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘As a provider of services in 3 different Local Authority areas there is wide variation.’ – Head of Safeguarding, Yorkshire & The Humber

‘Local Partnership arrangements have not vastly changed things compared with LSCB arrangements. We have our own unique problems in our area - inadequate Ofsted, constantly changing social care staff (and no stability at senior level from 2018 to early 2020). It feels like the work of the subgroups has slowed considerably during the pandemic, mainly because much of it is driven/propped up by health staff who have found themselves just too busy to focus on eg training/performance and audit in the early pandemic - now starting to get going again.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘The safeguarding executive as set out in WT 2018 is CCG, LA and Police, therefore other agencies are not part of the exec so I'm unclear why its suggested that providers need to be part of this as it is against statutory guidance. They do present to the exec group which I sit on, but they are not key partners as per guidance in either WT or the Social Work Act 2018.The second point in this section is also irrelevant as all those areas should and do have reps at the sub groups of the board so I'm unclear why this is a agree/disagree.’ – Designated Nurse for Safeguarding, West Midlands

‘As an acute hospital trust bordering a number of authorities their was either lots of involvement or none at all and as such we saw the sudden impact of the withdrawal of services on the ground which neither staff or families expected.’ – Named Nurse for Safeguarding, South East England

‘The relationships during the pandemic have lead to decrease in bureaucracy and an increased emphasis on making things happen.’ – Designated Nurse for Safeguarding, West Midlands

‘Operational links and shared action planning has improved with virtual platforms making everyone more accessible but decision making is still insular.’ – Designated Nurse for Safeguarding, Designated Nurse for LAC, South East England

‘Some decisions have been made without involving wider services and the impact this may have on their services. In lockdown 1 HV services in our area were reduced in relation to face to face visits and all potential visits were had to be risk assessed and then a team manager agree to the any visit. this has continued throughout the year and even in Lockdown 3 this has continued. At strategy meetings it is clear that the lack of visiting or even telemed appts has meant that there is no effective monitoring of children's weight or development and many one year assessments not done. In lockdown 1 there were no face to face visits by CAMHS and they wouldn't come to hospital thought after about 6 weeks this was resolved and since then most children have been seen appropriately.’ – Named nurse for Safeguarding, South West England

‘I’ve answered for one of my partnerships as I cover 3 - 2 of which have worked well through the transition, one of which has created a chasm between the statutory partners in the executive and the strategic leaders from the relevant agencies. There is a degree of secrecy and unaccountability in this partnership and over Covid there has been an absence of any meetings of the statutory partners with the relevant agencies. Sub groups work well and there is good engagement of all agencies in these subgroups but without clear oversight and accountability from the statutory partners it is difficult to move things on. Challenge has been made to the partners to review the lack of meetings but the response has been quite myopic.’ – Designated Doctor for Safeguarding, North East England

‘Working across a number of Safeguarding Partnerships, I noted marked differences in how proactively and effectively the Partnerships have dealt with and managed through the pandemic.’ – Head of Safeguarding, London

‘Our service covers a large geographical footprint which covers 7 Local Authorities with 7 Safeguarding partnerships. Some areas there has been an improvement in multi-agency working however some has stayed the same. We have tried to give an overall average.’ – Named nurse for Safeguarding, North East England

‘We seem to have developed a lot of meetings over the past few months between teams that would otherwise not have met face to face in the past - as online meetings are easier to attend - so I think networking and getting to know other partners has improved over the past few months,’ – Named GP for Safeguarding Children, London

‘In my area we had a very well working safeguarding board, therefore partnership has made very little difference.’ – Designated Doctor for Safeguarding, London

‘Governance for statutory responsibilities for looked after children and safeguarding looked after children is weak within LSCPs.’ – Designated nurse for LAC, South East England

‘Decisions were made regarding redeployment of staff from children to adult services without any consideration of the impact. If Safeguarding Partnerships had been consulted

some of the pitfalls might have been recognised and action taken to mitigate the risk.' – Designated nurse for Safeguarding

'Partnerships were and remain strong at operational and senior manager level but not a t executive level, they cannot hold all portfolios and do not give enough time to the safeguarding work required to truly make a difference and increase the effectiveness of partnership's.' – Designated Nurse for Safeguarding, South East England

'No significant changes noted with the LSCP introduction in my area. In fact it seemed to deteriorate with each partner working in silos. police leads changing frequently and no strategic long term planning. Funding of the LSCP was a real sticking point with the LA focused on wanting to contribute less, but maintaining overall control of decision making with health not included in discussions at strategic level.' – Named Nurse for Safeguarding, London

'Children's centres closed, leaving vulnerable families with limited aid. I am uncertain how this was allowed to happen. When they reopened, there was little communication to guide how they would operate. This is against a backdrop of falling competencies within Health visiting/ school nursing services as experienced staff left, morale was already low and quality control around preventative work delivered by primary care/mental health staff allowed to decline .' – Designated Doctor for Child Death, East Midlands

'Safeguarding partnership works well in my area and has improved the offer for children. I am still mystified why education was not included in it though, they seem essential.' – Named GP for Safeguarding Children, London

'My sense was we always had quite good working relationships, which were both challenging and supportive. This has both enhanced it, as it is easier to meet but virtual working isn't the same as meeting in person and longer term that may lead to challenge.' – Designated Nurse for Safeguarding, East of England

'The Local authority unilaterally paused clinical activity for Health visitors to visit new birth visit for first time parents citing first time parents are not anxious. A 4 month old baby died and investigation is ongoing. A number of babies also suffered Non accidental injury as reported by DfE data.' – Designated Nurse for LAC, London

'There was no discussion with the safeguarding partnership with regards to health offer during the covid lockdown period. There was a very gold command to the response with almost the cessation of all universal health services, HV, midwifery and School Nursing services were stopped. Staff and community Drs were redeployed, there was little regard for the wellbeing of children and families. High rates of DV and mental ill health, increased cases of CSA.' – Designated Nurse for Safeguarding, London

LAW

‘There is significant extra active work being pursued to strengthen as a response to covid but there were already strong relationships between the partners brought about by changes pre-covid.’ – LA Solicitor, East of England

‘Safeguarding Partners and multi agency stakeholders still "sit back" and wait for the Local Authority to lead, this is evident in the quality and nature of referrals against a backdrop of a failure to lead on a CAF.’ – LA Solicitor, North West England

‘I have observed that professional relationships have been well maintained and potentially strengthened during the pandemic.’ – LA Solicitor, London

MENTAL HEALTH

‘Technology for remote working supports multiagency communication and virtual meetings have much better attendance.’ – MH Safeguarding Lead for Children, North East England

‘With the removal of the old structure entire pathways and relationships disappeared.’ – MH Safeguarding Lead, West Midlands

‘I sit across 3 partnerships and they work very differently. The relationships in 1 area has gone from strength to strength whereas in the other areas it often feels it is getting harder to work with them effectively.’ – MH Safeguarding Lead for Children

‘In Lewisham there is a great recognition for the need for CAMHS professionals involvement in the Safeguarding Partnership.’ – MH Safeguarding Lead for Children

POLICE

‘LSCP is currently undergoing a review in Leeds and the new Board model implemented in the next couple of months, which should hopefully lead to further improvements.’ – Yorkshire & The Humber

‘Neither improved or damaged relations and collaboration.’ – South West England

‘The pandemic has been incredibly challenging for all partners, the front line police specialist teams continued working from the police stations during the pandemic where as colleagues from Children's Services, Probation etc worked from home. This clearly made it more difficult to work in partnership on a day-to-day basis when dealing with operational issues. Police technology in my force (lack of Teams or Zoom) also created issues for us in terms of engagement.’ – West Midlands

‘The main impact of the pandemic has resulted in a loss of face to face meetings, with the planned meetings continuing, but in a virtual world. Whilst this has a slight effect in the way communication takes place, in some cases, there has been added benefits in more people being able to attend the meetings as there is a reduction in meeting clashes when

attendance is from personal laptops, as opposed to many partners having to travel around districts or county wide locations.' – Yorkshire & The Humber

SAFEGUARDING PARTNERSHIPS

'Partners have looked to us to take on a leadership role and we have been monitoring the impact of Covid on services for vulnerable children weekly.' – Yorkshire & The Humber

'Weekly Covid partnership meetings were well attended.' – North West England

'In terms of a multi-agency response to those children deemed most vulnerable - very positive.' – East Midlands

'There has been positives - more regular calls, and better attendance. but its been information sharing rather than how do we collaborate.' – Business Manager, East of England

'The pandemic acted as a catalyst to enhance partnership collaboration at both strategic and an operational level.' – Business Manager, West Midlands

'We already have strong relationships in place and this has helped and continued through the pandemic.' – Business Manager, Yorkshire & The Humber

'Virtual meetings have allowed greater attendance from across the partnership.' – London

The quick uptake of online technologies has improved communication and the ability to meet more frequently and quickly. Conversely the impact of lockdown and the COVID response on services has obviously meant professionals are more stretched. Therefore there have been improvements and sometimes delays.' – Business Manager, Yorkshire & The Humber

'In [X], we have a single governance structure that brings together adult and children's safeguarding and community safety. The cross system discussion are enabling to work more together across a number of priorities.' – Business Manager, West Midlands

'Some areas have improved. There was more strategic meetings to plan the response to lockdown and surge for the first six months and increased communication. The redeployment of some health staff was discussed but the details were unclear so the extent of the redeployment only emerged later. other areas have improved not necessarily due to COVID but because they had to and the focus was maintained despite all the challenges with COVID.' – Business Manager, South East England

'Information sharing, police assisting re line of sight to vulnerable children.' – Independent scrutineer/chair, South East England

‘THE CHANGED LEGAL STATUS OF THE PARTNERSHIP HAS NOT AFFECTED INTER-AGENCY RELATIONSHIPS BUT THE COVID PANDEMIC HAS IMPACTED IN A WAY TO BRING PARTNERS CLOSER TOGETHER.’ – North West England

‘Some have improved but some have weakened as a result of focus on Covid especially health.’ – London

‘Some of my earlier responses are affected by other 'system pressures' such as the impact of LGR, recruitment challenges, transformation within services and across services (e.g. hospital mergers/changes and the CCG v provider relationships.’ – Business Manager, South West England

‘Strong partnership working has continued in response to the pandemic.’ – Business Manager, North East England

Appendix 7: RAG rating or risk assessment

If you would like to include any additional comments in relation to RAG rating or risk assessment, please do so here. (63 responses; 2 don't knows removed)

CHILDREN'S SOCIAL CARE

'We have regularly updated our CV-19 risk assessments for children which have informed both the type and frequency of our contacts with vulnerable children. We have carried out QA work including observed visits and feedback from families as part of our audit processes. In some cases we have increased our contact with young people for example our care leavers and all Section 47 activity has included face to face visits. we have quickly created workflow and reporting to highlight were there may be gaps in risk assessments being put in place of reviewed in line with changes in national guidance.' – East Midlands

'Sharing of intelligence and shared understanding of risk has improved as a result of the pandemic.' – South East England

'This has been very difficult to apply across large cohorts of children and addressed with a single agency perspective.' – East Midlands

'Limitations in provision of health input due to other covid response demands.' – North West England

'The RAG rating was undertaken by social workers and managers that knew children well. Schools contributed to this exercise in the first lock down, but not in subsequent lock downs. Health partners have been pulled into critical services leaving gaps in whole system risk assessment on a practice level. The challenge is what is not known or seen if children are not already known to the CSC system.' – London

'The RAG rating for risk assessment is a good tool to create an initial indication of risk but needs further professional discussion with the multi agency network to ensure accuracy and responses are appropriate to need and risk.' – London

'They are subjective to who is completing them.' – South East England

'Approach was single agency led through social care but with significant input and cross matching on a partnership basis. I think the approach has worked well and some elements are likely to be retained long term.' – North East England

EDUCATION

'The objectives of all the new Covid-safeguarding implications and rules have the wrong objective - that is to keep 'covid numbers down'. Covid is an airborne respiratory disease that is seasonal and very similar to the flu, which also kills more vulnerable (the old, those with underlying conditions etc...) than healthy. This means there will always be cases, it cannot be completely eradicated (I understand it technically could, but it's next to

impossible). The numbers of deaths also vary from the number of 'covid cases' - which is the driving factor and objective of all these regulations. By trying to keep children, and the whole country, 'safe', these risk assessments have thrown mental wellbeing out the window. Destroying social contacts and the motivation to be productive and even to just get out of bed in the morning. They spread irrational and unnecessary fear (of a virus that has a 99.99% survival rate in the under 40s) into the population and the younger generation that they claim to be saving, and the regulations restrict their livelihoods and freedoms.' – South East England

'We did individual risk assessments for all 70 of our pupils who have SLD or PMLD, as well as those for AGPs for suctioning.' – London

'Safeguarding successes depend on individuals' integrity rather than an organisation.' – West Midlands

'The lack of shared understanding and the lack of acknowledgment that in the significant majority of cases, schools will know families best - there is a reluctance to accept this and take advantage of the knowledge schools have. Also, other agencies are reluctant to take overall responsibility for specific cases and even when that has been agreed, communication is poor and actions are not carried out in a timely manner.' – London

'RAG rating is used to identify but nothing ever comes of it - no changes, no impact.' – North West England

'Schools were not consulted- we were instructed which children when we had a much more extensive list and more knowledge of families. The social services not going to homes has made the work in schools so much more. We still don't get consulted enough. Our viewpoint is not considered, family workers who were not going to homes have more impact than schools who work long term with children and families and see them daily.' – South West England

'Do not recall any information being shared about this.' – East Midlands

'As a tagging system has potential, but would need further evaluation.' – London

'This has appeared on the latest vulnerable list from the LA, with no prior indication to its use.' – East Midlands

'We were provided with a 'vulnerability criteria' by the local authority. We then complied a list using that criteria. We also added additional students and families to that list based on our own knowledge and concerns. We then did an individual risk assessment for each student which was reviewed at regular intervals during the lockdown period.' – East Midlands

'I devised my own system within school, I was unaware that this was a function of the safeguarding partnership.' – North East England

‘I was unaware of its existence.’ – East Midlands

‘Schools are best placed to identify all children who are vulnerable but we were not consulted in the RAG relating.’ – West Midlands

HEALTH

‘There was a lot of work in the first lockdown around vulnerable families/ children and lots of questions and info asked from community health but we never then really saw any final lists. So we had our own and made sure staff were communicating with CSC and education.’ – Named Nurse for Safeguarding, London

‘I don't think this was a collaborative approach and therefore one agencies decision contravene or exacerbated another agencies risk.’ – Named Nurse for Safeguarding, North West England

‘In primary care the RAG rating was just being aware of vulnerable children/families -not a systematic risk assessment.’ – Named GP for Safeguarding Children, South East England

“It did not consider the children we didn't know about only those where we already have involvement.’ – Designated Nurse for Safeguarding, South West England

‘The rag rating worked for children with known risk but my concerns were for the children who fell into Universal services who had less eyes on them due to schools and children's centres closing so early help could not be instigated.’ – Named Nurse, North West England

‘With agencies taking individual approaches to RAG rating partners accepted the validity of these ratings - an agreed RAG rating might have been a better approach .’ – Designated Nurse, East Midlands

‘It was done separately by each organisation and also by different teams. the priority for RAG rating was also about which children needed to continue with F2F appointments. this was v variable.’ – Named Doctor

‘As the pandemic has gone on we have adapted and strengthened the arrangements.’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘It is dynamic.’ – Designated Nurse for Safeguarding, AD Nursing, East of England

‘Agencies shared their top key risks, which helped to inform other agency risks.’ – NHS England, London

‘There is a lot of confusion about different risk assessments in different organisations including who leads.’ – Designated doctor for safeguarding, Yorkshire & The Humber

‘The RAG rating is backed up by weekly multiagency operation meeting.’ – Designated Nurse for LAC, South West England

‘I think the RAG rating system is a very good way of agreeing risk and prioritising although I think there needs to be a focus once done who is the lead agency pulling everything together.’ – Designated Nurse for Safeguarding

‘Different approaches adopted across 3 partnerships.’ – Head of Safeguarding, Yorkshire & The Humber

‘You fail to mention how the CCG raises safeguarding issues and uses internal risk matrices as there are a range of internal mechanisms for understanding safeguarding issues due to the pandemic e.g DVA, Training (currently monitoring suspended by NHSE for all providers).’ – Designated Nurse for Safeguarding, West Midlands

‘Person centered RAG assessments of vulnerable groups was fabulous, service level RAG rating was not.’ – Designated Nurse

‘RAG rating is probably not effective and easy to be subjective. From a hospital [perspective you could only RAG rate services not individual children.’ – Named Nurse for Safeguarding, South West England

‘There is a need for strategic leadership in relation to risk assessment and equality impact assessment.’– Safeguarding Lead, London

‘Lack of Face to Face visits a risk.’ – Designated Nurse for Safeguarding

‘Difficult to identify by each agency and no info sharing.’ – Designated Doctor for Safeguarding, London

‘Risk assessment on the whole took place after the first Lockdown commenced. Although there was co-operation between agencies more could have been done in the weeks leading up to lockdown.’ – Designated Nurse for Safeguarding, East of England

‘The RAG was done at service and client level but again not at exec level, so made a difference at ground level and required middle and senior managers to enact and report up.’ – Designated Nurse for Safeguarding, South West England

‘No inter sharing of risk assessments between health and social care.’ – Designated Nurse for LAC, South East England

‘Due to the high levels of serious youth violence in the area, contextual safeguarding took priority, often to the detriment of early help to tackle issues such as mental health, LAC and learning disabilities. Ironically all these are contribute to the risk of grooming with CSE and criminal exploitation, yet it was a reactive approach, rather than longer term planning.’ – Named Nurse for Safeguarding, London

‘The LA RAG risk assessment was done as a single agency and Health undertook their RAG assessment and cross referenced to ensure all children already known were seen. Education/schools did tremendous work to ensure school age Vulnerable child were seen or in school, with some schools being open over a weekend period.’ – Designated Nurse

‘Gave focus and prioritised risks. Regular monitoring allowed for review and mitigations to be put in place. Risks were shared and escalated to the Transformation Board and senior management team and NHSE/I.’ – Designated Nurse, London

‘All future RAG should be integrated across both health and CSC.’ – Designated Nurse for Safeguarding, London

‘Appears changes driven by finance - we need to focus on best for CYP.’ – Designated Doctor for Safeguarding, London

MENTAL HEALTH

‘Wasn't aware of it.’ – Clinician or Manager for LAC, South East England

‘The RAG is mental health focussed and not necessarily whole child/contextually focussed .’ – MH Safeguarding Lead for Children

POLICE

‘The risk assessment has been extended to other thematic areas including DA.MH. Offender Management drugs and alcohol and vulnerable adults so that interdependencies and a systematic approach can be considered.’ – West Midlands

SAFEGUARDING PARTNERSHIPS

‘This was led on by the LA with good engagement of partners.’ – East Midlands

‘As these ratings weren't shared - there was no discussion to understand those differences and that therefore created more risk.’ – Business Manager, East of England

‘We did both - a single shared risk register (across both child and adult safeguarding). Individual organisations also kept their own. A Specific COVID Section 11 was also collated. Any changes to services were communicated to the whole partnership on a weekly basis in the first lockdown. 'Impact of COVID' is standing agenda item on every strategic and sub group meeting to give people the opportunity to raise concerns. In addition every audit, SAR, CSPR or review now also asks the question about how COVID has impacted (along with IMD - poverty data and ethnicity).’ – Business Manager, Yorkshire & The Humber

‘The criteria for the RAG rating was discussed but not shared this lead to some discussion but general agreement.” – Business Manager, South East England

‘Done individually, not shared and no challenges accepted.’ – Business Manager, East of England

‘Organisations have their own Risk Register and the Partnership tries to capture those risks to safeguarding arrangements where we are working together that need addressing.’ – Business Manager, East Midlands

‘The Partnership held weekly COVID meetings which coordinated the risks for children.’ – L&D Manager, South East England

‘This was largely decided within individual agencies and then explained after the event to others. there may have been consultation between directors and executives but if so the detail was not shared. I do not think time allowed this.’ – London

‘Our Partnership has been slow to develop a fully populated risk register and this is not always regularly updated or referred to. It has not been shared beyond the statutory partners and does not really drive or impact on the work of the Partnership to any significant degree.’ – Business Manager, South West England

‘There was an agreement in relation to the risk areas that required close monitoring by the Partnership during the first lockdown.’ – Business Manager, North East England

Appendix 8: Appropriateness and management of redeployment decisions

Please comment on appropriateness and management of redeployment decisions here. (39 responses) **(Please note that this question was only asked to health, mental health and police respondents)**

HEALTH

'During first lockdown HV and SN were redeployed . this has caused a lot of stress and strain now trying to catch up and on staff left at the time. This was to bolster our community nursing teams / When they were asked again to be redeployed we had to fight for them not to be as we had more concerns about the welfare of staff and the impact on services for our children and families.' – Named Nurse for Safeguarding, London

'Redeployment happened in the first lockdown but the increase in safeguarding activity emerged after first lockdown and has continued to increase enabling an evidence base to no longer redeploy staff.' – Named Nurse for Safeguarding, South East England

'Don't get involved' – West Midlands

'First lockdown- it was considered and prepared for but did not happen. Currently staff redeployed/mutual aid for vaccinations' – Designated Nurse for Safeguarding, South East England

'Decisions about redeployment that affect Safeguarding processes should be discussed at the Partnership following consultation with the agency in the first instance.' – Designated Nurse for Safeguarding, South West England

'Redeployment for safeguarding staff is not an ask but an expectation which is very difficult to manage.' – Named Nurse for Safeguarding, Named Nurse for LAC, North West England

'Safeguarding staff had support to remain doing their jobs with only 1 redeployment to vaccination but we are extremely understaffed for the population size and work in an area with high diverse population and community we had Lockdown most of the Pandemic' – Designated Nurse, East Midlands

'Answered for health economy therefore some answers not known.' – Designated nurse for safeguarding, North West England

'I am aware that some London boroughs redeployed Safeguarding staff, In our community provider Trust we increased Safeguarding supervision , provided a 7 day Safeguarding help line for all staff . Issued clear directions promoting face to face visits to vulnerable children with PPE at a time that social workers were not doing statutory visits to CP children, this was due to effective leadership by our safeguarding director from the early days of Lock down 1.The 0-19 teams reported our safeguarding team had led them through the confusion of the early weeks in staff surveys.' – Named Nurse for Safeguarding, London

‘Redeployment was done internally and often without any direct consultation with the staff being redeployed. Those not redeployed were asked to take on additional workloads to cover staffing gaps or services usually provided by inpatient teams on top of their own workload.’ – Designated Doctor for Safeguarding, East Midlands

‘Decision agreed to support adult emergency services with redeployment of one staff member for the second lockdown made in agreement with all. The children's safeguarding establishment was increased between the 1st and 3rd lockdown and A&E and hospital attendances of children decreased therefore the team had more capacity.’ – Named Nurse for Safeguarding, South East England

‘No staff were redeployed from the CCG Safeguarding Team. Team leader had increased responsibilities.’ – Named Nurse for Safeguarding, South East England

‘We were not redeployed during any lockdown although were threatened with it. When I discussed that I have a statutory role and that we need to discuss any redeployment with CCG I was told it was 'proper redeployment' but 'helping out on wards for a few hours a day.’ –Named Nurse for LAC, London

‘There are times when experienced medical & nursing staff have been redeployed but this should not be the whole team & should not be at the expense of Safeguarding.’ – Named Nurse for Safeguarding, East of England

‘Locally, redeployment has been a 'last resort' decision depending on the severity of the situation facing acute provider organisations. On the whole, safeguarding staff have not been redeployed.’ – Designated Nurse, Yorkshire & The Humber

‘Safeguarding leads should not be redeployed. This leads to loss of supervision and loss of an overview of the health landscape. Safeguarding midwifery role is underestimated, as the referrals have increased to the midwifery safeguarding team. Redeployment has led to less supervision and oversight. Health visitors should never be redeployed as newborn babies are at risk and mothers need their in put for breast feeding, mental health support, safe sleeping, screening for domestic violence and other advice.’ – Designated doctor for Safeguarding, London

‘Redeployment happened despite this putting an unsafe strain on safeguarding services. executive managers did not understand the impact it would have on safeguarding services and our work was deemed unimportant in relation to ward staffing pressures.’ – Named Midwife for Safeguarding Children, South East England

‘50 % of School Nurses redeployed now HV's not redeployed now but were in first Lockdown Safeguarding staff from Designated Team redeployed to support safeguarding in Providers First lock down not redeployed now.’ – Designated Nurse for Safeguarding, East of England

‘Initially a knee jerk reaction, calling of all clinical staff back to the front line without a safeguarding risk assessment undertaken. Safeguarding was not considered critical business as usual.’ – NHS England, London

‘Staff have largely not been redeployed’ – Designated Nurse for Safeguarding

‘We were lucky that there was little re deployment in safeguarding. you only gave an option for "should NEVER be.." I would say they should rarely be re deployed but there may be circumstances where they should be.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘Safeguarding team's were maintained in lockdown 1 &2. Pressure of vaccination has meant one staff member redeployed to manage vaccination centre and others giving vaccinations in their own time.’ – Designated Nurse for LAC, South West England

‘No safeguarding colleagues were redeployed.’ – Head of Safeguarding, Yorkshire & The Humber

‘In our trust, the Named Nurse has had to take on chief nurse team responsibilities ie times where had to do rounds of the wards to check fridges, staffing, etc - some benefit in that she could check re SG as she went along (young people on adult wards) but overall not a good use of her time. Other SG specialist practitioners in team were redeployed to Neonatal Unit and ED. Named Dr had to go on to emergency rota for 6 weeks in first lockdown so little room for safeguarding. Not happened since and managed to largely protect time however cases on rise and having to do lot more supervision and peer review.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Our safeguarding service remained business as usual even with staff remote working someone was always present in the hospital.’ – Named Nurse for Safeguarding, South East England

‘Now asked regularly to add hours and contribute to vaccine programme.’ – Designated Nurse, South East England

‘There has been no redeployment in our hospital safeguarding children's service. Mainly worked in the hospital, minimal home working. Home working in safeguarding restricts contact with staff and staff much less likely to contact via phone/teams. Important to encourage 'open door' culture.’ – Named Nurse for Safeguarding, South West England

‘This seems to have varied throughout the country, have heard of a Named GP being redeployed, but that was unusual.’ – Named GP for Safeguarding Children, South East England

‘Uncertainty and anxiety was troublesome for many practitioners’ – Designated Doctor for Safeguarding, London

‘I think it needs to be in consultation and agreement but is impossible to say never as there has been a genuine and real need for physical redeployment in this pandemic.’ – Designated Doctor for Safeguarding, London

‘An early decision was made not to deploy safeguarding practitioners during the first lockdown. This time we have been asked to support the rollout of the vaccination programme but safeguarding is still considered business critical so only supported when capacity allowed.’ -– Designated Nurse for Safeguarding, East of England

‘No joint planning was seen it was organizational specific and reactive but applying nation instruction in many situations.’ – Designated Nurse for Safeguarding, South East England

‘I feel that safeguarding was not prioritised by those in power. They asked for agreement when decisions had been made. All unconscious biases went unchallenged in government and in higher echelons on NHSE etc’ – Named GP for Safeguarding Children, London

‘Decisions to redeploy staff were agreed and discussed on an individual basis.’ – Designated Nurse

‘Top-down approach no regard to the health of children and families. Thousands of babies born have been denied a service.’ –Designated Nurse for Safeguarding, London

MENTAL HEALTH

‘Any protection indicated nationally that SG staff were meant to have went out of the window as the pandemic grew worse. 2nd and 3rd outbreaks had less redeployment.’ – MH Safeguarding Lead for Children and Adults, West Midlands

‘First lockdown the whole safeguarding team were volunteered by the AD for redeployment with a rotational cover of the duty advice service for adults and children and minimal staffing remaining. This soon had to be reconsidered to ensure there was adequate Named Nurse cover at all times especially in view of compassionate leave and annual leave requirements. This was a mistake as this left the few remaining staff overwhelmed due to an increase in the complexity and severity of the cases that were coming to our attention and the relentless emotional strain on staff from the nature of the job in addition to the significant changes in their own personal circumstances and adapting to working at home.’ – MH Safeguarding Lead for Children, East of England

‘Appropriate consideration given to redeployment but a senior leadership understanding and acknowledgement of the risks this may pose.’ – MH Safeguarding Lead for Children, East of England

POLICE

‘There has been limited re-deployment, therefore nothing further to comment on.’ – Yorkshire & The Humber

Appendix 9: Supporting reflective safeguarding/child protection practice during the pandemic

How can reflective safeguarding/child protection practice be supported during COVID-19? (108 responses; 1 don't know removed)

CHILDREN'S SOCIAL CARE

'The wellbeing of our practitioners remains a key factor in delivering high quality services. good links to managers and peers has been crucial to maintain oversight and quality of services to children and families.' – East Midlands

'Through continued effective supervision and sharing of practice; clarity of communication; safe spaces in offices not doing all support virtually.' – South East England

'We are running drop-in reflective sessions on topics that are relevant during the pandemic - it's like talk radio with our Principal Social Worker. People can ask questions, put comments in the chat... it's helping.' – London

'Development of group supervision/ reflective practice forums.' – South East England

'By not being withdrawn by agencies and recognised as a priority duty.' – East Midlands
'Online group work.' – North West England

'A blend of online and in person safe supervision, same for training. Post pandemic support and development will be needed.' – London

'Ensure families are seen regularly.' – East of England

'Multi-agency close working very important.' – North West England

'Multiagency practice guidance during lockdown introduced and updated as required with partners.' – London

'Extra funding from central government to increase staff capacity.' – London

'Group supervision, enhanced strategic and operation multi agency meeting.' – London

'Increased use of technology/safe places. We have commissioned additional support linked to SW and Leadership academy to enhance opportunities for practitioners.' – North East England

EDUCATION

‘With the current covid-safety laws and pressure to stick with the guidelines, online meetings and covid-safe areas seem to be the only way to continue the work.’ – South East England

‘Wider forums of professionals.’ – London

‘More willingness to actually help rather than a desperation to close cases.’ – West Midlands

‘Must be seen as a priority.’ – East Midlands

‘By providing a multi agency supervision approach.’ – London

‘Greater working together.’ – East Midlands

‘Local authorities having expectations of a continuity across services rather than each choosing their own direction. They should also have the same level of direction and accountability and monitoring placed on similar to that of schools so as they have more onus of supporting schools to provide access to services and the quality of those services being also held to account.’ – North West England

‘Online supervision.’ – East of England

‘Schools need help- we need mental health professionals to actually come to schools- to help the children and their families and to support school staff in areas beyond education. Over time there has been a gradual creep towards schools taking on more responsibility for communities and what would traditionally be social care. This has been vastly accelerated during the pandemic. We cannot sustain this. It needs to be planned for and supported with staff who can fulfil the specialist roles.’ – South West England

‘Improved inter agency working with all agencies fulfilling part of the support plan- it felt as if it was all left to schools.’ – East Midlands

‘Ensure that pre-existing services are not reduces, if anything the inherent capacity needs monitoring and rapid response increase of both human, economic resources to be increased where needed.’ – London

‘A coordinated effort by all professionals.’ – London

‘More emphasis on F2F meetings, when safe to do so and if not access to Zoom / Teams etc. Meetings' – East Midlands

‘Good safeguarding practice has to be reflective at all times. Support for safeguarding staff is key, other responsibilities should be shared during Covid 19, to allow for full focus.’ – East Midlands

‘Means of sharing best practice and what has worked amongst professionals with those involved through forums, written papers, sharing these results, best practice elsewhere (outside of the UK).’ – East Midlands

‘Some criteria to risk assess the children that is consistent (not devised by each school independently).’ – North East England

‘Multi-agency working has been seamless and effective.’ – North East England

‘More doorstep conversations at the very least. Knowing more about the family context and bringing family support where possible.’ – London

HEALTH

‘Keep it as a priority and not redeploy.’ – Designated Doctor for Safeguarding, South East England

‘Use of technology to offer supervision.’ – Named Nurse for Safeguarding, North West England

‘We need more staff and resources.’ – Named Nurse for Safeguarding, London

‘Supervision has not been prioritised by frontline staff meaning that reflective supervision has been replaced with more ad hoc reactive advice and support.’ – Named Nurse for Safeguarding, South East England

‘Supporting new ideas to engage families, children and young people in a hybrid world of face to face and virtual contacts with professionals. What is the impact on the child? By understanding what is the impact on the parents- asking the why, are things happening in such a way rather than just what is happening.’ – Designated Nurse for Safeguarding, South East England

‘Through virtual supervision 1-1 and in groups.’ – Named Nurse, North West England

‘Online I suppose sharing good practice.’ – Designated Nurse for Safeguarding, Designated Nurse for LAC, East Midlands

‘We still have to see families and see the children. Remote conversations are not great but better than nothing. doorstep conversations would be better.’ – Named Doctor, Yorkshire & The Humber

‘Increased availability of Safeguarding supervision sessions were highly rated by supervisees in our trust.’ – Named Nurse for Safeguarding, London

‘We would like more staff to offer increased training, supportive forums for reflection. One to one supervision now needs more time to offer containment to staff. We have more staff calling for support and a reduced team. However we have not been redeployed which reflects the Trusts value and understanding of safeguarding children.’ – Named Nurse for Safeguarding, South East England

‘Dedicated time Facilitated by professional psychologist for Des Professionals.’ – Designated Nurse for Safeguarding, Designated Nurse for LAC, Yorkshire & The Humber

‘Peer support/review.’ – East Midlands, Named Doctor for Safeguarding

‘Remote meetings mean they can be more regular and flexible, and cross geographical boundaries - this is a huge opportunity for peer and cross-agency reflection and discussion.’ – Designated Doctor for Safeguarding, East Midlands

‘Regular peer group supervision meetings and support and time/ resources to enable reflection.’ – Named Nurse for Safeguarding, South East England

‘Access to peer support.’ – Designated Nurse for LAC, North West England

‘Allocated peer supervision between Named professionals and Designates. More sharing of good practice.’ – Named Nurse for Looked After Children, London

‘Mutli-agency snapshot audits when trends identified. Review of threshold documents.’ – Named Midwife for Safeguarding, London

‘Recognition from senior management that safeguarding remains constant and resources allocated appropriately.’ – Named Nurse for Safeguarding, East Midlands

‘Practitioners need protected time to take part in restorative supervision for most if not all of their CP practice.’ – Designated Nurse, East Midlands

‘Continuation of offers of supervision and safe space within and across agencies.’ – Designated Nurse for Safeguarding, Designated Nurse for LAC, Yorkshire & The Humber

‘Raising awareness of the importance and mandatory protected time.’ – Named Midwife for Safeguarding Children, West Midlands

‘Improve safeguarding supervision.’ – Named Midwife for Safeguarding Children, North West England

‘More supervision- facilitated peer sessions.’ – Named Nurse for Safeguarding, South East England

‘Enhanced skills developing in teams to continue group discussion online. Need to ensure that all safeguarding staff have peer supervision at least.’ – Designated Doctor for Safeguarding, Clinician or Manager for LAC, London

‘Continuous provision of supervision in agencies with professionals. Consideration given to staff resilience, well being.’ – Designated Nurse for Safeguarding, AD Nursing, East of England

‘Ensure that all safeguarding professionals have access to clinical supervision. Redeployment of safeguarding professionals sends out the wrong signals to the system. Redeployments should only be exceptional, and only if there is a full risk assessment undertaken.’ – NHS England, London

‘Development of multi-agency supervision in 'stuck' cases. Prioritisation and actively seeking out professionals to ensure it keeps going even in high demand times.’ – Designated Nurse for Safeguarding, South West England

‘Protected time for all safeguarding staff - online resources to guide reflective questioning.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘On line can be brilliant but many people need helping and formal training on how to manage online services are desperately needed eg how to manage your Wi-Fi, how to use zoom etc. only then do people have the space to be able to reflect.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘Prioritised appropriately.’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘By raising awareness.’ – Designated Doctor for Child Death

‘Virtual support and supervision.’ – Head of Safeguarding, Yorkshire & The Humber

‘I think this is difficult online. The use of sharing is important.’ – Designated Doctor for LAC, Named Doctor for LAC, London

‘We have moved peer review for consultant paediatricians online very early in the pandemic and it works really well - very positively received especially by people who couldn't get to the in-person sessions before. Similarly our SG supervision sessions for other staff are virtual. All our meetings are online including Health Safeguarding Group and subgroups of partnership - makes attendance easier. The Partnership have recently run a very successful child exploitation conference online.’ – Named Doctor for Safeguarding, Yorkshire & The Humber

‘Encouraging Safeguarding Leads to promote within Practices by showing the benefits to their practice population and staff.’ – Named GP for Safeguarding Children, North West England

‘Remote supervision is effective alongside child centred decision making rather than cost effective decision making (in some cases).’ – Named Nurse for Safeguarding, South East England

‘The need for understanding the impact to plan future service delivery.’ –Named Midwife Acute, London

‘More online multi-professional informal reflective sessions - discussing specific cases and actions taken - regular opportunity to engage with other professionals.’ – Designated Nurse for LAC, London

‘Don't redeploy staff safeguarding children. encourage MDT working to manage and assess risk.’ – Designated Nurse, East of England

‘Incorporating online work and the additional time it takes needs to be reflected in caseloads and provision of staff.’ – Named Nurse for Safeguarding, South West England

‘Whilst we have manage in the main to continue individual supervision, we have been unable to provide group supervision due to limitation of numbers in rooms, the hospital academy being shut for Covid storage and lack of It facilities for virtual meetings. Organisations seem to be keen for everything being done virtually but it is difficult to provide effective challenge or support virtually on a consistent basis. Reflective practice should be seen as essential during any pandemic response and not a nicety that can be disregarded.’ – Named Nurse for Safeguarding, South West England

‘I think we have and are developing good reflective practice already.’ – Designated Doctor for Safeguarding, North East England

‘Staff to be enabled to allocate time for reflection - perhaps this should be a quality metric?’ – Head of Safeguarding, London

‘Additional funding for additional safeguarding specialist roles.’ – Named Nurse for Safeguarding, North East England

‘Learning from every case that raises issues about the way the local agencies have worked together, even within complex agencies such as health; which is made up of many disciplines and organisations.’ – Designated Nurse for Safeguarding, London

‘More supervision, more training for practitioners on Trauma Informed Practice.’ – Designated Doctor for Safeguarding, London

‘Increase funding.’ – Designated Nurse for Safeguarding, North West England

‘Online peer meetings.’ – Designated Doctor for Safeguarding, London

‘Offering supervision more frequently.’ – Designated Nurse for LAC, Deputy Designated Nurse for Safeguarding Children, Yorkshire & The Humber

‘Remote supervision either group or 1-2-1.’ – Designated Nurse for Safeguarding, North West England

‘On-line reflection can be effective if sensitive and introduced carefully following real trust building in the group, walk and talk sessions have been really helpful for the human contact aspects.’ – Designated Nurse for Safeguarding, South East England

LAW

‘More training/support for professionals.’ – South East England

‘I am not sure what means. Services have been under extreme pressure and so have resorted to reactive rather than proactive practices.’ – West Midlands

‘For social workers to be more flexible and imaginative in their approach of how to seek to "make" things happen instead of the "easy" option of doing nothing and blaming Covid restrictions.’– North East England

‘More manager support – access to counselling, etc.’ – Children’s Panel Solicitor, London

‘More checks, more services and support offered.’ – Children’s Panel Solicitor, London

‘See above - all Social Care professionals involved in front line safeguarding should be provided with the jabs up front and all PPE to enable them to do their jobs. There should be a greater emphasis on working collaboratively.’ – LA Solicitor, East of England

‘It is very difficult as effective child protection requires professionals to be able to visit and observe families. You could say all vulnerable children attend school but some would be missed and you would be potentially putting people with health issues at risk.’ – LA Solicitor, Yorkshire & The Humber

‘Encourage staff discussion remotely - team meetings for example. Mentor system between senior and junior staff in the team. Works well in my team.’ – LA Solicitor, Children’s Panel Solicitor, London

‘Good communication.’ – LA Solicitor, East of England

‘Proportionate action is harder to correlate but it is teaching some practitioners to seek information from all sources.’ – LA Solicitor, East of England

‘Through regular remote training and social work supervision.’ – LA Solicitor, London

‘More sharing between areas, organisations and practitioners of what has worked and what has not.’ – Children’s Panel Solicitor, Yorkshire & The Humber

MENTAL HEALTH

‘Actually we have seen the strengths of online meetings.’ – Mental Health Safeguarding Lead for Children

‘Supervision via Zoom.’ – Mental Health Safeguarding Lead for Children, Yorkshire & The Humber

‘More communication outside of stat processes. Multiagency groups should be formed and teams require multiagency integration.’ – Mental Health Safeguarding Lead for Children and Adults, West Midlands

‘Unclear as most teams feel they have even less time to reflect.’ – Mental Health Safeguarding Lead for Children, East of England

‘Has to remain online. Restorative supervision has helped the actual safeguarding children practitioners.’ – Mental Health Safeguarding Lead for Children, London

‘Increased regular communication within professional networks, ie; keeping others up to date if remote or in person visit done and state if child seen so all agencies aware.’ – Mental Health Safeguarding Lead for Children and Adults, London

‘Wider areas of scrutiny.’ – Mental Health Safeguarding Lead for Children, London

POLICE

‘Promotion of practice within organisation (on-going with academic support).’ – West Midlands

‘By the continuation of virtual multi-agency meetings, in particular for practitioners, so to identify deficiencies in practice and by working together to implement processes to overcome issues.’ – Yorkshire & The Humber

SAFEGUARDING PARTNERSHIPS

‘We saw an increase in rates of supervision - maybe due to time gained from less travel.’ – Yorkshire & The Humber

‘COVID - has enabled virtual meetings- so we get better attendance across the piece and that is positive.’ – Business Manager, East of England

‘Regular staff supervision.’ – London

‘Statutory guidance to share information about potential safeguarding concerns - in order that agencies will share low level concerns.’ – Business Manager, Yorkshire & The Humber

‘We really need to be reflective at this challenging time due to there being increased risks to children and families.’ – Independent scrutineer/chair, East of England

‘We introduced fortnightly COVID partnership meetings and monthly dataset meetings to share information and create a space for the escalation of concerns. We have two Child Practice Learning Reviews where there were similarities so bought the practitioners together to explore their experiences of working with the children during COVID. A learning briefing will be shared across the Partnership. COVID escalation is a standing item on our Executive Group agenda. A theme emerging from our case reviews in the need to increase practitioners knowledge and skills about professional curiosity and triangulation so we're producing a poster to remind people of these principles.’ – Business Manager, West Midlands

‘There has been creative webinars and virtual sessions which have worked very well during lockdown and should be maintained.’ – Business Manager, South East England

Appendix 10: 'Shining example' of creative practice adaptation

If possible, please provide one 'shining example' of creative adaptation of safeguarding/child protection practice during the pandemic that you consider represents emerging best practice. (113 responses; 1 – don't know removed)

KEEPING IN TOUCH AND SUPPORTING VULNERABLE CHILDREN, YOUNG PEOPLE AND FAMILIES

'Many of our children in care have got more involved in our participation events - and a online talent show was very successful in summer when young people submitted short video clips of them showing off their talents - prizes were awarded and this was great fun for everyone involved.' – Children's Social Care, East Midlands

'Using creativity to see the young person ie going for walks, going to parks etc.' – Children's Social Care, East of England

'Early help creative offer links to open children's centres as space spaces in the community. Creation of virtual online Looked After Children Statutory Reviews and CP conferences really quickly and continued involvement where relationships with families already existed. More difficult with the need to create relationships.' – Children's Social Care, London

'Being very responsive to need and creatively involving children and parents to look at what will work best to support them.' – Children's Social Care North West England

'Schools visiting families with food parcels whilst having conversations with children to ensure their safety.' – Children's Social Care, London

'Closest thing to a shining example is posting signed (by a whole class/cohort...) letters or activity booklets to households.' – Education, South East England

'Our own school setting up our own food bank and clothes for our Romanian families.' – Education, West Midlands

'Home visits from school to the doorstep. working with community groups and food banks to provide for families we know. Schools really do know their communities well. Live lessons- for parents we could never get into school these have actually worked really well- we are training parents whilst teaching children.' – Education, South West England

'Regular contact, school support, parental support. People who genuinely have regard for the immensity of the task.' – Education, London

'We have a covid secure room where Social workers can come and see our YP. This is kitted out with full PPE and appropriate ventilation.' – Education, East Midlands

‘For us sending text messages and emails when we have not been able to contact Parents has really helped encourage communication with some difficult parents.’ – Education, East Midlands

‘Clear identification of whole-school vulnerable students (not just LA identified), close working with in-school team to ensure regular, weekly contact with the families to build positive and supportive relationships to get help in quickly as and when required.’ – Education, East Midlands

‘I think that the visits and regular contacts from the safeguarding team did serve to improve relationships with the parents/carers which has been maintained since March 2020.’ – Education, North East England

‘Matching staff to families for best engagement.’ – Education, North East England

‘Mini-bus to pick up primary school pupils at risk. Taking work and laptops to the homes and tutoring on the door step too. Taking gifts of fruit and resources. SEND pupils being given activity bags full of games and other resources to support learning at home.’ – Education, London

‘[X] provided 6 lap tops for parents to use to access remote hearings which enabled court hearings to proceed even if parents did not have access to IT or internet. This was then mirrored in the other Local Authorities and is now expected practice.’ – LA Solicitor, South West England

‘Provision of remote court access at the civic centre for parents via provision of laptops and a Covid secure environment.’ – LA Solicitor, London

‘Use of social media to directly communicate with children.’ – Police, South West England

‘Schools engagement with families and students and innovative ideas to engage on line learning.’ – Safeguarding Partnerships, East Midlands

‘Videos of what CYP can expect when attending health appointments i.e. what the environment looks like with reduced furniture etc and how staff look in appearance with PPE in place.’ – Designated Nurse, South East England

‘The quarantines which were award winning care experienced young people from Leicester city linking with LAC via internet links to stop loneliness do cooking on line and keep LAC feeling connected.’ – Designated Nurse, East Midlands

‘Our school nurses arranged to see young people in parks and outdoor areas, they were keen to get out of the house and many of these were children who wouldn't have turned up to appointments in school time pre lockdown.’ – Named Nurse for Safeguarding, London

'Walk and talk, using the exercise offer to get families out and about and talk while walking, often more was said then and it was less intrusive than any other assessment or support approach.' – Designated Nurse for Safeguarding, South East England

'We have done some great work with our Young Safeguarders to help us understand the approaches we need to take to engage young people.' – Designated Nurse for Safeguarding, South West England

'Creation of one single point multi agency early help website for families seeking advice and support.' – Designated Nurse for Safeguarding, North West England

'Development of a Crisis hub number with dedicated CAMHS provision during specific hours.' – Mental Health Safeguarding Lead for Children, London

'The development of a multi-agency Covid protected team who could go into infected households if necessary.' – Safeguarding Partnerships, Yorkshire & The Humber

RISK ASSESSMENTS

'Our link coordinator scheme - professionals allocated to schools to go through lists of vulnerable children on a weekly basis to achieved shared situational awareness and coordination of support.' – Children's Social Care, South East England

'Pre Covid risk assessments before every visit to keep families and staff safe.' – Children's Social Care, Yorkshire & The Humber

JOINT-WORKING, MULTI-AGENCY WORKING AND INFORMATION SHARING

'Visiting by police and social care all children who are being exploited and were being used less by gangs due to the lockdown to attempt to divert them away from this lifestyle and protect them post lockdown. Sharing of line by line data in live time which vulnerable children were in school. Introduction of PEP and Virtual school for Children in Need and CP project.' – Children's Social Care, London

'Closer working relationship school/ social worker. At school's request Social worker video conferenced family and fed back to school on child's well-being that school had been unable to contact.' – Education, South East England

'Very impressed with local authority and schools joint working to identify and support vulnerable children and families. A social care link co-ordinator with each school has been especially useful. There are plans for this model to continue.' – Designated Doctor for Safeguarding, South East England

‘Local cluster meetings held weekly to discuss vulnerable children across agencies that still exist almost one year on.’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘Weekly meetings with CSC, Designates, Police, Education to look at Covid pressures, issues, etc.’ – Designated Doctor, South East England

‘The responsiveness of our partnership and relevant colleagues to local and London wide concern leading to development of a shared strategy aiming to provide better support mental health of adults and children, and better awareness of risk by all partner agencies. Also aiming to include Housing in planning and discussions.’ – Designated Doctor for Safeguarding, London

‘Sharing the key themes, strengthening regional governance to capture escalations more effectively.’ – NHS England, London

‘Coming together of comms teams to ensure consistent messages and campaigns across agencies.’ – Designated Nurse for Safeguarding, South West England

‘Secure partnership email address for agencies to report to CSC when a child seen, this reduced number of professionals visiting homes.’ – Designated Nurse for Safeguarding, North West England

‘NNDHP network providing daily huddle and rapid dissemination of information.’ – Designated Doctor for Safeguarding, London

‘Every effort was made to continue Children looked After Assessments virtually. Those who had virtual IHAS were followed up to have physical assessment. Continued to deliver safeguarding training, hold multiagency learning events, promote training, shared business continuity plans with partnership, held weekly meetings with Partnership. Maintained close regular contact with Provider safeguarding Teams. Challenged any decision to redeploy HV's on this lockdown.’ – AD Nursing, East of England

‘The Trust has an information sharing guidance that is used for safeguarding and it was that data collection held by the safeguarding team that highlighted the numbers of under 28 day old babies being brought back into hospital, mostly to ED, strong collaborative working has kept this highlighted and work continues.’ – Named Nurse for Safeguarding, South East England

‘Police really stepped up and stepped in, leading on partnership locality based problem solving and alert meetings.’ Designated Nurse, South East England

‘Partnership introduced an early decision making proforma as an information gathering tool to make a partnership decision if criteria for notification to national panel was met of not.’ – Designated Nurse for Safeguarding, North West England

‘Pilot of increased resource into MASH for health. Multi-agency partners across 3 Local authority areas in one county were increasing/adapting their resources in MASH to meet

increasing demands per pandemic and did further work in the first lockdown. Health have piloted six month project to benchmark need in each MASH, for health information contributing to decision making/strategy meetings and pilot liaison with GP's to act as a conduit for MARAC and send frontline healthcare professionals (GP, HV/SN & midwives) domestic abuse notifications from the police; recognising increase DA and help keep children (& adults) safer.' – Designated Nurse for Safeguarding, South East England

'In Lockdown 1, we started a an inhouse daily 10am safeguarding meeting that has now been extended to include children, adults, maternity, IDVA, adult mental health liaison and sexual health. This has improved timely responses to complex cases particularly where there are see the adult, see the child concerns.' – Named Nurse for Safeguarding, South West England

'Monthly meeting with the local authority to go over the number of cases open for pre-birth assessment, promoting closer collaborative working.' – Health, London

'More joint working within different professions.' – Law, South East England

'The importance of speaking to each other even though we are no longer 'sitting next to each other'.' – Children's Panel Solicitor, LA Solicitor, London

'Strong multiagency networks, communicating and working really collaboratively. A 'tag team' approach.' –Mental Health Safeguarding Lead for Children and Adults

'More assertive comms by HVs and SNs.' – Mental Health Safeguarding Lead, West Midlands

'Cross thematic partnership/safeguarding/vulnerability management structure through SCG arrangements improving connectivity of agencies and partners.'– Police, West Midlands

'Holding a regular partnership (weekly) covid related safeguarding meeting to enable professionals to better identify gaps in service delivery and develop quick time solutions to emerging problems.' – Independent Chair/Scrutineer, East of England

'Overall there has been more focus on doing what is important and questioning the impact. There has also been more focus on working efficiently - e.g. not duplicating visits but better communication about who will visit and what is the purpose this still needs some work as some professionals felt uncomfortable stepping outside traditional roles.' – Business Manager, South East England

REMOTE COMMUNICATION WITH PROFESSIONALS AND CHILDREN AND FAMILIES/VIRTUAL ADAPTATIONS TO PRACTICE

'Hybrid meetings and court attendance.' – Children's Social Care, North West England

‘Some children in care have been able to lead their meetings more from their position due to the use of online methods when supported and encouraged to do so by IRO's.’ – Children’s Social Care, London

‘Families joining a child protection conference from the comfort of their own home.’ – Children’s Social Care, North East England

‘''Red button” on school websites - concerns can be recorded by users.’ – Education, East Midlands

‘Regular virtual Multiagency meetings - CSC, Paediatrics, Mental Health, LAC’ –Designated Doctor for Safeguarding, South East England

‘Use of technology to enhance multi agency working and attendance at meetings.’ – Named Nurse for Safeguarding Children, North West England

‘Some looked after children found online so much better and evidence of being really open …' – Designated Nurse for Safeguarding, South West England

‘Virtual meeting for strategy discussion which has meant more staff could attend and be part of the process adult services have had a more think family approach and accessed children safeguarding more for support than maybe before online. Webinars for training has been excellent.’ – Named for Nurse for Safeguarding, London

‘Delivery of safeguarding training via zoom has enabled greater attendance and the development of a pre course workbook has enabled a shorter more manageable length of training. Feedback has been overwhelmingly positive.’ – Named Nurse for Safeguarding, South East England

‘Use of MS Teams has allowed multiple teams to get involved more easily in complex safeguarding cases.’ – Named Doctor for Safeguarding

‘The use of attend anywhere virtual platforms to see children.’ – Designated Nurse for Safeguarding, South West England

‘Professional meetings are held easily, including GPs to fit their tight schedules. This has supported risk assessments and also reduced the feeling of isolated working. We hope this will continue now we are all competent to use remote working. Level 3 safeguarding training is developed and rolled via MS teams out to include contemporary issues including the impact of covid on families and children. This is well evaluated and is a good use of time.’ – Named Nurse for Safeguarding, South East England

‘National Network for Designated Health Professionals have met virtually a few times a week sharing good practice, sharing concerns and engaging others to support progress or highlight/escalate risks.’ – Designated Nurse, Yorkshire & The Humber

‘(when it works) we can set up a multiagency strategy meeting with everybody we need within minutes, including expertise from any involved agency.’ – Designated Doctor for Safeguarding, East Midlands

‘Improved online meetings which facilitated collaborative working were more effective and efficient and long travel times.’ – Named Nurse for Safeguarding, South East England

‘Use of MSFT to hold safeguarding meetings (not direct family meetings, general leadership and information sharing meetings) increased membership and allows attendance from wider group.’ – Named Nurse for Safeguarding, East Midlands

‘Remote discharge planning meeting-pre covid not all professionals could attend. Now they can.’ – Named Midwife for Safeguarding Children, North West England

‘Being able to have remote meetings with colleagues that are miles away, meetings can be pulled together faster and are more efficient. Locally we organised a regular meeting between health and CSC to discuss significant cases of concern, and organisational issues.’ – Named Nurse for Safeguarding, South East England

‘Quicker meetings, instead of all professionals trying to make it to a face-to-face meeting.’ – Named Nurse for Safeguarding, Yorkshire & The Humber

‘Virtual discharge planning meetings that allow numerous professionals to attend. Previously there was no physical space on the ward to hold these meetings which made it very difficult. Moving to virtual meetings allow more professionals to join and make better plans.’ – Named Midwife for Safeguarding Children, South East England

‘I do a lot of training, well thought out good interactive on line training using all the facilities eg whiteboard, polls, works really well and if recorded actually reaches more people. We can now do training across the country. Our courses are full and we have more faculty / trainers as they don't have to travel.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘The main positive is in child death meetings. The move to virtual has allowed much more attendance including from GPs.’ – Designated Doctor for Child Death, Yorkshire & The Humber

‘All training packages were adopted to be delivered virtually and very evaluated by staff attending.’ – Head of Safeguarding, Yorkshire & The Humber

‘…rapid move to (safe) online peer review.’ –Named Doctor for Safeguarding, Yorkshire & The Humber

‘More joined up working by virtue of meetings between agencies being online thereby increasing attendance of crucial professionals enabling more productive discussions. I hope more online interagency meetings will continue after covid.’ – Designated Doctor for LAC, London

‘More frequent focused safeguarding meetings in GP surgeries involving the wider health team. Better attendance by HV service as meetings were virtual. GP's able to be involved in strategy meetings held virtually.’ – Named GP for Safeguarding Children, East of England

‘GPs are now able to attend case conference and are often such a key voice for child and family so need to keep online.’ – Designated Doctor for Safeguarding, London

‘I am not entirely sure, remote access has been good but it is very limited in really getting a feel for a child and their home life.’ – Law, South East England

‘The use of video platforms for court hearings.’ – Law, West Midlands

‘Sometimes children enjoy meeting solicitors remotely.’ – Children’s Panel Solicitor, London

‘Virtual appointments at a higher frequency.’ – Children’s Panel Solicitor, London

‘Courts adapted well and started using online bundles very happily.’ – LA Solicitor, London

‘Better participation/attendance of GPs at Child Protection Conferences as they are able to attend remotely.’ – LA Solicitor, London

‘Conducting CP Case Conferences online in the absence of an ability to undertake this in person.’ – LA Solicitor, East of England

‘Viability Assessments and FGC done remotely to create robust safety plans for children.’ – LA Solicitor, East of England

‘Use of remote hearings/ conferences.’ – LA Solicitor, East of England

‘On line contact support to help guide parents how to make the best. True engagement of the courts in investing and learning to use technology which can improve engagement of professionals and make it more time effective for them when travel is significant (social workers and experts availability improved) as well as saving time and money with electronic bundling. Allow better attendance at FJB to fit in with working commitments but impacts ability to network properly.’ – LA Solicitor, East of England

‘Use of online platforms.’ – Mental Health Safeguarding Lead for Children, London

‘Online training.’ – Mental Health Safeguarding Lead for Children, London

‘Engagement particularly with teenagers has increased in some cases due to digital contact. This is something that should be offered alongside face to face discussions going forward.’ – Mental Health Safeguarding Lead for Children, East of England

‘YOT case of a young man who wasn't attending school and didn't participate well in sessions with YOT worker started to engage better in Zoom calls and then subsequently was coaxed back in to attending school. Also young boy who was not potty trained and virtually

mute in class flourished during attending school with smaller class size. He got potty rained and participated fully in class subsequently.' – Police, North West England

'Difficult to answer. The implementation of virtual meetings has improved attendance and reduced time wastage through travelling. This has had the benefit of arranging quick meetings for earlier safeguarding decisions to be made. The advantages of face to face meetings and the improved communication that this brings however should not be under-estimated.' – Police, Yorkshire & The Humber

'Virtual working has improved attendance from agencies.' – Safeguarding Partnerships, London

'Online strategic meetings.' – Business Manager, London

'We have established "expected standards" for our partners in relation to their responsibilities in relation to child and adult safeguarding and community safety. This includes seeing people in their home environment where risk and changing circumstances indicates it is required. If teams/organisations need to change their practice in any way, they are required to submit a staffing impact assessment to the Executive Group of the Partnership for their consideration. Staffing Impact Assessments are also a standing item for the Executive Group.' – Business Manager, West Midlands

PROFESSIONAL SUPPORT AND WELLBEING

'Development of staff wellbeing programme with a mix of resources and activities to help staff to practice in the pandemic environment.' – Children's Social Care, North East England

'Mentoring sessions - either face to face or remotely (always 2 members of staff) - just a chance for an informal chat and check in. Even remotely, staff could pick up areas of issues and where they might need to refer on.' – Education, East Midlands

'The development of the national network for designated health professionals, a really positive level of support not just professionally but also from an emotional well being perspective.' – Designated Doctor for Safeguarding, North East England

MONITORING OF AND SUPPORT FOR VULNERABLE CHILDREN AND FAMILIES

'Schools who were 'closed' were still supporting vulnerable children, nurseries just closed in the first lockdown and in some cases have actually gone out of business - the low level concerns about children under 5 were not being addressed as schools were addressing low level concerns about school aged children. The children of all ages on child protection, CIN, CLA or even officially on 'early help' pathways, were known to services, could be monitored, tracked and Safeguarding Partnerships could ask for evidence of their safety and wellbeing. School-age children who were known to school as being vulnerable (Maybe parental domestic abuse, drug alcohol abuse, mental health, potential neglect etc) were in our

experience being tracked, contacted and supported by schools and other community services. Pre-school (0-5) children who were not officially on a 'plan' we deemed as the most vulnerable through this pandemic - (not least because they have less opportunity to; tell someone' about abuse - either pre-verbal, can't articulate or can't leave the house alone) so we tracked this cohort of children to make contact and offer support through statutory and voluntary services.' – Business Manager, Yorkshire & The Humber

'Children on Child protection and child in need plans HAD to attend school as directed by their social worker and written in the plan.' – Education, North West England

'SW prepared to insist that family remained on CP.' – Education, London

'All children presenting with self harm/mental health are referral to social care and all have a strategy meeting.' – Named Doctor for Safeguarding, South East England

'As mentioned above, the vulnerable midwifery teams that enhanced their provision further.' – Named Midwife for Safeguarding, London

STRATEGIES RELATED TO DETECTING ABUSE

'Development of a domestic violence hub, which screens all domestic violence referrals in addition to providing immediate intervention, including one to one work with perpetrators.' – Children's Social Care, London

'Increasing the knowledge and preparedness of supermarkets and pharmacies for people reporting abuse. The increase in general awareness of the population about the prevalence of abuse.' – Named Nurse for Safeguarding, South West England

'A Local Domestic abuse strategy that worked across adult and child safeguarding; with mapping of services interventions and actions going forward. Another strategy of considering youth Safety from age 10 to 25 years; therefore considering transition and the role of adult safeguarding.' – Designated Nurse for Safeguarding, London

'Better recognition of ACE's.' – Police, South East England

OTHER

'The collective, committed working and engagement and responsiveness of individuals including young people, families and multi-disciplinary professionals across services.' – Education, London

'We moved our cp medical service to the teaching hospital from the community and undertook all CP medicals on children attending the hospital who were not medically needing treatment. This supported the acute team and reduced their workload and meant children were not sat around an inpatient assessment unit waiting to be seen. we are

getting this change commissioned to ensure only medically unwell children and the very small babies are admitted.' – Named Doctor, Yorkshire & The Humber

'Local revision of the medical assessment of prospective foster/adoptive/alternate carers to enable this to go ahead without delay in primary care - revisions supported by CoramBAAF.' – Designated Nurse, Yorkshire & The Humber

'Determination and passion of healthcare staff to deliver the best care.' – Head of Safeguarding, London

'Developing new safeguarding roles which includes skill mix.' – Named Nurse for Safeguarding, North East England

'Unfortunately, I am not able to do so, since the LA where I practice have come under constant criticism from the Judges due to their very poor practice and failure to assist the court.' – Law, North East England

Appendix 11: Areas of concern during the pandemic

If there are any other areas of concern during the pandemic that you would like to draw to our attention, please state here (114 responses)

CHILDREN'S SOCIAL CARE

'The length of time without a likely or known end of this way of living and working and the impact this has on staff where they are not able to have sufficient /direct face to face support including and particularly with peers.' – North East England

'Professionals working with children and families do well in their work if they feel they are making a meaningful impact in children's lives. This is harder to do in a virtual world and impacts on staff morale.' – London

'Multi-agency joint responsibility is of increased importance during the COVID period to ensure all professional eyes are open and alert to safeguarding implications, no agency can be given the opportunity to withdraw from this responsibility without there is clarity on how the gap will be filled to safeguard and protect children in their area of responsibility.' – East Midlands

'Cost of residential placements, and sufficiency for complex cases is poor.' – North West England

'Inadequate funding to councils to adapt to pandemic conditions and provide additional services - this will impact on future service provision due to budget reductions to meet funding gaps.' – London

'Domestic violence increase.' – East of England

'Lack from support from CAMHS services.' – North East England

'The government delay in providing: confirmation of ongoing furlough payments; free school meal vouchers; and, the potential removal of the UC top-up; all contributed to stress and uncertainty for families who were already struggling.' – North East England

'Due to complexities of trying to engage families both remotely and in-person more care proceedings applications have been made to manage risk. This creates additional strains on statutory child protection services, legal services and on the courts.' – London

'Main one is placement sufficiency and increasing complexity of cases.' – London

EDUCATION

‘The consistent use of lockdowns, which are not entirely effective especially for a virus as (not-so-) deadly as covid-19 (my view is disputed and denounced by the media). Repeating the same action again and again and expecting a different result is the definition of insanity.’ – South East England
‘Pupils with severe and profound disabilities are left out of everything.’ – London

‘Social care have a key role in safeguarding but in my experience they (social workers) were requested/their role/line managers outlined they should work from home. This put greater pressure on schools and was hard to understand when we were still completing face to face work. We were asked by some social workers to complete home visits as it was unsafe for them due to the risk of Covid??’ – South East England

‘Brexit and benefit changes, homelessness, evictions crippled Romanian families and no support.’ – West Midlands

‘Regular pattern of whole staff safeguarding training has been interrupted.’ – East Midlands

‘The assumption that all children with EHCPs were vulnerable - this is offensive to many families.’ – London

‘Child’s voice not being heard.’ – East Midlands

‘Mental Health of care givers.’ – South East England

‘FSM vouchers caused parents to accept school places as they wanted/needed the monetary value as opposed to the school place. Lack of in person safeguarding meetings resulted in ineffective plans with parents not engaging and having little regard for the seriousness of situations. Professionals have not behaved professional during online safeguarding conferences e.g. stopping to answer the door or put the washing machine on!’ – North West England

‘Schools need more support- the expectations have increased so much and it is not only time consuming but a huge responsibility for schools. We have different regulations and expectations around parents so it makes it really hard to navigate areas around home which are not part of education. It feels as if we are taking responsibility for families without the power to make changes or hold families to account. The responsibility is really stressful and certainly not part of education. As professionals we are dealing with situations we aren't trained for or supported with.’ – South West England

‘Children in mainstream schools who would have normally been referred to AP e.g. if they had been excluded or too anxious to attend, have not been referred and there will be a potential huge increase in referrals post lockdown.’ – East Midlands

‘Lack of uninformative of response and stability of responsiveness across LA.’ – London

'The care systems have been woefully inadequate. Schools are constantly checking if our vulnerable families are coping, have had contact with social workers and in many cases, we are providing the link between them and chasing them up more than ever before.' – London

'Children did not have F2F access to social workers and felt unsupported at times, especially LAC.' – East Midlands
'School safeguarding staff missed holidays to cover safeguarding throughout the pandemic and attended all CP, core group, CIN etc meetings whilst social care or health managed to have annual leave.' – East Midlands

'The increase in DV during the pandemic. The constant changing in the social workers dealing with families (use of agency workers).' – North East England

'Lack of mental health/ counselling support for primary aged pupils.' – South East England

'The risks for those pupils being groomed and actively carrying out activities with local gangs. Getting into flat-blocks: no one letting you in.' – London

HEALTH

'Mental Health of young people, families and staff has increased significantly and the complexity has also increased.' – Designated Doctor for Safeguarding, South East England

'Main concerns are that children and YP are not in school/ being seen and the impact on their MH; the impact on families lockdown together on increase of DA and toxic trio seen more neglect more NAI in under ones and long-term impact on community services we may be saving the older population at the expense of our next generation and need for more MH services which in effect is therefore NOT saving the NHS! They have just moved the issues from hospital to community!!' – Named Nurse for Safeguarding, London

'Hidden Harm - do not yet know the full consequences of the lockdown and pandemic. Lack of mental health support.' – Designated Nurse for LAC, South East England

'Impact on babies, physical and emotional - those born in the pandemic and up to age 2. Babies were either killed or seriously harmed at higher rates during first lockdown. Parental stress high- levels of domestic abuse, substance (including alcohol) misuse and parental mental ill health. SUDI report- out of routine, also highlighted risks. The effects on the parent -infant relationship without community and professional support is as yet not fully known. Some evidence is emerging negatively impacted upon- as a consequence infant mental health and ability to play and learn may be affected. The impact on brain development and effects on future growth, ability to learn and ability to regulate emotions is as yet unknown.' – Designated Nurse for Safeguarding, South East England

'Significant increase in mental health presentations over last 12 months. Some challenges reaching duty CSC when they were working remotely.' – Named Doctor for Safeguarding, London

‘Significant increase in mental health problems in young people.’ – Named Doctor for Safeguarding, South East England

‘The lack of eyes on a lot of the children as the offer for vulnerable children to still attend school was not taken up widely. Also the lack of Universal services in person such as clinics, home visits, parenting groups to support parents with practical skills and mental health. Feel the lockdown babies and families will have a lot of emerging issues after lockdown.’ – Named Nurse, North West England

‘Children not being seen. Looked after Children placed out of area not having physical initial health assessments followed up which does happen in house. Waiting lists for looked after children health assessments. No care intervention for LAC just health assessments..’ – Designated Nurse, East Midlands

‘The significant drop in referrals for CP medicals and still down since then. Children being seen far more significant injuries and complex cases.’ – Named Doctor, Yorkshire & The Humber

‘The majority of abuse children report is initially to school staff. This is not possible on-line from home. Children with known safeguarding concerns were prioritised for attending school in person but this excludes all first time disclosures. It was noticeable, particularly during the first lockdown, that most disclosures were from children alternating between the homes of two different parents, where they were able to disclose abuse by one parent to the other.’ – Designated Doctor, London

‘Lots of parents reported schools were not engaging their children into online classroom sessions and they struggled to get them focused onto online learning websites themselves. They reported lots of stress and tears and older children disengaging completely.’ – Named Nurse for Safeguarding, London

‘High levels of sickness-and continued anxiety impact on professional practice or professional curiosity. Increased levels of mental health needs for YP lead to reactive practice, focus on acute services rather than prevention. Continued decommissioning of services have not considered wider factors impacting on staff and client well being. We need more staff to manage the impact rather than less staff.’ – Named Nurse for Safeguarding, South East England

‘Increase in ED attendance and hospital admissions for C&YP suffering from a MH or Self-harm - block of transfer onto the right services due to capacity at T3 and T4 services. LAC access to CAMHS services remains problematic for those children place out of area.’ – Designated Nurse, Yorkshire & The Humber

‘Children aren't being seen, exposed to more neglect and abuse, concerns about their mental health.’ – Named Doctor for Safeguarding, East Midlands

‘Huge increased risk due to lack of F2F contact with any professional: e.g. Health Visitors not doing home visits or when attending they do not physically examine the baby/child, GPs

remote consults/not examining fully if seen, no school F2F to detect changes = several cases of life threatening medical and safeguarding problems not detected. Remote working makes it far too easy for the CYP to not be seen or spoken to.' – Designated Doctor for Safeguarding, East Midlands

'School closures- were too lengthy during the 1st lockdown. School is the best and safest place for children and should have reopened in June 2020. This was a missed opportunity to safeguard children. The education system needs an overhaul. Shorter terms, shorter summer holiday and better resourcing to protect and ensure children have a holistic education to meet the challenges they face It should be mandatory for all hospital provider organisations to have a hospital IDVA - this could be resourced by the NHS England instead of employing all the designates.' – Named Nurse for Safeguarding, South East England

'In initial stages processes just being stopped by providers without consultation eg stopped face to face IHA's. Constant updating of guidance and the challenges of then making constant changes to service delivery. Not thinking laterally regarding redeployment of staff eg School Nurses re deployed, who completes RHA's.' –Designated Nurse for LAC

'I have had to seek out not only safeguarding supervision in my Trust but I have also asked our CAMH's team if they are able to support some reflective practice. Both have said they want to support me as a colleague but do not have capacity even remotely. This has left me feeling quite frustrated, unmotivated and low at some points. There has been pressure from senior management to physically be in an office where we are unable to socially distance and colleagues are not wearing face coverings despite being able to work from home.' – Named Nurse for LAC, London

'Various reports have highlighted that families are being left without support however often fail to mention maternity services that have, largely, carried on uninterrupted during the entirety of the pandemic. For vulnerable pregnant women in my area we increased our provision of support and continued to see women face to face, even with covid in the home, with necessary PPE.' – Named Midwife for Safeguarding, London

'Lack of face to face contact from social workers & health visitors seems to have impacted on families causing additional stress & anxiety to families.' – Named Nurse for Safeguarding, East of England

'The rising numbers of seriously injured young babies which we have seen during the pandemic.' – Designated Nurse for Safeguarding

'Lack of communication, increased stress levels, little support for staff' – Named Midwife, West Midlands

'Leadership in regards to Safeguarding and Child protection- the work has increased in amount and complexity- but with no plan to manage this. Redeployment of any safeguarding staff -added to these pressures.' – Named Nurse for Safeguarding, South East England

‘FII of Long Covid in children.’ – Designated Doctor for Safeguarding, Designated Doctor for Child Death

‘Increasing cases needing to be managed by safeguarding midwifery. Increased population mental health. Increased SUDI. Decreased eyes on babies.’ – Designated Doctor for Safeguarding, London

‘Substance misuse services were scaled back. In person support was greatly reduced and no on-line offer replaced it.’ – Named Midwife for Safeguarding Children, South East England

‘Lack of sharing lists of CYP on CIN, whereas CYP on CP plans are identified via CP-IS. Lack of visibility of vulnerable CYP. Reports of children home alone increased, as did reports of online activity, domestic abuse CYP missing increased at times. Lack of education.’ – Designated Nurse, East of England

‘Not enough focus on on-line abuse and the effects on the mental well-being of young people.’ – NHS England, London

‘Increase in eating disorder reported by CAMHS and increased complexity of mental health for YP to acute providers. Impact on adult mental health services was huge for staff and patients becoming ill and isolating. Whole areas unable to function and all routine referrals halted for long period of time.’ – Designated Nurse for Safeguarding, South West England

‘The pandemic was a terrible time to change all managerial levels in social care. after a failed inspection our managers were repeatedly changed during the pandemic. It's harder to get to know new people online, than to keep up known relationships. This should be considered before changes being made. All changes were not done with any discussion with other agencies.’ – Designated Doctor for Safeguarding, Yorkshire & The Humber

‘Redeployment of staff who are crucial to the well-being of children and their families’ – Designated Nurse for Safeguarding, Yorkshire & The Humber

‘Less safeguarding referrals initiated by schools in our area.’ – Designated Doctor for Child Death, Yorkshire & The Humber

‘Number of long meetings where there are no breaks.’ – Head of Safeguarding, Yorkshire & The Humber

‘The inability of government/NHS to recognise that child protection is important even in a pandemic.’ – Designated Doctor for LAC, London

‘TRAINING! A challenge for all of us, in terms of moving to largely online training - both within health and also multi-agency. Requires a lot of work to adapt the in-person packages for use online when we are talking about a half day or full day training. Much of the multi-agency training in our area is driven by health and we are all v busy having to adapt and cover other areas at times plus our own internal training. The multi-agency training is definitely a gap over last 10 months and we are trying to get it up and running again but

suffering from lack of resource and manpower (our Partnership Lead trainer is on long term sick).' – Named Doctor for Safeguarding, Yorkshire & The Humber
'Too great a reliance on non face to face consultations in Primary Care.' – Named GP for Safeguarding Children

'Our Trust audited the attendance of under 28-day old babies attendance to the hospital and found a significant increase seemingly due to the lack of family support and lack of midwifery and health visitor care, this audit was repeated and despite some interventions this remains a problem, this is risk for babies and for parents who are struggling to learn how to parent in the absence of a wider family or friend network.' – Named Nurse for Safeguarding, South East England

'In March 2020 there was an absence of services going to family homes which increased risk as at the time mainly midwifery and community nurse were seeing families in the community. There should never be a shutdown of other community services.' – Named Midwife Acute, London

'CAMHS provision - staff needing training in effective virtual consultations.' – Designated Nurse for LAC, London

'Combined risk of support services going virtual/telephone so child would be seen virtually and then perhaps family support services like mental health or substance misuse services/GP's all going virtual. Other than school and perhaps hospital admissions who was actually seeing the child face to face? Concerned that Maternity services were only seeing mothers and rarely had contact with fathers until perhaps the birth. we have seen an increase in cases postnatally where we have found out risk factors in fathers that we were unaware of. Difficult to know if mothers didn't know the info or kept it from professionals. Have seen increase in complex mental health and substance misuse concerns.' – Named Nurse for Safeguarding, South West England

'The impact of deprivation and poverty and the increased levels of need in our population. The increasing use of telephone prescriptions for terminations.' – Designated Doctor for Safeguarding, North East England

'Generally a lack of strategic leadership and guidance. Staff wellbeing.' – Head of Safeguarding, London

'Looked after children at home on a care order. Youth Justice have seen a rise middle class academic young people accessing inappropriate online activity.' – Named Nurse for Safeguarding, North East England

'Partnership work increased during Pandemic, however Partnerships had just been introduced and this may have a bearing on the need to be proactive to build the collaboration; since there was a change from the structures of the LSCB to the LSCP.' – Designated Nurse for Safeguarding, London

‘There is nothing that you do not know about.’ – Designated Doctor for Safeguarding, London
‘Significant increase in abuse and neglect resulting in high number of notifications to national panel.’ – Designated Nurse for Safeguarding, North West England

‘Redeployment. Lack of f2f especially during the first lockdown.’ – Designated Nurse for Safeguarding, London

‘Number of electively home educated doubled from 200 to 400 following start pandemic.’ – Designated Doctor for Safeguarding, London

‘Impact of positive covid tests, lack of testing and vaccination adversely affected placement stability for looked after children that was not replicated in the general population of children living with birth family. Looked after children struggled to maintain online contact with birth family including siblings during lockdown, particularly 1st one. Foster carers did not allow children to access school provision in first lockdown due to concerns about transmission.’ - Designated Nurse for LAC, Assistant Head of LAC, South East England

‘Young carers.’ – Designated Nurse, South East England

‘Increase in DA and increase in MARAC as a consequence.’ – Designated Nurse, Yorkshire & The Humber

‘We are not a single system and in a crisis will revert to looking in first before impact assessing on outcomes for others of the actions and decisions. we are too reactive.’ – Designated Nurse for Safeguarding, South East England

LAW

‘The lack of resources for people who are victims of domestic abuse and the children within those households.’ – South East England

‘I think that safeguarding has decreased during the pandemic for various reasons (schools being shut, professionals working from home and not seeing children and families and the government introducing legislation to allow social workers not to see children in care in person) and this has had a negative impact on children.’ – South East England

‘Children have been involved in care proceedings for much longer and practice around the region (Courts and children's services) have varied.’ – West Midlands

‘Poor practice by some social workers, not being prepared to "look outside the box" when it came to eg arranging FGC, stating not possible because of Covid restrictions and yet the court could operate remote hearings. In the early days not making visits to see children, even through the window.’ – North East England

‘The lack of referrals from schools and other agencies during the lock down periods is of serious concern and leads to more cases needing to be rushed to Court as the situation has escalated without social services input.’ – LA Solicitor, London

‘The pressure on professionals has been concerning. Hundreds of additional emails are being sent by lawyers who are sending extra emails rather than travelling to court. Hours is spend sending links for advocates meetings and pre hearing discussions that someone always wants to rearrange, and more hours are spent doing that - it is unsustainable. lawyers need guidance from the president of the family division about these issues as we are now working longer hours than ever due to all the increased admin / emails and lack of boundaries about the end of the working day / week.’ – Children’s Panel Solicitor, London

‘Services open to carers difficult to access.’ – Children’s Panel Solicitor, London

‘There needs to be greater support for Social Care professionals to enable them to do their job - be that additional funding or greater protection for Social Care professionals to include them receiving their jabs early on so that they can get back to protecting children.’ – LA Solicitor, East of England

‘A rise in police protection orders as social care was not receiving school and other agency information due to the lock downs.’ – LA Solicitor, Yorkshire & The Humber

‘I don't think we properly understand how parents have found the experience of remote hearings. It would be great if parents were also being spoken to.’ – Children’s Panel Solicitor, LA Solicitor, London

‘I am LA Lawyer and we have experienced higher levels of odd or extreme parental behaviours requiring more out of hours call outs and emergency advice not necessarily increasing court proceedings . The Closure of schools has noticeably impacted our ability to safeguard children.’ – LA Solicitor, East of England

‘The health of the professionals working within this sector (social workers and lawyers in my field) has been significantly impacted. Work loads are far higher with little to no respite. Furlough is not an option in the Local Authority. The Court has continued to put increasing pressure on all due to its inability to manage the case loads and this has impacted also on children especially those with plans for adoption who have had to wait for months for final decisions.’ – LA Solicitor, South West England

‘Children not attending school meant children who present harm/ allege harm in schools was lost.’ – LA Solicitor, East of England

‘With regards to care proceedings: Delay in completion or accessibility of expert assessments and international assessments; limited opportunities to place children abroad despite final orders having been made for this to happen; proposed kinship carers form abroad unable to travel to UK for further assessment etc.; general delay in conclusion of proceedings, permanency decisions being made for children due to above.’ – CAFCASS Service Manager for Public Law, London

‘The issue of contact between children and their parents during care proceedings eg removal of new born babies and virtual contact being offered.’ – LA Solicitor, East Midlands

‘Potential for parents to disengage from assessments using Covid and self isolation as an excuse. There is potential for children who are being neglected to be "kept away" from professionals.’ – LA Solicitor, London

‘In this area there is an emerging concern of delay in issuing proceedings and children being left in risky situation or on S20 for longer than necessary. There was in the first lockdown an over reliance on telephone calls to check on children's safety.’ – Children’s Panel Solicitor, Yorkshire & The Humber

MENTAL HEALTH

‘Increased pressure on CAMHS specialist services.’ – Mental Health Safeguarding Lead for Children, London

‘The increase in risk behaviours between siblings which has often been regarded as normal sibling rivalry rather than abuse and the increase in child on parent abuse. Parental boundary setting has also become in some ways harder whilst at the same time in the first lockdown it gave some families the chance to rebuild relationships with children who may have become involved in risky behaviours such as gangs as children spent more time at home but not because the parents made them,’ – Mental Health Lead Safeguarding for Children, East of England

‘Impact on caseloads of CAMHS.’ – Mental Health Safeguarding Lead for Children, London

‘The differing approaches of individual workers and professional agencies regarding whether to undertake face to face visits. Not always made clear to each other.’ – Mental Health Safeguarding Lead for Children and Adults, London

POLICE

‘Access to trusted adults to report in person.’ – South West England

‘The issue of consent within Working Together 2018 needs further work in the Early Help section. some agencies are worried about sharing information when it does not meet statutory intervention.’ – South East England

‘There appeared to be an increase in children committing acts of self-harm, making suicide attempts and in a small number of cases taking their own life. I remain concerned about the level of mental health provision to both children and adults. If a child had a broken leg there would be an expectation that the leg would be treated at A&E within a few hours, when they have mental illness there is far too often a significant delay between asking for help and receiving it.’ – West Midlands

‘Concern around the impact of covid on children witnessing domestic abuse and how this may manifest itself in the future.’ – North West England

‘The postponement of Court cases has resulted in potentially dangerous offenders, being on bail for longer periods and remaining in the community. Some others who were initially remanded due to the risk posed, have been released on bail, further increasing the risk and safeguarding provisions placed on agencies.’ – Yorkshire & The Humber

‘A significant percentage of children did not return to education following the end of lockdown periods (analysis is required as to the underlying reason (genuine COVID concerns or a parenting issue).’ – Yorkshire & The Humber

SAFEGUARDING PARTNERSHIPS

‘Different issues are emerging, and so important LSCPS nationally share that ie last week teenage pregnancy was mentioned and so we've looked at our data to check on it.’ – Business Manager, East of England

‘Pressures on strategic partners Needs of local and national comms campaigns re seeing the children.’ – Business Manager, London

‘You have mentioned Early Years specifically that I can see? There is a lot about School closures, but not the impact of nurseries closing.’ – Business Manager, Yorkshire & The Humber

‘Very concerning that we are seeing an increase in serious injuries to young babies. It is also concerning that we are seeing a significant increase in the number of children being electively home educated as a result of the pandemic, a number of which could be at risk of harm.’ – Independent Scrutineer/Chair, East of England

‘In Shropshire there has been a significate increase in - the number of statutory case reviews about neglect and non-accidental injury - the number of children removed from home under Police Protection - the number of case going to court - the number of children going on to Child Protection plans Contacts have not necessarily increased but the serious of the situations we are dealing with, has.’ – Business Manager, West Midlands

‘The surge in mental health problems in children and young people- understanding and managing social media feeds (algorithms) needs to be addressed at a national and international level especially as social media became the dominant domain for YP.’ – Business Manager, South East England