GREEN TEMPLETON COLLEGE | UNIVERSITY OF OXFORD

Multiagency working to protect vulnerable children in the COVID era: What have we learnt? What should we do now?

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Project coordinators: Sharon Dixon and Catherine Pope

GTC student researchers: Jennifer Ginger, Yiwen Zhang, Chloe Mercer

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Final project report.
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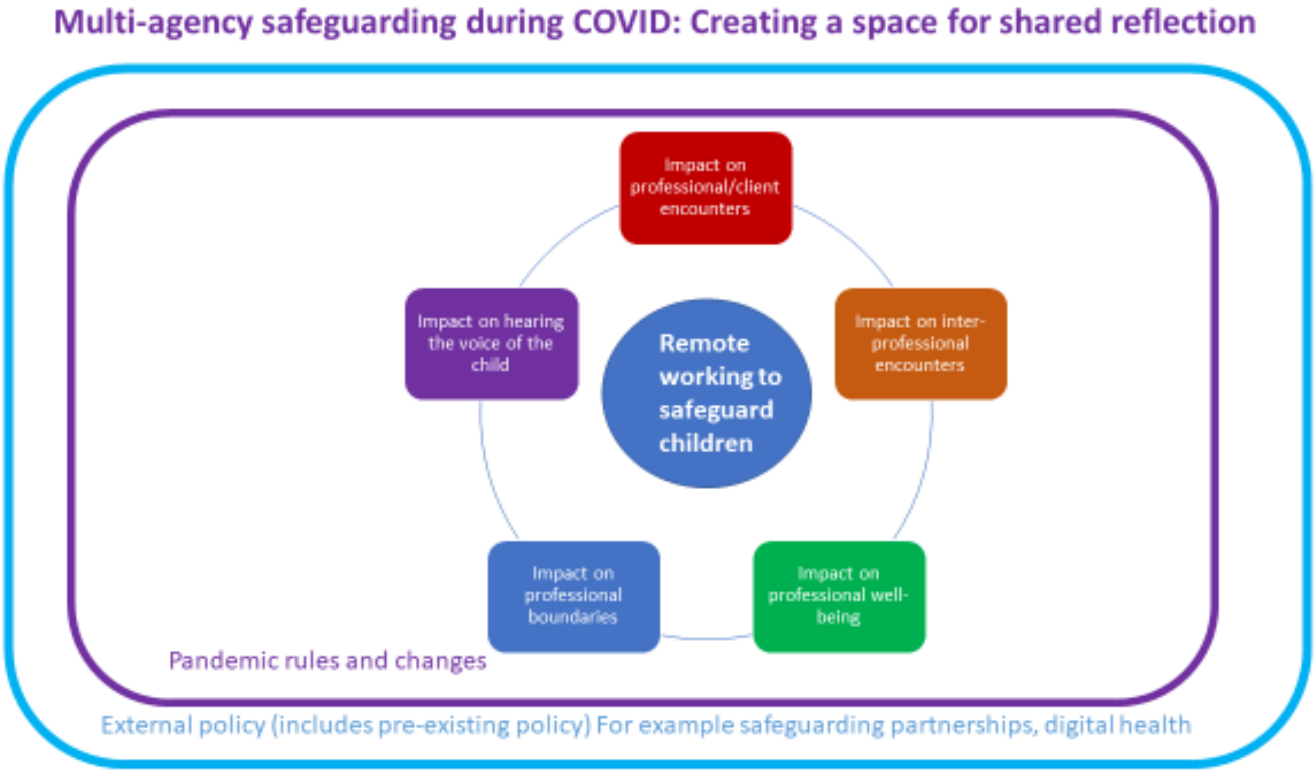

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Introduction:

Multi-agency working is the cornerstone of effective child safeguarding. This is embodied throughout safeguarding processes, from a policy and strategic level where safeguarding partnerships hold oversight of child safeguarding planning to the front-line delivery of safeguarding care (for example through multi-agency safeguarding hubs, multi-agency safeguarding meetings and inter-professional conversations).

Multi-agency working offers the possibility of bringing together perspectives and knowledge from across the different facets of families' lives and interfaces with services, to develop a fuller and more nuanced contextual understanding of the child within their family and social circumstances. As well as having shared

interests in the child's welfare and wellbeing the agencies and individuals engaged in multi-agency collaborations typically have shared aims and goals about the safeguarding process.

However, each agency participating in a multi-agency process or activity will also have their own internal structures, guidelines, and processes. Agencies on the front-line may be considered or treated as a 'single entity' under an umbrella heading, for example 'education' or 'health' and there may be significant differences and layers of complexity within their structures and teams. For example, 'education' for one family could include several schools or pre-school settings which can each function as discrete relatively autonomous units, or 'health' could include health visiting, midwifery, primary and secondary care – all of whom may be working within different work protocols, professional guidance and/or boundaries. This can complicate multi-agency collaboration; we know from serious case reviews that the gaps in these multi-agency processes are implicated in failings of child safeguarding processes, sometimes with devastating impacts. There is an urgent need to understand how these gaps arise and therefore could be bridged.

The COVID pandemic in March 2020 generated significant challenges for safeguarding care. Legislative changes including societal lockdowns designed to support infection control necessitated rapid adaptations and transitions in how safeguarding care was delivered. In parallel with grappling with these rapid changes, professionals recognised that the risks for vulnerable children were increasing. The message to stay safe at home worked less well for children and families who may not be safe in domestic settings. Rates of domestic violence and abuse (DVA) increased, and there were concerns about rises in alcohol consumption and the negative sequelae associated with this. Despite the concerns about increased risks, rates of referral to social care and for DVA support went down. Most children were not in school and thus had fewer opportunities to seek support. Children known to be vulnerable were allowed to go to school, but many did not. In some regions, health staff who typically would have been available to support families, such as health visitors, were re-deployed into other services, reducing opportunities for proactive routine care and opportunistic identification of safeguarding vulnerabilities. Medical consultations shifted rapidly towards a total triage model, with most appointments conducted remotely[1]. These adaptations largely happened within agencies and inside individual organisations.

At the start of the pandemic, it became clear that safeguarding processes needed urgent attention. A number of organisations produced rapid pragmatic guidance for their teams. For example, in primary care, the Royal College of General Practitioners (RCGP) offered suggestions about how practices could maintain and consider safeguarding needs[2]. However, there was little evidence to inform this guidance, with no pre-existing research about how best to approach safeguarding using remote consulting.

Recognising this gap, two of the authors (CP and SD) conducted a qualitative interview study with GPs to explore their perspectives on managing safeguarding concerns in the pandemic, which has been reported elsewhere[1]. While conducting this work we became aware that research to explore safeguarding in the pandemic was also being conducted within social care[3] and in relation to child protection[4]. CP and SD approached these researchers to explore shared learning about safeguarding and to consider how our collective research could inform better multi-agency working. These conversations led to the activity reported here.

Approach:

The Sheila Kitzinger Programme provides financial and administrative support to researchers seeking to maximise the impact of their research and their influence on policy and practice. This Programme supported a series of learning meetings where we brought together academics and clinicians involved in safeguarding practice, policy, and research to share learning about safeguarding in the pandemic[5]. While this was not a research project per se and thus did not require ethical approval, the participants consented to the inclusion of their contributions in this final report for the funder.

The meeting participants across the programme included representation from primary care (both researchers and clinicians with expertise in domestic violence and abuse and safeguarding), social care (academics and practitioners including from fostering and adoption), paediatricians, child and adolescent psychiatry, police, multi-agency researchers and education workers. A full list of meeting participants is included in the appendix, within the meeting minutes (Appendix A+B).

At the first meeting (July 2021), participants shared their research, and professional experiences of child safeguarding policy during the pandemic. These were typically focussed on experiences and roles in context specific settings, for example police practices in the pandemic directed to responding to DVA, social workers management of children known to be 'at risk'. Together the group identified areas for further reflection:

1. Advantages and disadvantages of remote working
2. Consideration of how (and when) there are opportunities to break down professional silos in multi-agency working to safeguard children.
3. How to identify and develop practices that fostered positive working and interactions during the pandemic (we gave this the shorthand term 'professional kindness')
4. What practices we would want to keep from our learning and working in the pandemic – and what we would like to leave behind.

To inform our deliberations on these topics, with support from three student researchers (JG, YZ, CM), we explored published research, policy, and guidance about child safeguarding during the pandemic. We re-convened the group in October 2021, to share the reviews of literature and reflect further on what we had learnt (summary slides included as appendix C).

This final project report represents a summary of the meeting processes and conversations, focussed on the key questions identified in our first meeting.

Discussion:

The advantages and disadvantages of remote working:

Participants' experiences of working and researching child safeguarding in the pandemic afforded a lens to explore and share our work. Across the reports from health, education, and social care, we identified many commonalities, including adaptations to processes of assessment, learning to navigate remote consulting with those we were supporting, and managing an evolving interface of professional and multi-agency interactions.

There were shared concerns about the potential limitations of remote assessments, including the lack of non-verbal and visual clues, the safety and privacy of electronic encounters, challenges in developing rapport and establishing trust, and impacts on those who were disadvantaged through digital contacts (for example excluded because of a lack of equipment, data, literacy, or language).

There were shared concerns that these transitions risked creating new and exacerbating existing health inequalities. Professionals in health, social care and education had a shared awareness that those who were just about managing before the pandemic may have become rapidly more vulnerable because of the stresses of COVID and the associated societal responses such as lockdowns (including physical, emotional, social, and financial impacts). These could be harder to evaluate and support, representing a source of unease and distress for professionals across disciplines. Many of these stressors could also be relevant to professionals themselves, as they held both professional and personal uncertainty and vulnerabilities as they worked.

Professional isolation and vulnerability could be compounded by staff illness and staffing shortages, meaning simultaneously increased workloads and reduced opportunities for respite or time off. The experience of the possibility of ill health (or death) as a potential 'occupational hazard' was new for some and magnified for all. In the initial phases of the pandemic, this was compounded by conflicting messages, and a lack of (consistent or adequate) access to PPE.

In sharing our work, we heard how the transition to remote consulting represented a profound change in practice across health, social care, and education. There were pervasive concerns about the challenges of delivering safeguarding care by remote consultations, with concerns about how safe the conversations were, and what might be missed. Knowing how to safely and effectively navigate to be able to hear the 'voice of the child', the heart of safeguarding, was hard, and a source of concern.

We discussed how remote working could create opportunities for some individuals and some safeguarding encounters. For example, in the study about remote working with GPs, they identified potential opportunities for utilising the flexibility of telephone triage and remote encounters to create spaces for those

in need; adapting to increase the equity of what they offered and suggested that this could be actively recognised and nurtured in policy and practice. In social care, working remotely could facilitate shorter but more frequent check in calls, or enable sharing of material by email with rapid follow up in a video call. Changes in bureaucracy meant that navigating access to material benefits such as food banks could be easier. Home school link workers told us how they had worked flexibly, using their local knowledge to individualise offerings and support. Safeguarding partnerships enabled local agencies to find solutions and work together. Many of these adaptations were enabled, at least in part, by a sense of relative professional autonomy, under-pinned by a professional commitment to compassion and kindness.

At the same time we consistently heard, across and between disciplines, that remote working impacted on personal and professional wellbeing. These included effects on worker welfare, on stress and isolation, personal and professional vulnerabilities, and in navigating the blurred boundaries between work and home. Working from home could lead to a sense of relative professional isolation, and holding these stresses without access to peer support or de-briefing was hard.

How (and when) there are opportunities to break down professional silos in multi-agency working to safeguard children:

We heard how the experience of increased isolation and stress whilst delivering or researching safeguarding care during the pandemic had been expressed by social workers, primary and secondary care clinicians, police, academics working in safeguarding and domestic violence and abuse (DVA), education workers and adoption workers. With the exception of research with a multi-agency focus (eg Driscoll et al., 2021), this work was typically documented in different role specific literature or meetings, with fewer opportunities for sharing between disciplines, resulting in less awareness of the challenges other professional groups were experiencing. For example, the research in primary care had been presented at a national RCGP conference, but there was no mechanism to communicate this to secondary care or social work research. Likewise, the research into social care remote consulting was not shared directly within health meetings or forums. Participants described an initial ‘tsunami’ of training, but again, we heard how in our participants experience, that this was typically developed and delivered within professional groups.

Participants described feeling alone in carrying the burden of safeguarding during the pandemic, which potentially undermines the shared trust and accord that needs to underpin effective multi-agency collaboration. Sharing the burden by understanding others’ stresses was helpful in creating space for collaboration and professional kindness.

These meetings offered a space for the shared reflection that is perhaps under-recognised or under-valued component of safeguarding work: listening and witnessing trauma and distress as a compassionate professional companion – ‘standing witness’. Being able to do this represented a core value for safeguarding professionals, but it can carry an emotional impact. Sharing these experiences and developing spaces for mutual support could represent another opportunity for inter-disciplinary solidarity and compassionate cooperation and enhance joint working. Spaces for mentorship, peer support, and spaces for reflection and supportive listening represent best practice and do exist, – but this could be further nurtured. These structures are largely within single agencies, but could be developed at a multi-agency level, for all frontline safeguarding workers. This could support nurturing practitioners new to safeguarding.

We also heard that ‘Silos’ in safeguarding were experienced not only between professional groups, but also between different types of safeguarding need. All these potential divisions warrant reflection and attention, to promote an understanding of how this intersectionality interfaces with multi-agency working and safeguarding care.

As we considered the gains made by coming together to share learning we identified the need for shared language and a shared understanding of what the language means, and how this is understood and operationalised within different agencies. One example focussed on the complex area of information sharing to support child safeguarding. This emerged as a potential source of tension between agencies, as agency-specific guidance and disciplinary practices tended to simplify information sharing, leading to expectations that this is a binary and straightforward process. ‘Rules’ for information sharing could

sometimes seemingly pit individual agencies against each other, which could hamper effective safeguarding. Many serious case reviews have identified that information sharing has been a failing, yet simply imploring professionals to do better, without developing a mutual understanding of the challenges and complexities each agency faces may not improve matters.

Even within the single agency 'health', where all practitioners are held within the supportive framework of professional guidance such as the GMC for doctors, differences in the challenges experienced between primary and secondary care were noted. Primary care often holds the records for many family members. This is part of the strength and value of primary care's contributions to safeguarding but can add tensions and complicate processes of communication about what information needs to be shared and when or whether consent is needed. If there is immediate concern, then this is relatively straightforward, as consent is not needed, however situations may be less clear and more nuanced requiring a shared understanding of processes and meanings of consent. An example discussed in the meeting was when a social worker has asked the family for consent to approach primary care; what does that mean for the GP? As data guardians who know what is in the record, GPs are obliged to establish consent (unless consent is not needed) and this process could be uncertain and nuanced. Together, we reflected on what could it be helpful for social care, primary, and secondary care professionals to understand about consent to facilitate information sharing.

How to support 'professional kindness':

One of the social care participants reflected that, in over thirty years of social work, this was the first time they had ever had a conversation about these questions with three GPs – with the converse being equally true! The need for better cross-agency working was seen as vital. While remote working may have complicated case-load care, it also enabled and improved some professional communication. For example, GPs found it easier to attend multi-agency meetings when these are on-line. While this could facilitate meetings, as with casework, understanding what this might mean for developing professional trust and rapport was important to be considered, including how this might both help and hinder network development. The group felt that more attention was needed to develop spaces for effective relationship building between teams. This was seen as an important step towards meaningful and beneficial multi-agency working.

Partnership working is the essence of safeguarding care and is embodied within formal safeguarding partnership structures. Yet this needs to percolate to the front line. While it is positive that 56% of respondents to a large multi-agency working survey (Driscoll et al., 2022) felt that working relationships among partners and relevant agencies had strengthened as a result of the pandemic adaptations, we need to ensure that we invest in this and nurture collaboration and relationships.

Compassionate leadership, shared learning and training could support these aims.

What we would want to keep from our learning and working in the pandemic – and what we would want to leave behind:

The pandemic rapidly transitioned how safeguarding care was delivered and experienced for front-line practitioners across disciplines. It represented a time of rapid learning and adaptation. The opportunity to pause, reflect and take stock in the learning meetings was valued, as was the chance to share this experience across disciplines. Remote working created risks and opportunities which need to be used to inform how services re-configure as the pandemic recedes and to ensure learning is available should it be needed again in a time of crisis.

There was a huge amount of positive and innovative work done during the pandemic, for example, school workers developing new relationships and outreach work with families and within their communities. Likewise, we heard about experiences of transition and compassion in family courts, (albeit alongside some challenges around access and digital transition). We need to appraise and evaluate transitions, recognise and value innovation and changes which worked well, and learn how to keep and build on this. This needs to include asking about and taking notice of what resources are needed to maintain both service structures and wellbeing of staff delivering and interacting with services.

Access to timely services that meet the needs identified in assessments was identified as integral to both effective safeguarding work and staff well-being. Early help access was singled out as an area for service

development and focus. Ensuring that there was something available and meaningful to offer facilitated exploring support needs for families and promotes the development of trust. Lacking access to this risks moral injury for safeguarding workers alongside potential adverse impacts on families.

Framing safeguarding within a public health lens, and as a social determinant of health could keep a policy focus on recognising the need to invest services and resources into the care of vulnerable young people. This needs to be accompanied by support, resources, and training for those who deliver safeguarding. Ten years of austerity have had a palpable impact on frontline services, for both those who deliver them and those who depend on them.

While there were many commonalities, there was also much that could be learned from this cross-agency learning process. We need to be mindful about what has worked well and what has been less effective. This could differ between roles and disciplines, and taking a multi-agency lens to this reflection will help evolve multi-agency collaboration. There was a strong sense that post-pandemic practitioners should not simply revert to 'what we did before' or jettison all the new ways of working, including remote practice. There had been much learning about what could work well (and when, and for whom). But it was equally important to reflect on where things had been difficult, so that as practice evolved towards a likely hybrid model, that this was done 'mindfully' and with open eyes. As one of our participants reminded, with the words of St Benedict 'Be careful to be gentle, lest in removing the rust you break the whole instrument'[6].

Conclusion

We are beginning to read about some of the devastating cases when safeguarding care during the pandemic was not able to protect vulnerable children. Our learning meetings have reinforced the idea that to deliver effective safeguarding we need to understand and consider what processes and structural factors underpin points of divergence as well as points of alignment for multi-agency working. Suggesting that there should not be points of divergence, or that cohesion should be straightforward, without accounting for the culture and working practices of individual agencies, will not enhance multi-agency working. We need to work collaboratively, and collectively understand how to enhance the capacity and capabilities of multi-agency safeguarding teams, through from frontline practice to strategic policy. Sharing learning, practice, and research between agencies could form part of this process.

Key messages:

1. Remote communication with families and between professionals became routine in safeguarding work during the pandemic.
2. Remote communication offers opportunities for fostering inter-agency communication and working, and can promote access for some, but is not without significant risks.
3. Pandemic learning and agency adaptations to remote working largely occurred within single agencies or institutions, and we need to urgently consider and evaluate the impacts of these on multi-agency working.

Next steps:

We have been able to collaborate on a grant application, and on a personal view submission, which has been published on BJGPLife[7] and will form a BJGP editorial.

References:

1. Dixon S, Frost L, Feder G, et al. Challenges of safeguarding via remote consulting during the COVID-19 pandemic: a qualitative interview study. Br J Gen Pract 2022; DOI: https://doi.org/10.3399/BJGP.2021.0396
2. RCGP guidance on managing safeguarding in COVID. COVID-19 and Safeguarding (rcgp.org.uk) Accessed 3.8.22
3. Ferguson H, Kelly L, Pink S. Social work and child protection for a post-pandemic world: the re-making of practice during COVID-19 and its renewal beyond it. Journal of Social Work Practice 2022; 36(1): 5–24

4. Driscoll J, Lorek A, Kinnear E, Hutchinson A. Multi-agency safeguarding arrangements: overcoming the challenges of Covid-19 measures. Journal of Children's Services. 2020 Nov 2.
5. The Sheila Kitzinger Programme: Sheila Kitzinger Programme - Green Templeton College (ox.ac.uk), accessed 3.8.22
6. 10 helpful quotes from St. Benedict of Norcia (aleteia.org) accessed 3.8.22
7. Supporting the 'Multi' in Multi-agency working for child safeguarding – BJGP Life accessed 3.8.22

Appendix A: Minutes of meeting 1

Multiagency working to protect vulnerable children in the COVID era: What have we learnt? What should we do now?

Via zoom, 2hours 27.07.21

Participants
All work clinically or in research
Sharon Dixon: GP, Nuffield Dept of Primary Care health sciences, University of Oxford
Bryony Kendall: Named GP for safeguarding (instead of Joy Shacklock for the RCGP)
Jennifer Ginger: DPhil student at Oxford studying adoption and on the board for CoramBAAF
Catherine Pope: medical sociologist and group lead in Nuffield centre in Oxford
Chlo Mercer: grad student in education at Oxford
Yiwen Zhang: grad student in psychology at Oxford
Jenny Driscoll: child protection barrister now in academia, part of MDT at Kings College London (KCL)
Gene Feder: GP, lead for domestic violence research group at University of Bristol
Laura Kelly: social work researcher at Birmingham university
Mina Fazel: associate professor of child and adolescent psychiatry, University of Oxford
Alison Steele: Consultant Paediatrician and Officer for Child Protection RCPCH

No formal agenda – to create a space to take stock and think
Following a study by SD and CP about safeguarding during the pandemic, recognition that researchers in other fields within health and social care were doing similar work
So what? What now? What next?
Opportunities to break down silos
Opportunity to create actions for 3 students – what evidence is needed? Who from? Thinking of the group as a select committee
Opportunity for research and/or policy

Introductions – and need to pull out what each other is doing in terms of projects, especially those that are unpublished

GP work (SD)
Development of pragmatic guidance during pandemic by JS
Finding evidence that GPs were nervous (assumptions made)
Move to remote consulting a balance of losses and gains – increasingly transactional but strategies to mitigate risk, including consideration of safeguarding and vulnerability as a valid reason to conduct a face to face consultation
Access and accessibility – the digitally excluded but opportunities for flexibility and equity
Safe spaces – loss of the sanctity of the consulting room especially knowing who else was there
Space for other problems – red flags, doorhandle issues
The visual – loss of non-verbal clues but being able to see into houses we wouldn't have previously
Connection with teams – increased isolation, loss of secondary care support but increased access to online meetings including case conferences

KCL MDT (JD)
Multi-agency Investigation of support of children safeguarding during the pandemic
7 professional groups, 67 people
Survey ended September 2020
Effect of pandemic adaptations on working relationships primarily positive: strength within partnerships "we're all in this together" – and felt to be maintained

Safeguarding partnerships had only been in place for about 6m: most neutral about this change improving inter-agency collaboration; social care felt to still be the lead agency by default
How will ICSs impact the tri-partite arrangements?
Feeling that other agencies should be involved: education, housing, CAMHS – at strategic level if not operational
Most strongly agreed that schools were taking on more responsibilities
Remote communication: statutory processes better attended with more efficient use of time; accessibility concerns for some professionals but significantly for children and families – felt most strongly by panel lawyers supporting children
Adaptations to information sharing – high levels of support for maintaining and extending the new IS agreements, especially within health
"Professional wellbeing has plummeted" – how do we know if we are making a difference and making a meaningful impact?
Amongst it all, voice of the child less readily heard
Complexity and severity of referrals have both increased since the onset of the pandemic – what will be the impact on children, the care system, foster carers, professionals?...

LK
Similar outcomes with different methodology – spoke to core practitioners every month, including some parents
https://www.birmingham.ac.uk/schools/social-policy/social-policy-matters/news/2021/may-issue/the-child-protection-and-social-distancing-project.aspx
Online meetings – attendance of GPs noted as a positive outcome
Partners in practice work
Hybrid conferences – children attend social care offices and professionals dial in, enabling effective engagement and ongoing support afterwards
"People adapted surprisingly well"
Digital casework deemed as less valuable than face to face, and need to move back as soon as possible
Digital intimacy – different way of being able to speak to a professional
Key message: social workers felt alone, missing opportunities for family visits, especially dealing with high-risk cases where health visitors were not attending
Families using social workers for therapeutic support which was felt to be some out of their usual
Perception gap – leaders felt things going well with multi-agency work, frontline staff felt abandoned, that they were taking risks that other professionals were not

AS
NHSE recognise that there was a mistake about redeployment of the vulnerable children's workforce – which was addressed and reversed. There was also an inequity in areas of the country.

MF
How not to lose the gains whilst focussing on the losses
Some interesting needs to find new strategies: "what to do when you find yourself in bed with your patient?!" lots of boundary issues
Need to provide more resources to schools; location not staff – already barriers to workforce feeling the need to do more
Will look at children who feel safe at home, and safe at home

AS
Lots of schools did excellent work supporting vulnerable children
Loss of travel time vs "Team fatigue"

Juggling home and work
Universally identified as an issue
Supervision opportunities lacking
watercooler moments - bumping into other professionals
Young police felt unsupported
House prices high in London – live in small places, impact of housing – people working on their bed for 3m
Isolating staff – different local authorities using different strategies – most debate as to what could be done in the future?

Those early in their career or in an organisation have fewer network to draw on
Need to identify specific groups e.g. those with dependants at home
Changing rules e.g. do not socialise with your group outside work so that the team is resilient to being pinged
Burden on performing research at home

General practice (GF)
Challenges around remote working, especially supporting families and survivors – initial access for patient is harder, correlating in reduction of numbers of referrals
Who else is in the room?
Access – an issue pre-pandemic and harder now
Signposting for support – perception that services were closing both by patients and GPs
Personal anecdote of receiving disclosure felt would not have come about otherwise

JD
Nobody knew that Early Help was still in place – confusion about provision, how to access

Disclosures from people being seen alone
Positive maternity services
but not seeing fathers, e.g. with fathers and ICON

AS
Information from RCPCH
Wished to continue to deliver education and support as well as workplan, yet still respond to pandemic
Advice to Named Doctors – principles – how do issues affect all children and young people, as well as those known, those hidden and becoming more hidden
Impact on school closures
Impact of LAC and contact with parents; IHAs
Impact on young carers
Guidance+ created
Co-working with RCGP on working remotely
Engagement officer obtained children's views
Rapid changes within the workforce
How to obtain real-time data in future? responding to need
Have there been more serious head injuries? And accidents? – no answers no data
Matching people with clinical and strategic experience with research experience

Where next?
CP summarised
What or who is missing?
Police, education, **children and young people and families,** young carers
Needing to support practitioners and researchers
Thinking laterally and innovatively
JD has some information on what schools did to keep in touch with children: food parcels, doorstep visits
What support was given to teachers? Gaps in knowledge here – would be useful to do especially going back in September 2021
RCPCH – could collect the view of CYP through engagement team
Third sector research: NSPCC, Barnardo's etc
"community level safeguarding" – new collaborations with the 3rd sector during the pandemic

A model of supervision that can be shared? Pressures of safeguarding practitioners and this is the support that is to be provided – policy guidance
Link with research and practice looking at unmet needs

Mapping learning – power of professional kindness – and silos flourish when people are beleaguered

Ethics
Kindness

St Benedict: Be careful to be gentle, lest in removing the rust you break the whole instrument

Attempt to pull out themes…

Complexity and severity of referrals have both increased since the onset of the pandemic – what will be the impact on children, the care system, foster carers, professionals?....
How can we support each other? What do safeguarding professionals need/expect?
How not to lose the gains whilst focussing on the losses
Access and accessibility
The perception gap between what other services do and what other agencies think

So what and what next?
What would add value?

If we learnt things that promote trust between families and between professionals, how do we find out what they are and share them further?

Appendix B Minutes from meeting 2:

Multiagency working to protect vulnerable children in the COVID era: What have we learnt? What should we do now?

Via zoom, 28.09.21

Participants

Sharon Dixon: GP, Nuffield Dept of Primary Care health sciences, University of Oxford

Bryony Kendall: Named GP for safeguarding Liverpool

Joy Shacklock: RCGP safeguarding lead, Named GP for safeguarding Harrogate

Jennifer Ginger: DPhil student at Oxford studying adoption and on the board for CoramBAAF

Catherine Pope: medical sociologist and group lead in Nuffield centre in Oxford

Jenny Driscoll: child protection barrister now in academia, part of MDT at Kings College London (KCL)

Yiwen Zhang: grad student in psychology at Oxford

Jane Birchenough: safeguarding lead at Rose Hill Primary School, Oxford

Harry Ferguson: Professor social work, University of Birmingham

Tracey Taylor: Thames Valley Police child protection unit

John Simmonds: director of policy for Coram BAAF

Chloe Mercer: grad student in education at Oxford

Alison Steele: Consultant Paediatrician and Officer for Child Protection RCPCH

Gene Feder: GP, lead for domestic violence research group at University of Bristol – apologies

Introduction from Sharon

- Learning from her own work, looking for evidence in only general practice, let alone health
- Safeguarding is multi-agency in essence so make sharing learning multi-agency too

JD: how communication between agencies changed during the pandemic

JB: 17% children supported by CPP or TAF

JS: developing toolkits and policy

HF: monthly interviews of 48 practitioners of experience of protecting children during the pandemic, practice focussed, April to December 2020

JG: research on adoptive parents who also have birth children

Voice of young people

Capturing through NSPCC and RCGP book group

Professional-client encounters

Pros and cons in all of the research, challenges between individuals we care for

Between silos and within silos

Positive issues with digital ability to rapidly arrange meetings

Including parents and carers – family time of children being taken into care being restricted due to the pandemic – long term implications

Police taking statements over the phone, with 50% presence in the station

Impact on professional well-being

Less explored

Perception gap – between frontline workers and senior Mx

Role of agency decision maker (ADM) – e.g. if adoption is long term plan – reviewing all evidence provided - judge described this person as “naïve and simplistic”, lack of corridor conversations for clarifications affecting competence and confidence

Challenges of access to informal peer support: water cooler moments

Risk of death due to going to work new for most

Retention of staff becoming a real problem for the future – risk is rising as we hold more uncertainty

Uncertainty about hearing VOTC

What have I missed and what have I not seen?

Compounding of inequalities including digital

Different rules for assessment by frontline practitioners e.g. social worker and police (wearing PPE) and usually in the garden

Organisational and governmental guidelines

Interpretations differed e.g. PPE wearing

Systemic risk and regulatory framework – moral injury from (Ofsted) inspections continuing and perception of blame culture

Physicality of how children communicate

When the child runs off on zoom does someone follow them with a camera? Capturing their physical nature not just their *actual* voice

Impact of friendships – and lack of social interactions missing school

Vulnerable children and schools

LA stated key-worker and vulnerable – so who should be invited in to school?

Impact of food poverty

Digital inequalities – “families of 12 using 1 phone to access google classrooms”; donated chromebooks not accompanied with internet access

Decision to clap eyes on every child in the school – “decisions made on the doorstep”

Uncertainty of vulnerability – in educational context and in medical context

Feelings and fears of parents

Schools feeling beleaguered

Themes arising from DA work

Safety: who is off screen? How much of the story are we getting?

Police taking statements – “as far as we know people are on their own” – appointments made in advance for adults

Interactions between people present

Those families just about coping before the pandemic and it pushed them over the edge

People (GPs) became keener to learn how to deal with issues – more engaged with safeguarding education

SW role broadened as often the only people going into homes “social work had a good pandemic, children’s social work emerged stronger due to innovation and energise, responding to the challenge, finding a voice”

“The politics of affirmation is messy and dirty” – admittedly complicated

Review of research

What we could we do with what we are hearing?

- How can we join up the learning and perspectives of people doing the multi-agency work supporting children? ('silo-busting')
    - What further knowledge and perspectives will help? Who do we need to still hear from?
    - How can we share learning and experience?

What can (should) we do that could help break down 'silos' in safeguarding?

When things get tough, people become more silo-ed

Looked for policies acorss and between agencies in the pandemic

Little crossed barriers, evidence presented in silos

Breaking Down Silos: Education & Safeguarding

- Lower call rate to child protection duty teams
- Impacts of the move to safeguarding partnerships by 2019. While these 'partnerships' are still able to join with relevant agencies (including schools) did not place education at the heart of the safeguarding process.
- Vulnerable children offered places in school during lockdown - highly variable take-up (DfE)
- Emotional burden of responsibility for vulnerable children in the pandemic; an augmented sense of responsibility for welfare due to reduced contact; takes control away from staff ; consequences of this when caregiving = central part of identity?
- Child safety, protection, and safeguarding in the time of COVID-19 in GreatBritain: Proposing a conceptual framework Diane Thembekile Levine[a] JulieMorton[b] MichelleO'Reilly[c]]

Policing in the pandemic published April 2021
https://www.justiceinspectorates.gov.uk/hmicfrs/publications/the-police-response-to-the-coronavirus-pandemic-during-2020/

Breaking Down Silos: Examples: Police & Safeguarding

- Extended their remits and worked flexibly
- Police continued to work with Operation Encompass
- Visited vulnerable families
- Worked with childrens' services
- Worked with/supported probation staff

Is this ”breaking down silos" or a "short-term emergency" fix? (Police were out in the community vs WFH directive so more able to step in?)

Is this sustainable or desirable? Where do the resources come from?

Breaking Down Silos: How do we do this?

Childrens' Commissioner's Office – lack of communication had a negative impact on vulnerable children

House of Lords report (2020) - a critical juncture for public services:

- Communication and cooperation: central Government and national service providers and local service providers
- Working together at local level – supported by working together at govt dept level – including information sharing
- Become more resilient and withstand future crises – address tendency for service providers to work in silos

Is the only way to do this to get the Government involved? (But the Government chose not to provide oral evidence for the HoL report). How else might it happen?

General practice – information overload –which would explain reinforcing staying in silos

The expectation is there: everyone has responsibility but no-one has complete control, and there aren’t resources in place to support early identification: need for a realistic conversation: “we can’t do what we want to do to protect children”

10 years of austerity has had a significant impact – and no easy solution

Families under stress and in distress (bereavement, parental conflict, school) – system based on trust and confidence

Safeguarding system is risk-averse and compliant, with an investigative approach – with many examples of where professionals get it wrong and someone dies

Information sharing

- ongoing issue
- high support for a formalised pre-agreement for all agencies from strategic leads
- need for shared understanding of what agencies hold
- especially with children people want access to parental records – when their Hx of trauma is brought up this can be re-traumatising – GPs can share with IRO rather than the whole CP conference
- usually considered as a failure to share, especially at a lower level

Moral injury

Practitioners working at capacity

Especially not being able to contact other professionals ("the SW has not shared the history with me")

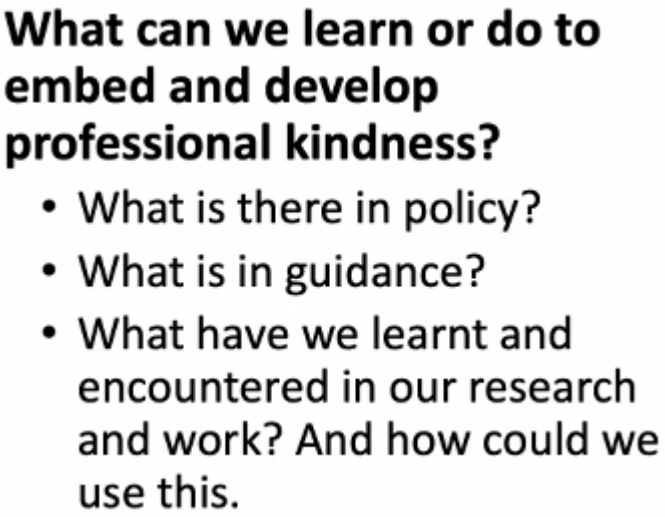
Who is responsible for the risk and who is going to do something? The risks were not shared equally amongst agencies

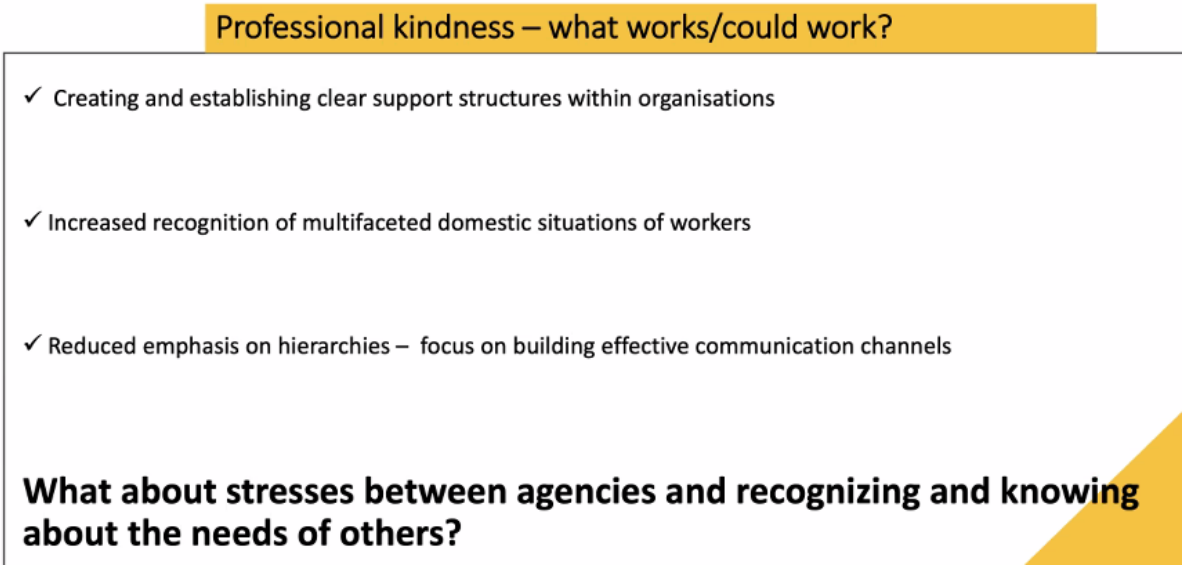
Working in isolation

The challenges of the interface is often around IS between agencies

Positively progressing the learning

The intercollegiate documents are due to be revised – what do we want health staff to know and focus on? Especially around information sharing.



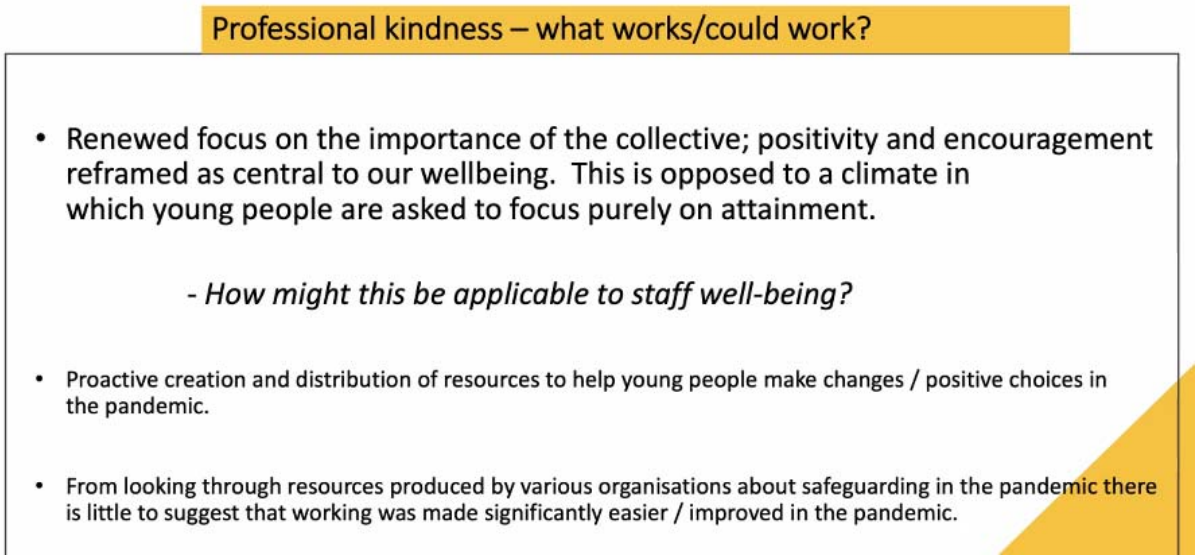


Who is consistently familiar and working with the families?

Ability to identify your own stress and that within the organisation

Layers of organisations able to use their voice

People not aware how different agencies were responding to guidance



From schools: focus on positivity – how use in work?

Care for Staff

- Covid-19 related risk-taking is not just an individual choice but systemic - e.g. sector-specific best practice guidance on the use of PPE that engages with the realities of social work interactions.
- Develop guidance and share best practice on the use of face masks
- Importance of peer support and informal interactions with colleagues, as well as formal supervision, in managing the emotional demands of the role of care providers and the pandemic.
- Example of how workplaces can provide support: rotas and other workplace distancing measures to allow groups of colleagues to work together safely, opt-in occasional office attendance, 'well-being desks', socially distanced walks and outdoor meetings, online catch-ups and team WhatsApp groups.

Brighton and Sussex – quality circle

Multi-agency working with courts, health and LA

Discuss one topic at a time – "everybody has to agree that they will listen to, agree, acknowledge and reflect on what is brought"

No criticism

Promotes an open-ness

Reflective supervision

Schwartz rounds?

Being and doing: bearing witness but needing witness protection - the people who hold the families – who will hold them? And how is this hard-wired into training for juniors?

"Resilience has been weaponised"

What should we hang on to and what should we jettison?

HF: this conversation itself has been hugely important "I've never been in a meeting with three GPs in the room". Recognise the restrictions of covid.

AS: recognition of good practice by staff during pandemic. Digital enabling of staff for multi-agency working. Listening is a core skill.

JD: efforts of schools made is some ways strengthened relationships between schools and families. How we build on these? Issues for children with their families and remote access for contact. Early help was hard to access, making it hard to build trust.

BK: intersectionality, multi-agency working, framing safeguarding as public health, compassionate leadership including boundaries, honest conversations, give people hope for recruitment and retention

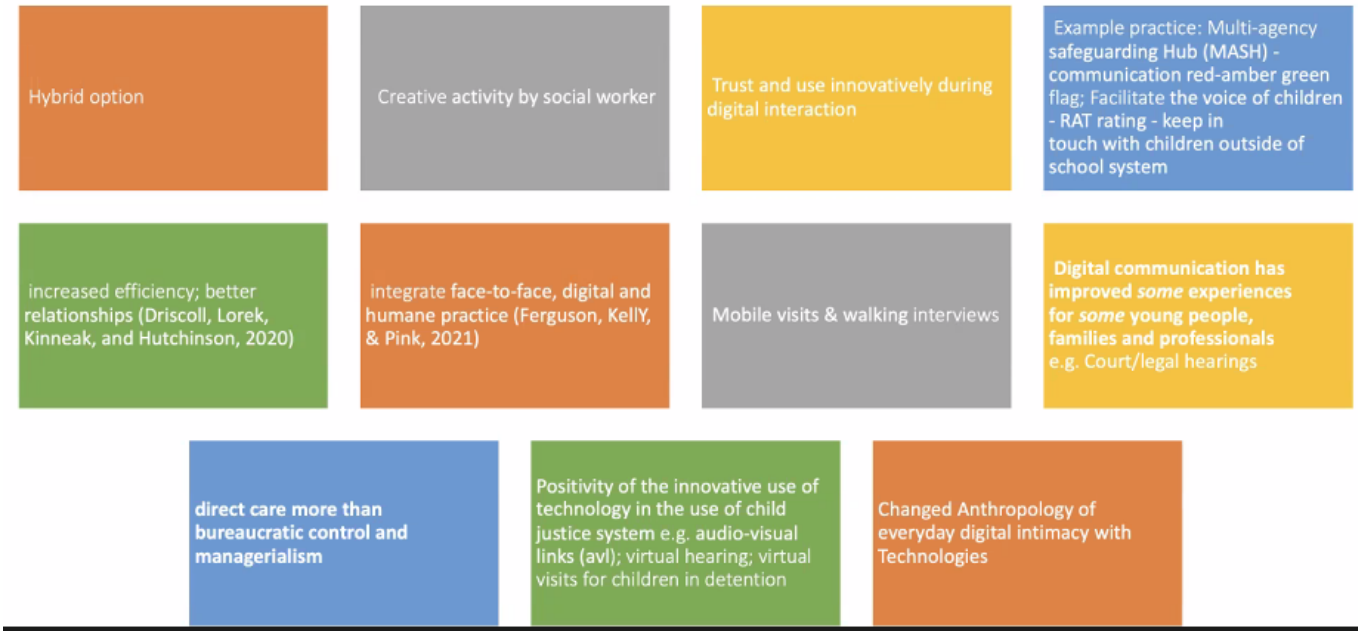
JS: reflected on a judge who moved from being a decision maker regarding children coming into care, to facilitating a discussion, using the court in problem-solving to help parental addiction – giving the parents a chance to be listened to

JSH: are we setting people up to fail during safeguarding training? The resources are just not present. Relationship building between professionals and with families

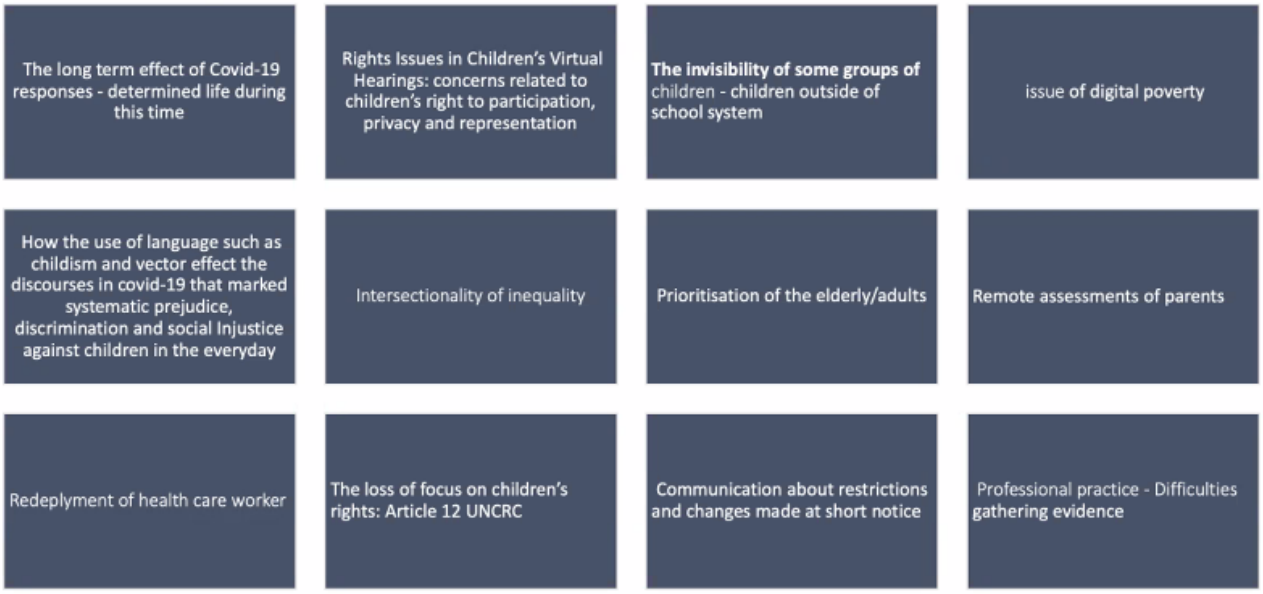
Concrete deliverable: report will be on https://www.gtc.ox.ac.uk/academic/health-care/sheila-kitzinger-programme/

Scholar Map

Positives



Negatives



The intersectionality of inequality

Multi-agency working Recommendation Practices

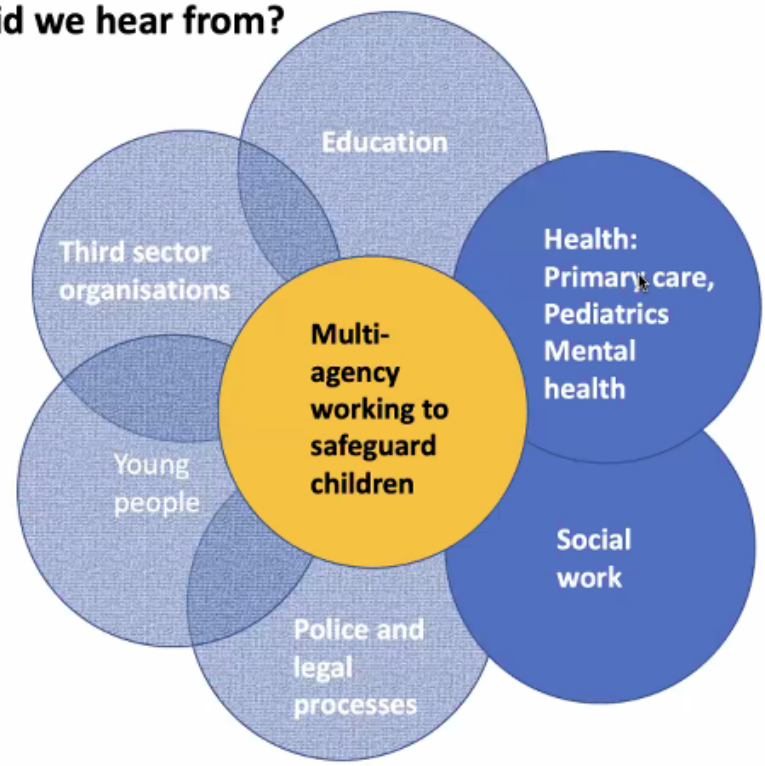
- Introduction of a system to share pre-agreed information relating to Safeguarding children
- Joint risk assessment
- Safeguarding related training
- Careful redeployment of critical safeguarding nursing staff
- Recognize staff well-being

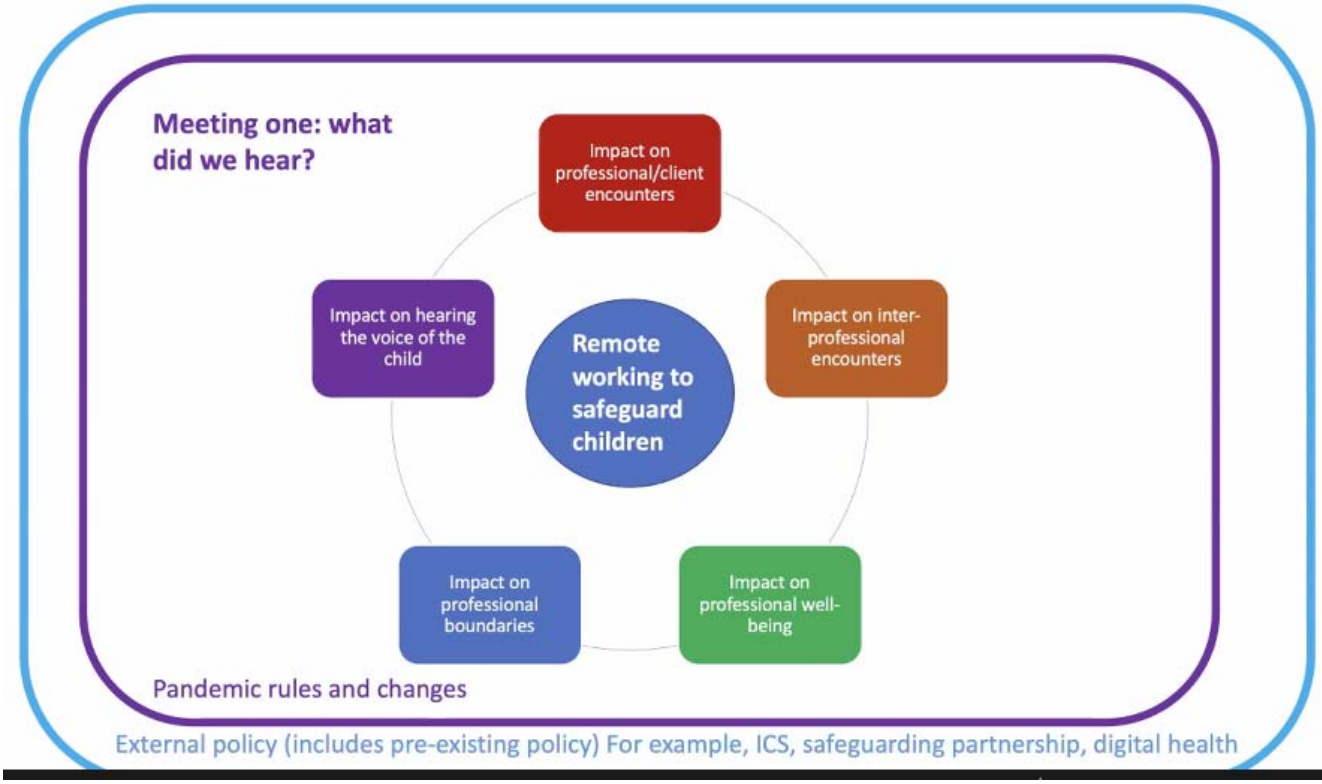
Children in Justice system practices

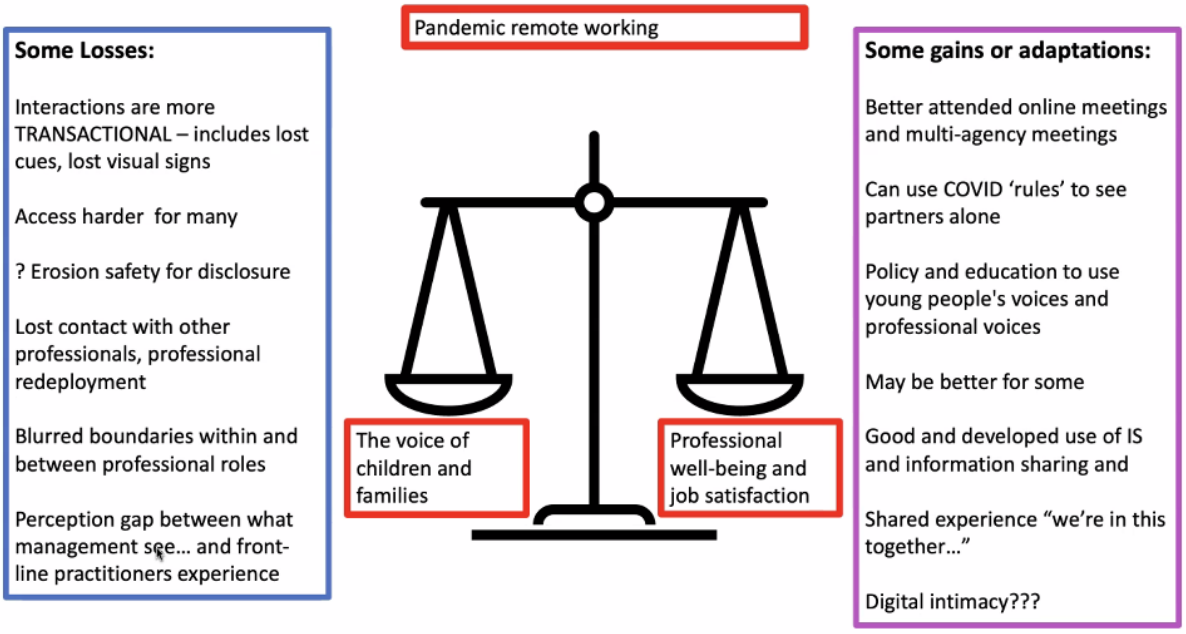
- tailored and easily understood guidance produced by Talking Trouble (2020)
- universal & early help service
- take an intersectional lens to explore how racism, sexism, ableism and childism intersect in the marginalisation of children in different contexts.

Appendix C First meeting slides:

Meeting one: Who did we hear from?

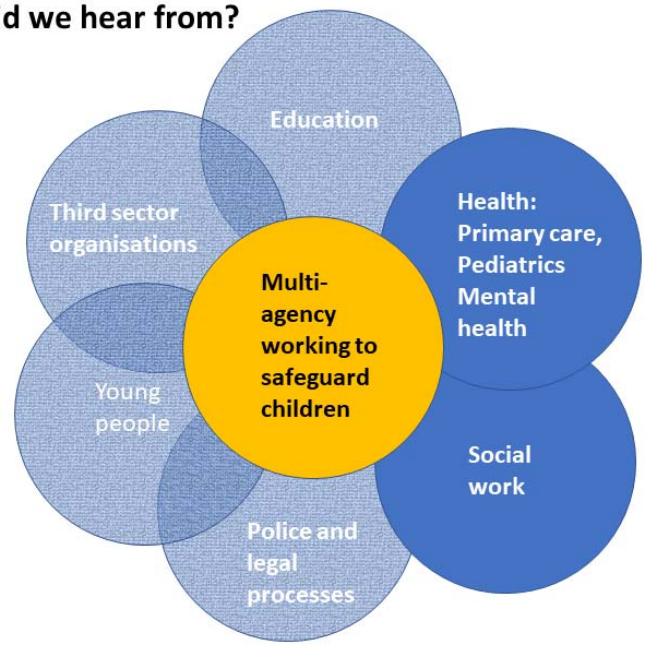


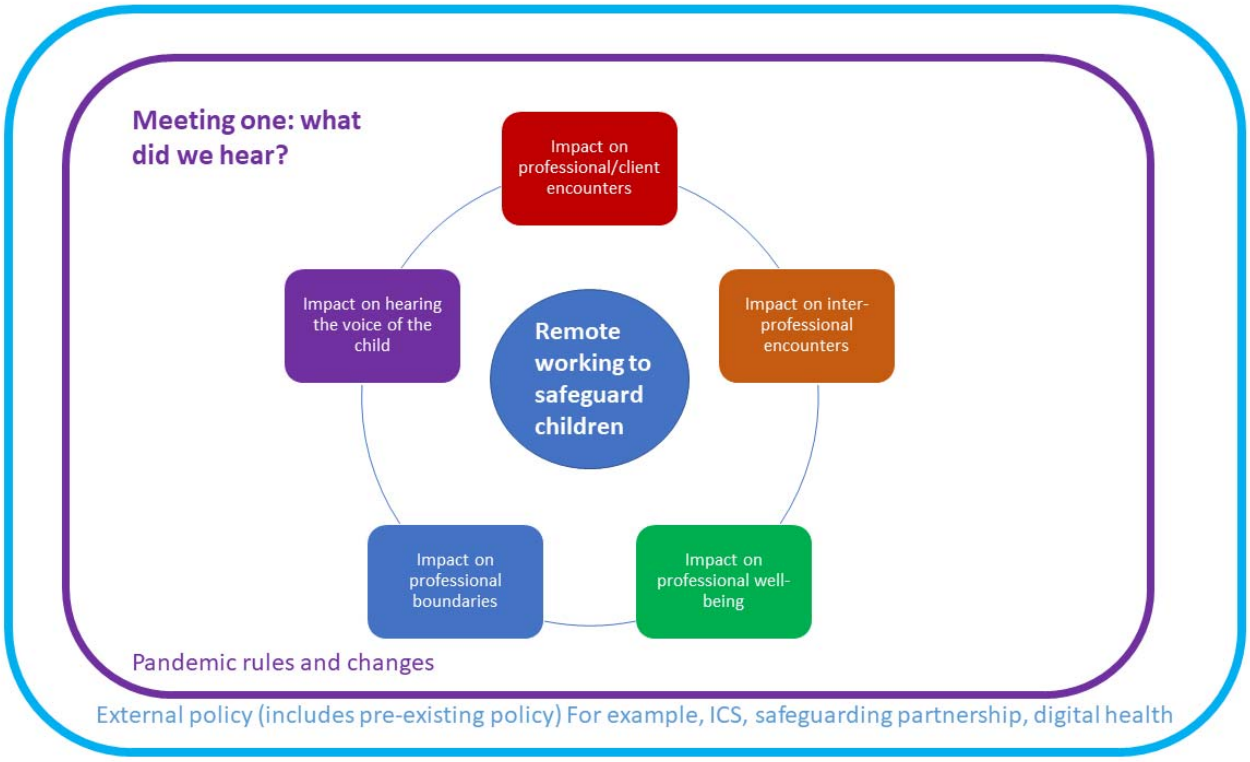




Appendix D Final meeting slides:

Meeting one: Who did we hear from?





Some Losses:

Interactions are more TRANSACTIONAL – includes lost cues, lost visual signs

Access harder for many

? Erosion safety for disclosure

Lost contact with other professionals, professional redeployment

Blurred boundaries within and between professional roles

Perception gap between what management see… and front-line practitioners experience

Pandemic remote working

Some gains or adaptations:

Better attended online meetings and multi-agency meetings

Can use COVID 'rules' to see partners alone

Policy and education to use young people's voices and professional voices

May be better for some

Good and developed use of IS and information sharing and

Shared experience "we're in this together…"

Digital intimacy???

Meeting 2 Outline

- Introductions
- Quick reminder about what we discussed during meeting 1….
- Then onto the three questions that we decided upon for further reflection and discussion at the first meeting.
- Finally – what next? What outcomes would help? Research? Shared publications? Blog? Guidance? A further meeting

Our work since Meeting 1

- Research
- Policy
- Education and young people
- Looking for gaps
- Examples of where we have looked and what we have done
- Looked under headings/questions from last meeting
- We have been collating this and they are working together to present overarching findings
- Report to follow

Question 1: 4.30-5.05

- How can we join up the learning and perspectives of people doing the multi-agency work supporting children? ('silo-busting')
  - What further knowledge and perspectives will help? Who do we need to still hear from?
  - How can we share learning and experience?

What can (should) we do that could help break down 'silos' in safeguarding?

Breaking Down Silos: Education & Safeguarding

- Lower call rate to child protection duty teams
- Impacts of the move to safeguarding partnerships by 2019. While these 'partnerships' are still able to join with relevant agencies (including schools) did not place education at the heart of the safeguarding process.
- Vulnerable children offered places in school during lockdown - highly variable take-up (DfE)
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- Become more resilient and withstand future crises – address tendency for service providers to work in silos

Is the only way to do this to get the Government involved? (But the Government chose not to provide oral evidence for the HoL report). How else might it happen?

Question 2: 5.15-5.50

- **What can we learn or do to embed and develop professional kindness?**
  - What is there in policy?
  - What is in guidance?
  - What have we learnt and encountered in our research and work? And how could we use this.

Professional kindness – what works/could work?

- ✓ Creating and establishing clear support structures within organisations
- ✓ Increased recognition of multifaceted domestic situations of workers
- ✓ Reduced emphasis on hierarchies – focus on building effective communication channels

What about stresses between agencies and recognizing and knowing about the needs of others?

Professional kindness – what works/could work?

- Renewed focus on the importance of the collective; positivity and encouragement reframed as central to our wellbeing. This is opposed to a climate in which young people are asked to focus purely on attainment.

  - How might this be applicable to staff well-being?

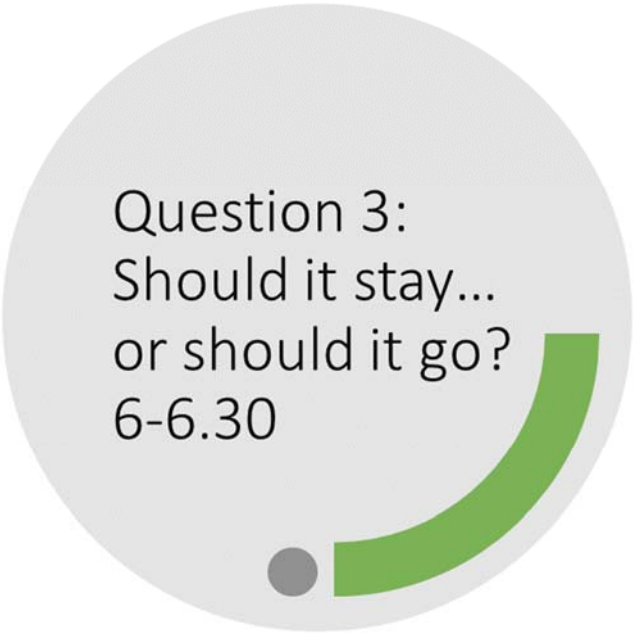
- Proactive creation and distribution of resources to help young people make changes / positive choices in the pandemic.
- From looking through resources produced by various organisations about safeguarding in the pandemic there is little to suggest that working was made significantly easier / improved in the pandemic.

Care for Staff

- Covid-19 related risk-taking is not just an individual choice but systemic - e.g. sector-specific best practice guidance on the use of PPE that engages with the realities of social work interactions.
- Develop guidance and share best practice on the use of face masks
- Importance of peer support and informal interactions with colleagues, as well as formal supervision, in managing the emotional demands of the role of care providers and the pandemic.
- Example of how workplaces can provide support: rotas and other workplace distancing measures to allow groups of colleagues to work together safely, opt-in occasional office attendance, 'well-being desks', socially distanced walks and outdoor meetings, online catch-ups and team WhatsApp groups.

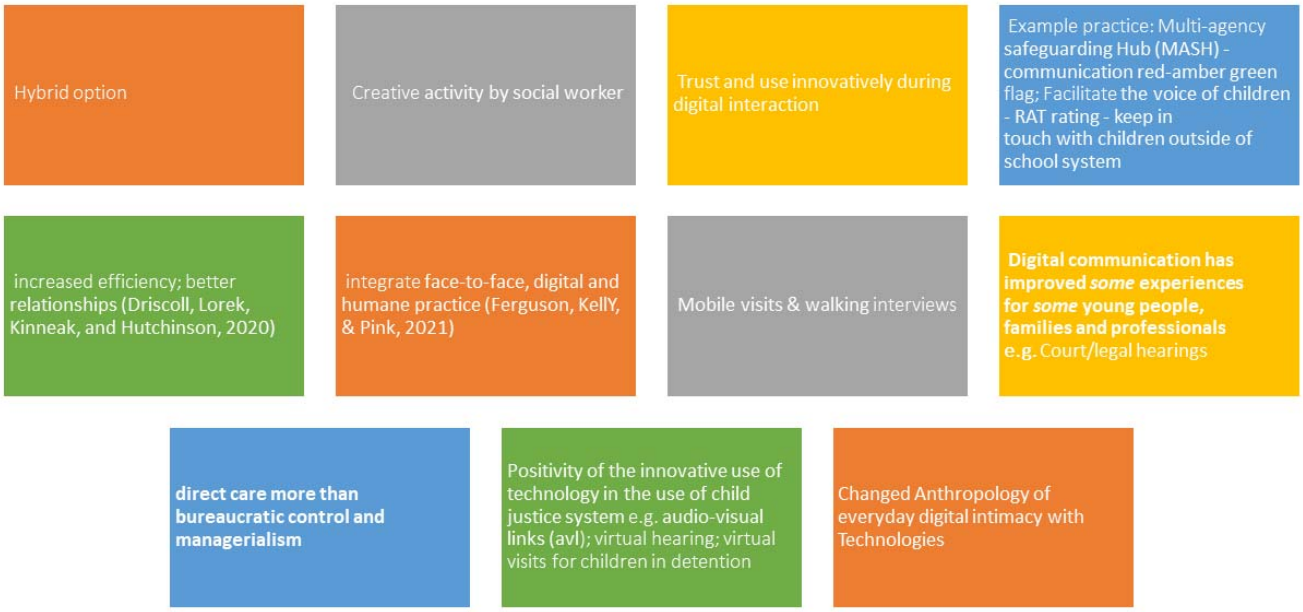
- That's it really. What should we keep? And what do we want to leave or let go of?
  - How can we use and keep the good things we have learnt?
  - What have been the unintended consequences or adverse things that we have learnt?

'St Benedict: Be careful to be gentle, lest in removing the rust you break the whole instrument'



Scholar Map

Positives



What to keep?

Negatives

The long term effect of Covid-19 responses - determined life during this time	Rights Issues in Children's Virtual Hearings: concerns related to children's right to participation, privacy and representation	**The invisibility of some groups of** children - children outside of school system	issue of digital poverty
How the use of language such as childism and vector effect the discourses in covid-19 that marked systematic prejudice, discrimination and social Injustice against children in the everyday	Intersectionality of inequality	Prioritisation of the elderly/adults	Remote assessments of parents
Redeployment of health care worker	The loss of focus on children's rights: Article 12 UNCRC	Communication about restrictions and changes made at short notice	Professional practice - Difficulties gathering evidence

What not to keep? What should change? (example)

- **COVID Bookclub:**
  17% of young people are not happy that exams have been cancelled, as it feels like they won't get the end they had planned to their school life, with others feeling that everything they had worked for was now going to waste. *what can be done to rectify this?*
- Some people talked about issues with access to online education because of not having a computer or sharing one device with lots of other people in their home or having faulty equipment. Young people said they feel that they are now further behind because of their disabilities due to online education, like having dyslexia and not having 1:1 support anymore.
- A key thing is that there hasn't been the same help or support from every school to every child or young person, which has made some feel unhappy about the support they have received.

  [https://www.rcpch.ac.uk/resources/covid-19-summaries-key-findings-children-young-peoples-views#theme-2---education]

  Increase access to **mental health services** to support children and young people impacted by the pandemic.
- Young people claim to be impacted by not being able to access 1:1 support throughout the home learning period.

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Children in Justice system practices

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- universal & early help service
- take an intersectional lens to explore how racism, sexism, ableism and childism intersect in the marginalisation of children in different contexts.

What not to keep...

- Communication about restrictions and changes made at short notice – if any – difference between legislation and guidance unclear – not much time to brief staff.
- Variability in how contact centre staff assessed the risks of pandemic for people who were vulnerable. – there were predictable additional risks e.g. MH or more instances of online CSE
- Police officers had to spend more time with vulnerable people in A&E
- Difficulties gathering evidence
- Children spent more time in police stations for extended periods under police protection due to lack of emergency accommodation

What to keep?

Digital communication has improved *some* experiences for *some* young people, families and professionals e.g.

- Court/legal hearings – if there is good support for children remote work can reduce the trauma caused by a court visit, but care must be taken to ensure full understanding. Some children have reported feeling uninvolved and trust relationships affected eg. unable to speak privately with lawyer. Easier involvement of experts e.g. psychiatrists
- Family visits to children in detention or contact visits – child can see more family members and more of normal family life
- GP vulnerable families list – designated team members phoned people as a good back up but this cannot replace face to face.
- Innovative ways of staying in contact: besides phone calls to families, professionals met with people in parks/gardens, going for walks etc.
- Where there is a shared risk assessment accessed by multiple services/professionals there can be shared responsibility/action plans – not just all sitting with children's social care or schools.

But these are dependent on access to/supply of technology and support (including good smart phones for work for professionals – esp. social workers)

What not to keep? What should change?

X Prioritisation of the elderly/adults over children (Adam and Dineen paper)

X Remote assessments of parents

X Sacrifice of early help services for statutory services during a crisis. (Early help facilitates the voice of the child and can prevent escalation)

X Midwifery and health visitor services being redeployed.

X The loss of focus on children's rights: Article 12 UNCRC – (Lundy 2007)

- Space: providing opportunities for children to express their views
- Voice: facilitation of that expression
- Audience: the requirement that adults listen and give due weight to children's views
- Influence:the appropriate action in response to the child's views

Police Safeguarding Children in the Pandemic: What worked ?

- **Accelerated and wider use of technology** reduced travel time for officers and staff, improved attendance by everyone at meetings, leading to more coherent and robust decision-making
- **Training staff** in how vulnerability may be hidden
- **Vlogs updating officers and staff on how to spot and act on concerns** - PEEL a call for help. Public messages: eg. poster "At home shouldn't mean at risk".
- **Reports by 3rd parties of vulnerability incidents increased** – people were spending more time at home so noticed more things.
- When demand reduced for some services, **staff engaged with children at risk** of exploitation using audio and video tech – lead to some children more engaged with safeguarding professionals.
- **Reallocation of staff** to focus on online paedophile investigations where possible or nighttime policing reallocated to more **policing of communities at risk.**

'Hidden Children'

- The invisibility of some groups of children, enhancing access to and quality of communication; Attention to processes and mechanisms; voices of all children (Driscoll, Hutchinson, Lorek & Kiss, 202)
- Facilitate the voice of children - RAT rating - keep in touch with children outside of school system
- digital inequality (Pink, Ferguson & Kelly, 2020) - support of digital devices for staff
- Facilitate the voice of children - RAT rating - keep in touch with children outside of school system

Meeting 2 Closure

WHAT NOW?

WHAT CAN WE DO NOW?

Appendix E Bibliography

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Useful references and reading suggestions