NIHR | Policy Research Unit Children and Families

The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk of poor outcomes or who have complex social needs

Stage 2 findings

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About

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Funding

Authors

Jane Barlow; Anders Bach-Mortensen; Olha Homonchuk; Jenny Woodman.

Contributors

Acknowledgements

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Introduction

In Stage 1 of this study we conducted a survey of 871 professionals (74% health visitors; 6% midwives; 7% social workers; and 11% community paediatricians) delivering or commissioning (n=44) community-based services to preschool children across England. We found that the changes to practice that were implemented in response to the outbreak of SARS coronavirus-2 (SARS-COV-2) were perceived to have increased the risk to children living in families dealing with complex problems (and in particular those just below the threshold for children's social care) as a result of their 'invisibility', and to have increased stress on staff. We made interim recommendations about a) contact with families; and b) planning and co-ordination of community-based services supporting preschool children in families with complex needs (see Appendix 2). Stage 2 of this study used interviews to explore the survey findings in more detail and to identify practitioner's views about changes needed going forward.

Methods

Twenty in-depth interviews were conducted virtually using Microsoft Teams, with a sample of respondents who took part in the first stage of the research, and who consented to be contacted to take part in an interview. The aim of these interviews was to explore in more depth, some of the issues raised in the national survey, and were not as such, intended to be representative of the views of all practitioners. A similar number of respondents for each professional group were selected randomly from those consenting to take part in an interview, and invited to take part by email. Where there was no response within the required timeframe, replacement with the next random consenting practitioner was then made, until data saturation was reached (i.e. no new themes emerged). This resulted in a sample comprising four commissioners and one provider manager of health visiting services, six health visitors, four social workers, three midwives, and two community paediatricians. A semi-structured interview schedule was used, and data were fully transcribed and a thematic analysis was conducted.

Key findings

Two overarching themes were identified, each with a number of subthemes: **1) The realities of safeguarding vulnerable preschool children in the current context** including: a) pandemic-related factors; b) the managerial response to the pandemic; c) the pre-pandemic erosion of services as a result of the austerity measures; **2) Suggestions for urgent changes going forward in terms of addressing the secondary impact of the pandemic on vulnerable preschool children** including in the _immediate term_: a) the reinstatement of key services with appropriate measures to enable safe face-to-face visits; b) the restoration of wider services that play a key role in supporting families with complex problems; c) an urgent review of all vulnerable preschool children who have been 'invisible' during the pandemic; d) a continuation of the improved collaborative and holistic working established during the pandemic; and in _the long-term_ a) reinvestment of significant funding in early intervention services; b) a review of the Key Performance Indicators used to monitor health visiting; c) changes to the commissioning processes (e.g. longer tendering cycles; integrated cross-boundary commissioning; jointly owned outcomes). The limitations of this stage of the research include small numbers of interviewees in some professional groups (i.e. midwives and community paediatricians), and the self-selected basis of the sample.

However, the findings confirm those of Stage 1, which were based on responses from 905 professionals.

Key recommendations (some of which have already been addressed by the changes issued by NHS England at the end of July 2020)

Emergence from lockdown: a) all services supporting vulnerable families with preschool children be re-instated as a matter of urgency (including face-to-face with appropriate protection); b) plans be put in place for urgent review of all known vulnerable preschool children and children new to the service; c) practitioners be consulted about all future changes to working practices (see below).

Implications for future lockdowns: a) future lockdowns take account of the potential impact of changes to practice on children; b) frontline practitioners with key roles in safeguarding vulnerable children should not be redeployed; c) face-to-face visits/clinics (with necessary protections) for all vulnerable families should be continued by practitioners delivering statutory services; d) virtual services should only used with this population in the event of exceptional family circumstances; e) face-to-face wider services should continue to support high risk caregivers (e.g. with mental health or substance use problems and domestic abuse); f) frontline staff should be consulted and involved in all decision-making with regard to changes in practice; g) pre-existing challenges (see below) should be addressed in order to make the service more robust to future lockdowns.

Executive Summary

Context

Following the outbreak of the SARS coronavirus-2 (SARS-COV-2), the UK Government announced a range of 'lockdown' restrictions and an Emergency Preparedness, Resilience and Response plan (EPRR) that were aimed primarily at limiting the spread of the disease and strengthening NHS capacity to treat infected patients (primarily adults). In response to these, the NHS produced guidance regarding the prioritisation of services delivered both in hospital and the community. This guidance required significant change to the practice of all key health and social care practitioners, including a "partial-stop" to contact in terms of the delivery of routine services, and the delivery of prioritised contacts using virtual methods, with face-to-face contact in the home or clinic only being provided when there was a 'compelling reason' to do so.

The results of Stage 1 of this study, which involved a rapid survey of professionals delivering and commissioning services to the above population across England, showed that the above guidance was perceived to have increased the risk to vulnerable children (i.e. living in families with complex social problems; preschool children with disabilities, or on the edge of care or designation as Children in Need; and Children on Child Protection Plans), and in particular those just below the threshold for children's social care, as a result of their 'invisibility', and to have increased the stress on staff. A range of interim recommendations were made.

Methods

The second stage of this study involved in-depth interviews with a sample of survey respondents who volunteered to take part. The aim of these interviews was to explore in more depth, some of the issues raised in the national survey, and they were not as such, intended to be representative of the views of all practitioners. Twenty in-depth interviews were conducted virtually using Microsoft Teams, with a sample of respondents who took part in the first stage of the research, and who consented to be contacted to take part in an interview. A similar number of respondents for each professional group were selected randomly from those consenting to take part in an interview, and were invited to take part by email. Where there was no response within the required timeframe, replacement with the next random consenting practitioner was made, until data saturation was reached (i.e. no new themes emerged). This resulted in a sample comprising four commissioners and one provider manager of health visiting services, six health visitors, four social workers, three midwives, and two community paediatricians. The interviews aimed to explore the findings of the survey in more depth, and in particular, the issues encountered in safeguarding vulnerable preschool children following the guidance relating to social distancing; their views regarding the steps that were needed going forward both in the short and longer-term; and the impact of wider service context prior to the pandemic. The interviews were semi-structured and based on a topic guide that served as a prompt to questioning, and that built on the findings of Stage 1 of the study (see Appendix 1). The interviews were conducted over the telephone and ranged from 25 to 95 minutes. All interviews were recorded and transcribed verbatim, and a thematic analysis was undertaken.

Findings

Part 1: The realities of safeguarding vulnerable preschool children in the current context

There was consensus across the interviews that the ability of practitioners to safeguard vulnerable preschool children during the pandemic had been significantly impacted by three sets of factors, all of which confirmed and extended the findings of Stage 1 of the research:

1. The way in which children were **rendered 'invisible' due to the changes to practice instigated in response to the pandemic, and in particular:**
   - the impossibility of satisfying the requirement to 'continue practice as usual' on the part of social workers, in the absence of adequate PPE and guidance;
   - the way in which the requirement to conduct virtual visits on the part of key frontline safeguarding practitioners in addition to the loss of universal services, undermined their ability to a) identify and b) assess vulnerable children, and in particular newly emerging vulnerability and those below the threshold for social care services;
   - an increase in the caseload of an already overburdened workforce following redeployment and increased sickness levels;
   - the extensive shutdown of many services providing face-to-face support for families with complex problems (e.g. alcohol/substance misuse and mental health problems) in conjunction with increased levels of risk to vulnerable children due to increased poverty and domestic abuse.

2. **The government/management response to the pandemic** including:
   - a high level of 'micro-management' which was felt to have a) added significantly to practitioner workload; b) prevented them from delivering the service that was needed;
   - a lack of central co-ordination and regional variation, which meant that practitioners such as social workers did not know whether they were still meeting their statutory legal requirements;
   - a redeployment processes in which key frontline healthcare practitioners (mostly health visiors) had either volunteered or were sent to work in other areas, and for which some felt that they had no expertise and inadequate preparation, and that were perceived in the case of health visitors, not to have utilised their public health skills.

3. **Pre-pandemic issues related to the impact of austerity measures on services** including:
   - the erosion and devaluing of practice including the loss of most preventive work with families on the edge of care and all 'meaningful' (i.e. as opposed to tick-box) work with complex families;
   - practice that was perceived to be driven largely by a 'tick-box' culture;
   - unacceptably high caseloads;
   - key monitoring targets (KPIs) for health visitors that were felt to distort practice and prevent them from identifying vulnerabilities;
   - an inability to commission the services needed and to deliver the Healthy Child Programme in full.

Part 2: Urgent changes needed to safeguard the wellbeing of children

A range of urgent changes were identified by practitioners and commissioners in the immediate and longer term, some of which have already been made by the changes issued by NHS England at the end of July 2020,[1] including: reinstatement of key services with appropriate measures to enable face-to-face visits to be conducted safely; reinstatement of wider services for families with appropriate protection to enable visits; an urgent review of all vulnerable preschool children and those previously not known to services who have been invisible during the pandemic and are likely to have had their needs and vulnerabilities missed; a continuation of the improved collaborative and holistic working. Other more long-term changes focused on the need to address pre-existing challenges in order to make the service more robust to future lockdowns including reinvestment of funding in early intervention services that are focused on addressing the secondary effects of the pandemic; more upstream work to enable practitioners to prevent potential problems becoming a crisis; better support for preschool children on the edge of care; more intensive working with families with complex needs; a review of the Key Performance Indicators used to monitor health visiting to better reflect the work undertaken by health visitors and in particular with vulnerable families; changes to the commissioning process.

Recommendations

The following recommendations are suggested for local authorities and providers in addition to NHS England, PHE, and DHSC to consider taking forward, based on an integration of findings from the survey and in-depth interviews and with reference to revised guidance about restoring community health services issued by NHS England in July 2020, which affirms some of the recommendations.[1]

Emergence from lockdown
- **Re-establishment of universal services** to enable practitioners to identify and support newly emerging vulnerability. The July 2020 PHE guidance states that the antenatal, new baby and 6-8 week health visitor review should be continued as 'essential' and other contacts assessed and stratified for vulnerable and clinical need, offering the opportunity for newly emerging vulnerability to be identified in families who have or are expecting a new baby.
- **Re-instatement of key services supporting vulnerable families with preschool children should be re-instated** as a matter of urgency including face-to-face visits, with appropriate protection. The July 2020 PHE guidance recommends prioritising home visits where there is a child safeguarding concern
- Development of plans to **urgently review all preschool children with known vulnerabilities and children who have not been seen by the local community health service since March 2020 in order to identify newly emerging vulnerability among toddlers and preschoolers as well as babies.**
- **Plans to maintain the benefits of the pandemic** in terms of improvements in collaborative working and more rapid decision-making; this could include evaluation of

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[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-with-note-31-July.pdf accessed 10th November 2020

continued virtual contacts and meetings, virtual meetings for staff and certain groups of families (e.g. those without any known vulnerabilities);

- **Development of plans to ensure staff have the necessary support during the restoration of services** and to create high quality workplaces for all staff in the future; this includes the development of leadership skills to drive service improvement and commissioning in the future. This should also include **the routine consultation of senior practitioners** in terms of all future changes to working practices.

Implications for future lockdowns
- **Preparation of services for any future waves of COVID-19**. NHS England should revise the Community Prioritisation Plan (for phase one pandemic management) and develop clear messages on the importance of continuation of the service to ensure the needs of children are prioritised. This should include removing wording on the redeployment of health visitors.
- **Redeployment does not involve frontline practitioners with a key role in preventing potential problems from escalating and safeguarding vulnerable children**; all children should be seen at least once by a health visitor irrespective of their pre-pandemic level of need;
- **Continuation of face-to-face visits/clinics by practitioners delivering statutory services with all known vulnerable families and at least one home visit being provided to families previously not known to services,** with the necessary protections to mitigate known limitations of assessment of vulnerabilities using virtual methods;
- **Use of virtual services with vulnerable populations only in exceptional circumstances;** wider services supporting high risk caregivers (e.g. with mental health, substance use problems or domestic abuse) should also receive face-to-face services.
- E**valuation of the use of virtual, non face-to-face service delivery methods** is implemented to assess their effectiveness in the identification of vulnerabilities and risks and their impact on child and family outcomes including reducing inequalities, in order to inform future digital delivery of services.
- **Consultation of frontline staff and involvement in all decision-making** with regard to future changes to practice in terms of social distancing, in addition to the opportunity to feedback on management practices without detriment.
- **Planning to address pre-existing challenges in** order to make the service more robust to future lockdowns, including improved investment in the service, identification of KPIs that reflect the full spectrum of practitioner work, and improved commissioning processes.

Context for the current study

The issue

Following the outbreak of SARS coronavirus-2 (SARS-CoV-2), which was declared a Public Health Emergency of International Concern in January 2020, the UK Government announced a range of 'lockdown' restrictions, that were aimed primarily at limiting the spread of the disease. Initially put in place for three weeks, they have since then been extended at regular intervals, until on the 18th May some restrictions were lifted. In terms of the public, the lockdown restrictions required social isolating measures that involved only leaving the house for essential items.

In response to these lockdown restrictions, the NHS England produced guidance regarding the prioritisation of hospital and community services.[2] These specified the key services that should continue to be provided during the lockdown to pregnant and newly delivered women and preschool children. Guidance for practitioners delivering prebirth and 0 to 5 services specified that all services should be discontinued other than Antenatal contact (virtual) and New baby visits (or when indicated virtual contact) and other contacts to be assessed and stratified for vulnerable or clinical need (e.g. maternal mental health). The guidance suggested that sustained services were likely to include interventions for identified vulnerable families, e.g. intensive home visiting programmes such as Family Nurse Partnership and Maternal Early Childhood Sustained Home-Visiting (MESCH), child safeguarding work such as Multi-agency Safeguarding Hubs; statutory child protection meetings and home visits, phone and text advice and digital signposting

Priority services identified for midwives included key antenatal and prebirth visits, and the postbirth visit. Community paediatric services were limited to services/interventions deemed a clinical priority; child protection medicals; telephone advice to families; risk stratification and initial health Assessments (urgent referrals to continue; some routine referrals may be delayed with appropriate support, e.g. initial basic advice to parents/carers).

In terms of Children's Social Care services, the duties to the most vulnerable children that are set out in primary legislation (such as in section 22(3) of the Children Act 1989 and section 1 of the Adoption and Children Act 2002) remained in place, but with greater flexibility in terms of their delivery.

Overall, these guidelines required significant changes to the practice of all community-based practitioners with significant implications for the services being provided to all families.

In addition, emergency legislation was enacted that involved the National Pandemic Influenza Service being implemented, which involved non-urgent operations and services being cancelled or delayed, aimed at releasing staff who could be deployed to other critical services.

Concern about these changes began to emerge during the early stages of the pandemic. A Facebook contact with health visitors on the part of the Institute of Health Visiting (iHV), for example, identified three areas of concern:

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[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-with-note-31-July.pdf accessed 10th November 2020

- inconsistent practice across the country in terms of the use of face-to-face visits and availability/use of PPE;

- redeployment of an already depleted workforce of health visitors to other areas of health care, and a severely stressed remaining workforce;

- concerns regarding the secondary impact of SARS-CoV-2 on children and families through the predicted, significant increases in domestic violence and abuse, safeguarding, mental health problems and substance misuse.

For further introductory discussion regarding the secondary impact of SARS-CoV-2 on vulnerable children see Report 1 from this research.[3]

Results of Stage 1

Stage 1 of this study involved a rapid survey of professionals delivering and commissioning services to the above population across England, which was distributed via the professional organisations of the key groups of practitioners (e.g. iHV; BAACH; BASW; NHSCC; ADCS etc)., and was completed by a total of 861 practitioners (74% health visitors; 6% midwives; 7% social workers; and 11% community paediatricians), and the commissioners survey was completed by 44 in total (34% Commissioners of Health Visiting and School Nursing Services; 25% of Local Authority Children's Commissioners; 9% HCP Service Commissioners; 23% NHS Children's Service Leads; and 9% of commissioners of other public health services or Local Authority Early Help).

The key findings of the Stage 1 were as follows:

Despite many respondents reporting a 'significant' increase in concerns about families on their caseload since the start of the pandemic, around half of the respondents stated that their role was not protected during the pandemic, and **the group reporting the highest level of redeployment were health visitors.** Two-thirds of respondents had colleagues within their team/practice who had been redeployed, of whom two-thirds described having **5 or more colleagues who had been redeployed.** Of those redeployed two-thirds received preparation for this role, of which **half felt inadequately prepared to take up their new role**. **Redeployment was described as affecting all aspects of service provision including safeguarding.**

Up to 33% of respondents believed that **at least half of the vulnerable families on their caseload did not receive the level of contact needed** during the pandemic in order to keep their children safe, with health visitors being most likely to report this. **A third of social workers also reported that they had not been able to provide some critical services** including face-to-face visits in the home to assess home conditions; and Section 17 (Children in Need) services.

While around 70% of respondents had been offering **face-to-face contact in the home or the clinic there were large differences across professional groups** with these midwives and social workers most likely to be delivering these. Two-thirds of health visitors

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[3] Barlow J, Woodman J, Bach-Mortensen A, Fang Z, Homonchuk Z. The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk or have complex social needs. November 5th, 2020.

reported that in accordance with government guidance less than 10% of their contact with clients was delivered in this way. Health visitors commented that retraction of universal services during the pandemic could in fact place vulnerable children at risk as these contacts allow identification of 'new' or increased need. **Personal Protective Equipment was described as being inadequate based on need, by a quarter of** social workers and midwives. The main reasons for providing face-to-face contacts across all professional groups were safeguarding concerns; needs assessment and ongoing support; parental mental health issues.

Social workers, health visitors, and community paediatricians were much more likely to use **online platforms to provide face-to-face contacts,** than midwives (i.e. two-thirds compared with one one-third). Of those respondents who were providing online video contact around **two-thirds of respondents had not received any training** for this. IT problems and insufficient training were the main reasons for not providing such support. A range of benefits and limitations of such provision were described, and although two-thirds of respondents would consider using online platforms to deliver face-to-face care after the pandemic, **most did not recommend their use for work with vulnerable clients** going forward, recommending their use as a supplement to home visits for low risk families.

Most of this sample (90%) described themselves as working from home some (54%) or all of the time (35%), with midwives being the least likely to work from home. Around half of respondents had experienced an increase in their overall workload as a result of this, **around one-fifth reporting an increase of more than 40% in their workload.**

Around one-fifth of respondents reported that the pandemic had had a significant impact on their mental health, and while all but a fifth of respondents had experienced additional organisational support for their wellbeing, 10% felt that this was inadequate.

Changes that were described as being needed to improve stress levels, mostly related to service management, in terms of the need for clearer and more supportive communications from practice managers, the opportunity to be consulted and have their concerns heard, and less 'micro-management' in terms of being trusted to make decisions.

Up to a third of commissioners described having a slight or significant increase during the pandemic in vulnerable children in terms of Child Protection (s47); Children in Need (s17); Universal Plus/Partner Plus HV; or families with Open Early Assessment Plans. Seventy-three percent of commissioners reported that they had been able to provide all of the services for vulnerable pregnant women and families with preschool children specified in the key priority areas set out in the Community Prioritisation Plan or as specified in law to safeguard children. The majority described these services as 'adequate' or 'highly adequate. This finding contrasts with that for the level of financial provision to support for vulnerable families during the pandemic which was reported as being moderately (34%) or significantly (25%) below the level needed. Around a fifth of commissioners reported having a slight increase in financial resources during the pandemic However, **such additional resources were described as being allocated against already overspent budgets,** with core funding being descried as 'remaining under significant pressure'.

In terms of immediate changes perceived as needed, the majority of respondents identified the need to end the redeployment process, and for health visitors and social workers in particular to be enabled to conduct safe face-to-face visits for vulnerable families and clients. Many health visitors identified the need to restore universal services as soon as possible to enable them to identify 'invisible' cases in need of support, in addition to the facilities needed to enable them to do this. Respondents also highlighted the need for more coordinated services and better information sharing, improvements to the organisation and management of staff such as the use of 'hot and cold teams', and urgent planning for the 'missed cohorts'. Commissioners further identified the need for additional funding to deal with the anticipated surge in vulnerable families who will become visible as lockdown is lifted; improved co-ordination of services; and improved data sharing across the system of child/family services so that services are aware of any other agencies also involved in safeguarding a family.

A range of interim recommendations were made with regard to a) contact with families; and b) planning and co-ordination of services (see Appendix 2).

Aim of Stage 2 of the study

The overall aims of the research were to develop a set of responsive recommendations addressing current areas of concern in terms of service provision, and thereby to reduce the secondary impact of SARS-COV-2 on vulnerable families with preschool children going forward. The specific questions posed were:

- What has been the impact of SARS-SARS-COV-2 in terms of the required changes to health and social care practices on the provision of services in England for vulnerable pregnant women and families with preschool children?

- What are the key priorities for these groups going forward following the gradual lifting of lock-down?

We aimed to explore some of the survey findings in more depth and in particular, the problems encountered by the guidance relating to social distancing; their views regarding the steps that were needed going forward both in the short and longer-term; and the impact of wider service context prior to the pandemic.

Methods

Design: In-depth interviews were conducted with a sample of respondents using the results of the survey to inform the questions posed (see below for further detail).

Sample: A total of 20 providers or commissioners of frontline services for vulnerable preschool children who took part in the survey in Stage 1 of the research, consented to being contacted to take part in an interview after being emailed an invitation.

Data collection: Digital (video) interviews were conducted using a semi-structured interview schedule designed to explore further some the issues raised by the survey and to identify stakeholder perspectives regarding what is needed going forward (see Appendix 1). Specifically, the focus of the interviews was on exploring the wider context for the delivery of services during the pandemic (i.e. the impact of austerity measures); the impact of the changes introduced by guidance relating to social distancing and some of the recommendations made in Stage 1 of the report in terms of a) contact with families; b) planning and co-ordination of services; and their views regarding the steps that were needed going forward both in the short and longer-term.

Data analysis: Interviews were fully transcribed and imported into NVivo for analysis. A thematic analysis was conducted in order to facilitate cross-case analysis.

Ethics: Ethics committee approval was *obtained from the University of Oxford Central University Research Ethics Committee (CUREC): Number: SPICUREC1a 20 010.*

Results

A total of twenty interviews were undertaken with four commissioners, one programme manager; six health visitors, four social workers, three midwives, and two community paediatricians. The sample were predominantly female with only three male interviewees, and they ranged in experience from being in post for less than one year to over 10 years.

The results are presented within two overarching themes that were identified from the interviews. First, the realities of safeguarding vulnerable preschool children in the current context including: a) pandemic-related factors; b) the managerial response to the pandemic; c) the pre-pandemic erosion of services as a result of the austerity measures; and second, the changes that were perceived to be needed going forward in a) the immediate and b) longer term. These two themes relate to our two research questions on the impact of policy changes in delivering services to vulnerable preschool children March-August 2020 and professional priorities going forward.

Part 1: The realities of safeguarding vulnerable preschool children in the current context

1a) Pandemic-related challenges in the protection of vulnerable preschool children

Interviewees described a number of issues resulting from the lockdown that they felt to have exacerbated the secondary impact of the pandemic and reduced their ability to keep vulnerable preschool children safe including: inadequate PPE and guidance for practitioners; the difficulties of remote contact in safeguarding work; unreasonably large case-loads; reduced overall support for parents; and a significant increase in need (i.e. domestic abuse).

Inadequate PPE and guidance in terms of practice

Interviewees identified a lack of PPE and guidance with regard to practice, as having contributed to what was described as the 'invisibility' of preschool children, due to their inability to conduct face-to-face visits safely. They referred to the fact that many vulnerable preschool children had not been seen in-person by any of the key statutory professionals, at a time that they were also not attending the usual preschool settings (e.g. children's centres, nurseries) in which risks or harm might have been identified. Furthermore, the issue of invisibility was perceived to be specific both to the youngest children (i.e. because vulnerable school-age children were being contacted by school staff), and also to children who were below the radar in terms of children's social care services:

> *[Children who are too young to be in formal education are] the ones we've been most worried about. So, because all the nurseries got shut very quickly, and then they couldn't afford to keep their staff and then they put them all onto Furlough, and that meant that the nursery workers weren't able to work, […]*

This social worker went onto say:

> *You know, the Health Visiting Services aren't going out and doing visits almost at all now […] So, suddenly, we're not seeing children for months and months, some of them, the ones who are not open to Social Care, and particularly the ones who are maybe borderline in a risky situation, because all of the normal points of contact [..] have*

stopped. And given how vulnerable that age of child is, that's been a real concern. (Interview 15 – Social Worker)

Social workers in particular reported that they had not been given clear instructions on how to conduct their work safely and that they were not given adequate access to PPE. This resulted in what one social worker referred to as 'compassion fatigue' because they had to continue their work, whilst not being provided with the appropriate support to do it safely. One social worker described how angry social workers were and how the need for social distancing risked undermining their relationships with children:

[T]here was huge outrage I think amongst social workers. I know that, in my pod, there was lots of anger around that because it's incredibly difficult to socially distance […] when you're working with [the most in need regulated] children, when you're working with preschool children, when you're working with neglect, when you're working with trauma, to instruct children to back off is…is really hard […] when you've spent a long time building relationships. (Interview 12 - Social Worker)

Shortfalls in terms of remote contact in safeguarding work
Practitioners were also required to work virtually for the first time in their careers, many of whom in the initial survey in Stage 1 of the research described not having any training for this mode of working, and as experiencing IT problems. Importantly, it was felt to be inadequate for work with vulnerable families due to the inability to assess risk adequately:

I did a developmental check, a pre one-year check, over the phone. I thought everything was fine, and then, the next week after I'd done the development check, I got an invite to a conference for this family, that they'd been drug-dealing in the house, and that the baby was at risk so… So, I think had I – what would have happened if I'd have gone round? Would I have identified anything […] would I have still come up with the same [decision]? (Interview 2 – Health Visitor)

Remote working due to the pandemic was, nevertheless, perceived to have improved communication and joint working, by increasing the time available:

In general, I'd say joint working has improved because people have had a bit more time to communicate… (Interview 15 - Social Worker)

The use of virtual meetings was also perceived to have improved communication and collaborative working due in part to the benefits of bringing practitioners together more efficiently in terms of time:

*It's all about good communication, communication between Obstetrics as well and Mental Health and Midwifery really. And I think at [location omitted] they've been quite accommodating about making sure that those women are kind of accompanied to Obstetric appointments, that plans are shared by email between obstetricians. **In some ways, it [pandemic] has improved the communication.** […] It's had to be quite tight in terms of emails and making sure everyone is included in e-groups and that plans are very, very clear. If you're not seeing women as much, then you need to really know what everybody is doing. (Interview 16 - Midwife)*

Unreasonably large caseloads

Large caseloads, particularly in relation to HVs where redeployment was perceived to have been the greatest, was also described as having impacted their ability to provide adequate care to families.

> *I: And what are the caseloads like for your health visitors?*
> *P: [Laughs] Well, I'm glad this is confidential. It was nearly 800 recently. Ridiculous. Just ridiculous.*

While some of this reflected very high pre-pandemic caseloads, it was also perceived as resulting from other pandemic-related issues such as the reassignment of roles:

> *So, my looked-after children workload has gone up a lot because I had to re-think how to redesign the service [….]. We had to think about how we could do those assessments by phone, and obviously kind of make the social workers aware of the differences and make sure they were available by phone, and when the middle grade staff were redeployed restructure who was going to do that work. So, there was some sort of reassignment of roles amongst the people who didn't get redeployed. So, somebody took over some of my school-age clinic so that I could do some extra looked-after children clinics. (Interview 19 - Community Paediatrician)*

Social workers also had significantly increased caseloads due to high levels of sickness, which were perceived to be due in part due to the increased stress of working during the pandemic:

> *It's been very stressful. We've had a lot of my colleagues being off sick recently because all this stress has aggravated health conditions and injuries that people have had. So, in terms of my team, our caseload has gone massively up because there's been members of my team that have been off long-term sick, and we can't just leave cases not progressing, so we've all had to take on extra to cover that colleague who is sick. (Interview 10 – Social Worker)*

There was also concern that caseloads were going to increase further following the easing of lockdown with most interviewees expecting a surge over the coming months in the number of children identified as having been exposed to harm and thereby referred into services. One community paediatrician was concerned not just about the anticipated surge in cases following the easing of lockdown but the potential of services to deal with these:

> *We are all very concerned that when all the children go back to school, that there is going to be a surge of safeguarding referrals at that point. And it may not be acute issues. It may be that a child begins to talk about […] that awful time, domestic violence, physical abuse, sexual abuse, or anything […]. So, we're kind of feeling that we're going to be dealing with a surge, but have we really got the mechanisms in place to work with children to help them unpick that period in time where the services perhaps let them down? (Interview 11 – Community Paediatrician)*

Reduced support for, and help-seeking of, vulnerable parents

A commonly reported factor that was perceived to have increased the secondary risk of harm to children was the significant reduction of central services for vulnerable parents. Most concern was expressed in terms of the caregivers who had mental health or

substance dependence problems, and who relied heavily on in-person drug addiction and mental health services that were not accessible during the pandemic:

"A lot of the drug, alcohol and mental health services stopped for a while, and then restarted virtually, and I think the stop caused a huge problem because a lot of people […] who had kind of started to engage, they just stopped attending, and haven't re-started again [...]. So, what we're seeing is just that there's a lot of people […] who want help and need help, but from specialist services, who just aren't getting those services, or are now reluctant to engage with them because they're kind of done over the phone" (Interview 15 – Social Worker)

In addition to reduced support, the pandemic was also perceived to have negatively affected the help-seeking behaviour of vulnerable clients.

There is a couple of people that I'm looking after that have purposefully not booked as early as they should have done because they've been scared to come into the hospital, worried about the impact of Covid on their unborn baby, and not able to access the right information about that, so they've kind of come in and missed potential screening that they could have had earlier on. That's a shame. That's a bad outcome of Covid. (Interview 16 – Midwife)

Increase in cases of domestic abuse

The most commonly described risk to caregivers to have been exacerbated by the pandemic was domestic abuse. In the Stage 1 survey, all community-based practitioners reported an increase in domestic abuse cases, which in the interviews was reported to be difficult to respond to because it was 'hidden from them' due to the inability to conduct in-person visits:

[…] The other thing has been not being able to be as kind of present in families' lives, not being able to visit so much. That has also led, in some cases, to not being able to get a really full picture of what's going on, in terms of domestic abuse, because, you know, often, a victim will kind of not want to talk about it, and creating a close relationship over the phone is quite difficult, and you need time […] and space, and like physical space, to be able to explore these really, really difficult subjects, and we're not getting that so much. And so, actually, I think there's probably been quite a few – well, I know there have been cases where like you know that domestic abuse has been happening but it's been…it was essentially hidden from us. (Interview 15 – Social Worker)

1b) The managerial response to the pandemic

The second theme identified focused on the managerial response to the pandemic which included: i) an increase in the use of micromanagement; ii) a lack of central coordination and regional variation in practice; iii) an inadequate redeployment process.

Micromanagement

The style of management and leadership during the pandemic was described by many interviewees as involving significant micromanagement in addition to a general disregard of staff concerns. Examples of micromanagement that were provided included practitioners being required to ensure that clients were dressed 'appropriately' during virtual meetings, which reportedly took important and unnecessary time and energy away from the consultation itself:

And we've actually received guidelines today on what we should be asking over the phone before we do consultations, and that list is quite extensive, and I think, by the time I've got through that list, half my visiting time is gone. And I didn't agree with some of the […] recommendations in it either. Like one of the things that we've been told is to tell the parents that they're not to record the conversation, which I understand that, but then it goes on to say that we have to tell the parents they have to be dressed appropriately, and that means not in pyjamas or naked. (Interview 2 – Health Visitor)

The consequences of such micro-management were perceived by one practitioner as demonstrating a lack of trust in her judgment:

I work part-time and I'd spoken to my managers on the Friday, and on the Tuesday, when I opened my email, it said that four of my top child protection families […] I wasn't going to be their keyworker because they needed home visits. And I was like, oh, didn't expect this coming, you know…and kind of feeling mistrust – you know, I'm an experienced health visitor, do you not think, if I were worried about these families, I'd be…bringing them to you (Interview 1 – Health Visitor)

Many interviewees felt that this style of management also reflected the failure of managers to understand the realities of frontline practice:

[Management] keeps bringing things in, and every now and again one of them will say something like, "Well, it makes up for the times that you only have a 20-minute visit, doesn't it?" and I just really want to reply, "I've never had a 20-minute visit in the whole time I've done health-visiting!" I would love to go in and just do a quick "Hi, are you alright? See you later!" It's not how it works. There is no 20-minute visit. […] It just feels like the people at the top that make the decisions need to come out and see what's happening in practice because they've forgotten. (Interview 2 – Health Visitor)

[…] because it's almost like senior managers don't really get what's going on at the moment on the frontline, so their expectation, and their creating tick-box forms, basically, is just adding more workload to what we have to do, and it's taken away time from us actually doing the actual work that we need to do to protect families." (Interview 10 – Social Worker)

One interviewee described how this perceived disconnect between management and frontline practitioners was in part due to managers not having enough current experience of frontline care or having forgotten what it was like:

I think, quite frequently, they're people that were either in the ranks a long time ago or were in the ranks for a very brief – it wasn't their thing. You know, they did it, they got the qualification, they did the frontline, but it wasn't…actual, you know, person-centred, hands-on, stuck-in social work wasn't necessarily their thing, and they perhaps moved into other areas, you know, learning & development or, you know, management, quite quickly. And I think that they perhaps…have forgotten, maybe? (Interview 12 – Social Worker)

Some practitioners viewed this disconnect to be underpinned by the fact that management 'super-stressed' about being only one step ahead of frontline workers:

I think our managers were only five minutes ahead of us all the time, to be honest. They were super-stressed because […] they were having to work with all the other services that we may have been deployed into as well[…]? So, they weren't much further ahead than us really. (Interview 5 – Health Visitor)

Health visitors and social workers also felt that the execution of the pandemic guidelines did not allow for feedback from frontline staff, even though these were perceived as having put the safety of staff at risk, such as when they were required to deliver in-person services without adequate PPE. One social worker described how this had impacted the morale of staff:

All the social workers' morale is on the floor at the moment. And they ignore us, and they use the responses from planning workers, who have been at home since March, saying, "Oh yes, we feel wonderful! It's been great, you know, all the IT that's been put in and stuff!" And we're stamping our feet and saying, "We are not okay," and our responses are completely ignored […] (Interview 12 – Social Worker)

Lack of central coordination and regional variation in practice

Variation in practice across LAs and regions was identified as having contributed significantly to the reduced ability of practitioners to safeguarding vulnerable preschool children:

I mean, the big problem that we had in social work was the complete lack of clarity. Each local authority is doing something different. There is no uniform standard on what is the priority, what do we need to actually do, what do we need to achieve, and how's the safe way to do it. My local authority is quite close with another local authority, and what they're doing in that authority is completely different to the standards that our senior managers are setting, and that's really challenging […] (Interview 10 – Social Worker)

This variation in practice was highly significant for social workers in particular, where the lack of clarity meant that they couldn't be sure that they were meeting their legal requirements:

I think, for all the local authorities, it would have been useful to know where we stand in terms of virtual visits. So, some authorities are saying that they do satisfy our legal requirements, while my authority are saying that they don't meet legal obligations, so if you do a virtual visit, fine, you can record it on the system, but it counts for nothing and you've got to go and see them face-to-face, which is nigh-on impossible with shielding and things going on at the moment. (Interview 10 – Social Worker)

Problems with the redeployment process

The process of redeployment, which was described as having significantly affected the ability of practitioners to safeguard vulnerable children due to its impact on caseloads, was described as 'not having gone well' and as 'a waste of time':

All of our nursery nurses were redeployed, and quite a few nurses and midwives in the team were redeployed, but that didn't go very well […] because of the hold-up with the redeployments. So, when they'd decided what needed to be redeployed, it took a long time getting everything sorted, […] so by the time they went, the areas that they went to,

which were maternity and neonatal, weren't really needing them […] (Interview 17 – Health Visitor).

There was a strong feeling that practitioners and health visitors in particular had been redeployed to areas that did not utilise their strengths as public health practitioners:

[…] the impression the staff had is that the health visitors had gone because they weren't doing their own visits, which wasn't the case, so they thought they just had to kind of babysit them there to keep them doing something, instead of really using the expertise that my colleagues had. So, it was quite a waste of their time really. (Interview 17 – Health Visitor)

In addition to not addressing the skills of the practitioner, interviewees felt that the redeployment process did not reflect the needs of the population being served:

I think the management of the redeployment of staff wasn't very good. They gave very little information. It kept on changing all the time. Our particular team is quite a heavy caseload, quite a deprived area, yet they seemed to pull a lot of staff from our team to be redeployed, and I don't know quite why that was. (Interview 17 – Health Visitor)

This health visitor went on to describe how managers also failed to redeploy practitioners with the relevant skills to undertake the work in the area to which they had been redeployed:

I don't understand the rationale […]. So, some health visitors have newly qualified, they've got recent work experience on a Neonatal Unit, they were quite happy to go in and volunteered, yet they were left in place and other members of staff who maybe hadn't worked in a Neonatal Unit for a long time were taken. The reasons were never explained to us, so that was quite frustrating. […] (Interview 17 – Health Visitor)

One health visitor referred to the way in which the organisation of the redeployment in terms of the need for retraining and shadowing in particular, defeated the whole purpose of rationalising staff time and social distancing:

We had to go and do face-to-face training in sepsis and vital signs, moving and handling. […]. When we did go out, it was only for two weeks because they didn't need us. And it didn't make sense because we were shadowing, and it didn't make sense that we were going into […] vulnerable adults, mainly the elderly, you know, two of us going in although we had plenty of PPE. (Interview 5 – Health Visitor)

The overall impact of this process was described as making practitioners feel further devalued:

[Many] just got the training and then they were sent back to health-visiting. But while that was all going on, that just made me feel very devalued, and I just thought what's the point in doing our job if you can just redeploy us at a drop of a hat? You know, we're here supporting all these very vulnerable families […]. So, even though we cannot see them, lots of parents have said to me how much they value just the telephone contact. But then […] you're telling me that […] next week, I'll be working somewhere else… That just makes me feel that, well, what's the point in doing our job if it's not valued? (Interview 3 – Health Visitor)

1c) The pre-pandemic erosion of services as a result of austerity

The pre-pandemic erosion of services as a result of austerity was perceived to have influenced the ability of frontline practitioners to respond to the pandemic including i) an erosion and devaluation of practice; ii) the move to a 'tick-box' culture; iii) unacceptably high caseloads; iv) inadequate performance indicators for health visitors; and v) the impact of a significant reduction in funding on service provision.

The erosion and devaluing of practice

Both social workers and health visitors appeared to feel devalued as a result of the way in which they felt themselves to have been treated as being invisible during the pandemic:

I feel that social workers are the invisible keyworker until the child dies. And, you know, even good old Boris, when he lists them, he never says us, ever! […] All this time, we've been plodding away with our visits – you know, we've even got politicians saying, "Oh, children aren't being protected during Covid! You need to lift lockdown!" And it's just like, "Actually, they are! We're still here! We're still doing visits," you know. (Interview 12 – Social Worker)

This was perceived by both professions to reflect a wider devaluation of their service that began prior to the pandemic:

For many years the agenda was to get rid of health visitors because we're deemed expensive as Band 6s, and our role has been eroded. I mean, when I started health-visiting, I was a G grade, which is the equivalent of Band 7, and when we changed over, years ago, to the new pay structure, we suddenly became 6, […] and with [corporate caseloads] you're not managing your own caseload…you might be managing a bigger caseload. (Interview 4 – Health Visitor)

One health visitor referred to the gradual erosion of their role as a result of the austerity measures:

I love health-visiting. And I just really want the Government to acknowledge and respect health visitors, to stop trying to erode our role, to stop trying to get people who aren't qualified as well to do our role, and if they are, then to accept that what they're doing is tick-boxing – they're not actually getting a really good picture of what's going on. (Interview 4 – Health Visitor)

One health visitor described how the failure to recognise the work being done by their profession, was undermining their ability to protect vulnerable children.

I just think the whole system, from Government down, is not working in favour of a good health-visiting service, and certainly not providing an adequate service for vulnerable families because they're not recognised, certainly in our area, as part of the key performance indicators, which is madness – madness! (Interview 4 – Health Visitor)

Some practitioners perceived their difficulties in safeguarding vulnerable preschool children during the pandemic to be related to the impact of ten years of austerity measures on their capacity to deliver key statutory services. A number of practitioners and commissioners

referred to the underfunding of children's services over ten years and highlighted how this had negatively influenced outcomes for children compared with pre-austerity provision:

It's a Government strategy of prioritising downstream work over upstream work. [10 years ago] the budgets were much better and […] local authorities had more flexibility to support […] things like community groups who did a lot of work that was hidden, and I think that budget was definitely much better and we know there was a million less children in poverty – the figures are just terrible now. (Interview 8 - Commissioner)

Practitioners reported the way in which this prioritisation of downstream working had prevented them before the onset of the pandemic from working with families who were on the edge of care, and the long-term risks of such an approach:

Five or so years ago or 10 years ago, there was a lot more that helped people, kind of what we call Tier 2 services, that allowed people who were maybe struggling […]. Because of austerity and because a lot of these services have been cut, […] we've had to raise our thresholds, which means that we do not have the capacity to deal with a lot of referrals from, you know, schools or early years or health visitors […] it has a huge, huge impact when they become teenagers. And I think that's one of the biggest issues that I have come across is that its [austerity] has shifted social work practice to late intervention. (Interview 15 – Social Worker)

Development of a 'tickbox' culture

Health visitors and social workers in particular felt that the pandemic had increased the 'tickbox' culture established pre-pandemic. Practitioners reported that austerity measures had led to this change towards a culture in which managers were happy if certain boxes had been ticked, despite the fact that practitioners could no longer deliver the level of service that was needed to vulnerable families. The government safeguarding response to the pandemic was felt to have taken this 'tickbox' approach to a new level in terms of the forms and procedures that they were now required to complete, most of which were perceived as being irrelevant to the care that was actually provided to families:

In my authority, the forms that we had to do, told us to drop all casework and focus on this one form that actually has no benefit to the family whatsoever. Like I said, everything is very tick-box-y at the moment, and it's affecting staff morale in taking away the time from what we actually really need to do, which is focus on the family during this really difficult time. (Interview 10 – Social Worker)

On more than one occasion, stuff came down from central government where central government want assurance that we're doing the right thing, and I found that frustrating because we knew we were doing the work and we were confident we were doing the right thing. I know we need to be accountable to central government, but some of the things that we had to complete, it was exactly, literally, a tick-box exercise which had no real kind of meaning. (Interview 14 – Commissioner)

Interviewees expressed a strong desire to be given the time and resources to prioritise the needs of children and families they work with rather than ticking boxes:

I'd say the focus needs to be on the children and the families, rather than trying to do tick-box exercises in the hopes that that will satisfy Ofsted and the Government when

things do settle down, because I feel like senior managers are losing sight of the children and the families that we work with, and more focusing on how will this look like when Ofsted come, say, in a few months' time. So, we really need…we need the children and families back in the centre of things. (Interview 11 – Social Worker)

Unacceptably high caseloads

The trend towards unacceptably high caseloads, increasingly seen during the period of austerity measures, was perceived to have continued during the pandemic with further increases in caseloads:

Caseloads are too high. So, when we do take on a case, we…there's lots and lots of stuff that we could do, and we could do better, […] We kind of end up not having as much time as we would like to do the work that will make a difference. You are kind of helping to support the family emotionally perhaps, but what you really want is enough time to be able to do a predictable, structured intervention that will actually make a difference. (Interview 15 – Social Worker)

Inadequate Key Performance Indicators (KPIs)

The issue of safeguarding vulnerable children during the pandemic was felt by many health visitors to be complicated by the issue of KPIs which were felt to be inadequate in terms of their failure to capture the full nature of their work:

It is frustrating because it's such a small proportion of the work that we do. Just a few parts of the Healthy Child programme that have been picked to measure our service, and I think it does us a disservice. It's not recognising the rest of the work that we do (Interview 17 – Health Visitor).

KPIs were also described as distorting the practice of health visitors by making them target-driven and focused on activities that were not a priority in terms of their own caseloads and communities, including safeguarding:

It makes us quite target-driven then because the - we don't have to worry about some other things because they're not being measured in the same way as a KPI. So, it draws away from some of the other things that are quite important for us to be doing. It makes us focus more on targets than on the needs of our communities […] (Interview 17 – Health Visitor).

Health visitors described how the need to be seen to be 'doing a piece of work', had eroded their practice in terms of them no longer having the ability to keep vulnerable children under their surveillance:

It's the same with the KPIs – it's: are you doing a piece of work? […] unless you can actually demonstrate that you're doing a "piece of work", you can't count people as… being vulnerable or that you're doing a piece of Universal Plus work with them. They have to go back down to Universal. And, for me, that means a lot of children get lost (Interview 4 – Health Visitor)

This was perceived to have reduced their ability to monitor the ongoing wellbeing of vulnerable families:

They want us to get rid of families quite quickly once sort of things have stabilised, but one knows, particularly with something like domestic violence or poor parenting, that everything might be singing along quite happily for a few weeks or months, but you do need to check in, and it's the checking in that we're not doing, and therefore I think we're missing things. So, I think a bit more flexibility around how vulnerable children, once identified, get followed up - perhaps who follows them up might be something to think about – but that there should be some link person following them up. (Interview 4 – Health Visitor).

Health visitors in particular reported undertaking unpaid and under-the-radar work using their own time or at the cost of being reprimanded by management in order to deliver the care that they felt to be necessary based on their professional judgment.

The impact of a reduction in funding on service provision

Commissioners were concerned that existing and newly developed vulnerability had not been addressed during the pandemic with children being invisible:

I think, particularly in relation to children and young people, the kind of level of vulnerability risk has really been…not ignored, but not taken, in my view, as seriously as it should have been […..] I think a lot of children have become invisible. Those that perhaps weren't vulnerable to start with are becoming increasingly vulnerable. We know that health inequalities are increasing, as a result of Covid. (Interview 6 – Commissioner)

Commissioners viewed these outcomes as being an extension of the impact of ten years of austerity and the way in which this had impacted the commissioning process with the adoption of practices that were aimed at promoting value for money having become unnecessarily time-consuming and lacking in real value (see Section 2 below). In addition, frequent re-tendering was also described as having resulted in fragmentation with no joined-up commitment across sectors to key outcomes, and an inability to capture whether specific services in the early years deliver long-term benefits (see Section 2 below).

Part 2: Urgent changes needed to safeguard the wellbeing of children

Both frontline staff and commissioners provided important suggestions with regard to what is now needed as we move out of lock-down, which have been classified as: a) urgent changes as lockdown is ended; b) longer term systemic changes.

2a Immediate changes going forward

Keeping children at the heart of all future decision-making

One community paediatrician identified the need to think about children in all future decision-making with regard to the pandemic:

We've absolutely got to remember children in every decision we make, whether it's about Adult Social Care or whether it's about pandemic planning or whatever it's about. There should always be a question about: what's the impact of this on children? Yeah. Because I feel we've really let them down over these last few months… (Interview 11 – Community Paediatrician)

Multiple interviewees emphasised that although virtual services worked well for low priority families, it did not allow practitioners to adequately assess risk for those who were most vulnerable. They highlighted the need for key statutory community-based practitioners to be re-instated, to enable frontline practitioners to undertake the necessary level of face-to-face contact:

> *I think that Health Visiting, Social Care, Midwifery, and Perinatal Mental Health, need to be supported by the powers that be to get back to a normal state of play as quickly as possible. Because they're kind of like the four kind of titans of care for vulnerable women, and the sooner we are all supported to get back to a place where we are having an appropriate amount of face-time with those families, the better. (Interview 20 – Midwife)*

The reinstatement of all essential family support services was also highlighted, and in particular the need for guidance and the necessary PPE to enable them to do this safely and thus with confidence.

> *I think the other agencies, Children's Services, Family Support, that those kind of agencies need to be back out and visiting people and […] they need the confidence and the guidance to do it, and the correct equipment, the PPE. […] So, I think, to get services back up and running really is what's needed, and they need the protective equipment and the guidance to be able to do that. (Interview 17 – Health Visitor)*

Interviewees referred to the urgency to get things running normally, and identified that the rapid decision-making that had accompanied the pandemic needed to continue following the easing of lockdown:

> *I'm horrified because we were able to close clinics in days, you know, hours, in some cases, but we can't re-open them at the same speed, and I think that is not child-focused and is adding to the detriment of not seeing children, and I'm really saddened actually because I thought, you know, the lessons learned from Covid were that we can make decisions quickly and we can do them well, but we've gone back to old ways of working, which is so disappointing. And I'm just one, you know, one service within many, many services where waiting lists are growing by the minute. (Interview 11 – Community Paediatrician)*

Identification and provision of support for the 'missing cohorts'

Many practitioners referred to an urgent need to review vulnerable children who were neglected during the pandemic due to their invisibility. Efforts were also felt to be required to reach out to caregivers at risk of domestic abuse. One health visitor described the situation as a 'ticking timebomb':

> *There's going to be children who've obviously been at home, locked in with increased tensions in the family, an increase in domestic abuse or abuse of the child, and then they're going to be going back to school and disclosing that. So, I think there's a ticking timebomb that's waiting to go off in the homes for those vulnerable children. It's just been undetected. There's a lot of things that haven't been detected now that are going to come to light further down the line, and it will be like a second crisis affecting our children. (Interview 17 – Health Visitor)*

Working in partnership with key frontline practitioners

To achieve the above goals, it was felt necessary for all future work plans to be developed in conjunction with frontline staff to ensure that their expertise, and voices are heard. One commissioner referred to the need to work in partnership with practitioners going forward, who were described as knowing their population best:

> *I do still want to aspire to this partnership model, rather than commissioner/provider. So, for example, Public Health could easily provide ward-based profiles for the service, […] to then say, right, given the differences in localities, we need to reconfigure our service to tailor what we offer that takes account of need. […]. And then let us take account more of their insight…they know their population better than we do. So, we're bringing different skills to the table – let's use them…let's have a system that enables us to use our skills and assets to best effect. (Interview 18 - Commissioner)*

This was also felt to be important in the name of transparency:

> *They need to be a bit more transparent. I think sometimes there's worry caused unnecessarily. I really feel like managers don't like answering questions, and it really upsets me that I have to feel pushed into a corner before I'll say, "Can you just answer me this? Can you just answer me that?" and I think they feel like… It's almost as though they take it really personally when you're asking a question. (Interview 2 – Health Visitor)*

Maintaining improved collaboration and holistic working

Related to the above theme was the need to continue the significantly improved collaboration and joint working that developed during the pandemic which was described by one commissioner as 'people having to work together' and the absence of 'protectionism' with a move to a more 'holistic' way of working:

*So like the support to special needs children - again, enablers that support the way school nurses work with community paediatric nurses and paediatricians. It just feels like the way things are organised just creates chasms rather than bridges. […] (Interview 18 - Commissioner)*One commissioner suggested that better collaborative working going forward should also include more consultation with wider stakeholders including the public:

> *I also think what, as a system, we don't always do that well is really talk to the members of the public. We kind of…we impose… We try and do some consultation and discussion with community groups and certain, you know, parent organisations, etc., but we don't really understand what type and level of services mums/dads/children really want, and I think we need to get better at understanding that because, otherwise, we'll just carry on doing the same things forever and not necessarily making any kind of longstanding change. […] we need to do more community engagement really and understand what families really want from our services. (Interview 6 – Commissioner)*

2b. Other more long-term changes focused on addressing pre-existing challenges in order to make the service more robust to any lockdowns in the longer term

Re-investment in early years services

A number of interviewees highlighted the need for re-investment in early years services to address the potential tsunami of problems caused jointly by the austerity measures and the

pandemic. Multiple frontline workers expressed the need to be able to stop 'firefighting' and for investment to enable them to work upstream:

It is going to be really difficult because, you know, they [health visitors] have a diminished team because of austerity. You've got to catch up on all your year one visits, you've got to catch up on all year two and a half year checks, you've got to catch up - and all the safeguarding that comes through has got to take priority. (Interview 7 – Commissioner)

This investment was also seen as necessary to facilitate more intensive work with families with complex needs, as opposed to support that is felt to be ticking boxes:

I think we just need more resources again. I think we need things that we can refer into that can offer… We know, the research shows us, that actually, you know, for changes to be real and to be sustained, intervention needs to be intensive and it needs to be long-term. We can't do these short little blips of support. (Interview 12 – Social Worker)

Review of Key Performance Indicators

One of recurring suggestions amongst staff and commissioners was the need for more relevant and qualitative KPIs against which health visitors are monitored. Both commissioners and practitioners were concerned about the nature of the KPIs and perhaps most importantly, the role that these play in shaping/distorting work and care practices, and identified the need for indicators relating to safeguarding.

For example, one commissioner described the need to stop counting visits and to identify more meaningful KPIs going forward:

"So, if you tell me that you have seen 75% of your 2-2.5 year population, what I want to know is […] is that 25% that you haven't seen, are they people that you have or haven't got concerns about? And of the 75% that you've seen, how many of those would you consider to be universal-plus or universal-partnership-plus families? And I want to know that you are seeing 100% of your universal-plus and universal-partnership-plus families. And I want to know that you're seeing 100% of your Terrific for Two population. So, that should be an absolutely standard indicator that here is your Terrific for Two population and we know them all, and we see them all and we have contact with them all. (Interview 18 – Commissioner)

One health visitor also described the inflexibility of the KPIs in terms of the need to reduce the overlap and duplication between some of the visits made by midwives and health visitors, particularly in terms of the post-birth visit:

So, the KPIs are quite inflexible. Especially the 14 days – it doesn't make sense. You're going in sometimes on the same day as the midwife [laughing], and you go in and they say, "Is it okay, I need to go now – I've got to go and see the midwife," and you think it's ridiculous. Whereas, years before, we would make contact, you know, telephone contact, which we are doing now, and then we visit a week or two weeks after, so that you've got somebody going in more frequently and not all – you know, more regularly rather than all in the same intensive space. (Interview 5 – Health Visitor)

Changes to the commissioning process

Commissioners discussed the way in which significant inadequacies within the commissioning process such as the constant need to re-tender services following very short time periods incentivised them to identify easily quantifiable outcomes that could be evaluated within a relatively short time span

> *I think regular review is important of what we do, [but] regular re-tendering is a bad idea. […] What I think is an absolute nonsense is where you have, say, three-year contracts because all you will get is first year setting up, spend the second year, if you're lucky, delivering, and then the third year, thinking about an exit strategy or trying to write the tender for the next one. […] (Interview 14 – Commissioner)*

One commissioner described the need for commissioners to use the Health & Care Act to stop the repeated retendering process:

> *So, it's Section 75 of the Health & Care Act, and it's basically where we say we have a really good provider, it is detrimental to the system. We feel we can…this is the best use of money, is to continue to work with the current provider, and we use a Section 75 agreement. So, that is still an agreement that's a contract, there's still KPIs attached to it, you can still both get out of it, but what you don't have to do is go through a competitive negotiation process to achieve it. (Interview 7 - Commissioner)*

The need for the move to a more systemic and holistic model of commissioning was identified. One commissioner referred to the need for more integrated commissioning

> *I think if we could work towards a much more integrated commissioning model for children, we'd be in a much better place. I mean, obviously, the CCGs commission Mental Health Services, etc. Children's Social Care commission all the residential provision, you know, leave in care provision, all that sort of thing…so, we do…in terms of as a group of commissioners[…], we do work together and we do communicate well, but actually, the reality on the ground, and the contracts that we have, and how services work together is …it could be so much improved…. (Interview 6 – Commissioner)*

This type of cross-boundary or inter-agency commissioning was viewed as being needed to address the fragmentation within the system:

> *The whole integrated care stuff that's kind of coming in slowly. It's come in in some areas more than it has here. I like the idea of it, the theory is fabulous, where we have cross-boundary […] or inter-agency [commissioning], you know, that we're thinking much more about the whole system rather than tiny, weeny, little pockets of it. […]. (Interview 8 – Commissioner)*

One commissioner identified the need for systemic changes going forward to include jointly owned outcomes/KPIs:

> *And I want it to be seamless. I want it to be absolutely seamless. In fact, it should be a jointly owned KPI... (Interview 18 – Commissioner)*

Addressing the significant gap between jointly owned outcomes and the ability to develop a service specification capable of delivering them, was seen as important:

There's this…you know, I kind of sense there's this massive discrepancy between people knowing what they want, in kind of high-level terms, and the outcomes they want to achieve, but not being able to turn that into a specification which delivers that or delivers the process and the milestones, with good proxy measures, towards that, and that is, I think, an underrated and under-present, if you like, commissioner skill. (Interview 14 – Commissioner)

Conclusions

The survey (Stage 1 of this research) suggested that a range of health and social care practitioners s across England felt changes to health and social care practice required as a result of government guidance in response to the SARS coronavirus-2 pandemic, and in particular the requirement for 'social distancing', had significantly undermined their ability to safeguard children living in families with complex problems. It was noted that this occurred at a time of significantly increased risk to young children as a result of the higher levels of domestic abuse, mental health problems, and poverty, in conjunction with the removal of the standard safety net that is provided by nurseries, schools and perhaps most significantly health visitors.

The in-depth interviews explored some of the survey findings in more depth and in particular, the problems encountered by the guidance relating to social distancing, their views regarding the steps that were needed going forward both in the short and longer-term; and the impact of wider service context prior to the pandemic.

The data from the interviews showed consensus with regard to the following three main themes: pandemic-related issues; the government and managerial response; and the impact of the previous 10 years of austerity. Although these findings both corroborate and expand on the results of Stage 1, they nevertheless reflect the views of a small group of practitioners, at a specific point in time.

The **pandemic-specific issues** included inadequate PPE and guidance, particularly in the case of social workers, where the requirement to 'continue practice as usual' was felt to be very difficult in the absence of such measures. The requirement to conduct virtual visits on the part of other key frontline safeguarding practitioners, such as health visitors, was felt to have significantly hindered their ability to safeguard vulnerable children due to limitations in terms of actually seeing and assessing the child in person. In conjunction with the caseload increases for an already overburdened workforce, the almost complete shutdown of many services providing face-to-face support for families with complex problems (e.g. alcohol/substance misuse and mental health problems), and the increase in the incidence of domestic abuse, preschool children living in families with complex problems were viewed as being rendered virtually invisible. Children just below the statutory threshold were perceived to be most invisible, in addition to children who were new to the services (e.g. newborn babies) for whom their vulnerabilities/needs had never been assessed using a face-to-face contact in the home.

The interviews highlighted the way in which these problems were perceived to have been exacerbated as a result of the **government and managerial response to the pandemic.** This was described as being characterised by a high level of 'micro-management' which

was perceived to have added significantly to the workload of frontline practitioners, both preventing them from undertaking the work that they believed to be needed by families, and being virtually meaningless in terms of improving outcomes for this high-risk group. The data also revealed that the lack of central co-ordination and significant regional variation meant that practitioners such as social workers did not know whether they were still meeting their statutory legal requirements. These problems were exacerbated by what was universally perceived to be an inadequate redeployment process in which key frontline practitioners were redeployed to areas for which they had no expertise, whilst newly qualified colleagues, with more recent relevant experience, were not redeployed. The redeployment process was viewed by health visitors in particular, to have added to the low morale and sense of not being valued, by failing to acknowledge their significant frontline safeguarding and specialist preventative public health role.

These problems were also viewed as exacerbated by **ten years of pre-pandemic austerity**, involving significant underfunding and resulting in a depleted service, characterised by practice that had been reduced in significant ways including the loss of most preventive work with families on the edge of care, and all 'meaningful' work with complex families. Relatedly, practice was now seen to be driven largely by a 'tick-box' culture, with key monitoring targets for health visitors viewed not only as inappropriate in terms of capturing the work that they do, but in fact distorting practice. Perhaps most importantly, health visitors and commissioners were concerned that the safeguarding activities of health visitors, which are now a large part of their workload, were not being captured by any KPIs.[4] Commissioners highlighted the way in which the unending need to cut services as a result of the austerity measures, had limited their ability to commission the services that they felt were needed and with greatest impact for the most vulnerable families.

These findings are consistent with other studies that have examined the secondary impact of the pandemic on babies and preschool children. A report by the Children's Commissioner entitled 'Lockdown Babies', for example, showed that the normal routes of referral into children's social care (i.e. schools, health services, adult services, legal agencies and non-statutory services like children's centres) that were closed during the pandemic, account for 60% of all referrals for unborn babies into children's social care, and around half of referrals for children aged 0-4.[5] It recommends the need for in-person visits to be made to babies, for children's social workers to be provided with sufficient protective equipment to complete visits and that the Government should share best practice on in-person visits, including ideas like 'socially distanced' visits at the park. This report also recommends that ministers and local authorities be alert to the anticipated spike in demand when planning for the 'new normal' after lockdown, and that they prepare by 'investing in surge capacity,

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[4] See Vision for Health Visiting - in which they conclude what gets measured gets done: *https://ihv.org.uk/news-and-views/news/ihv-launches-health-visiting-in-england-a-vision-for-the-future;* Also Lowe T, Wilson R (2015). Playing the Game of Outcomes-based Performance Management. Is Gamesmanship Inevitable? Evidence from Theory and Practice. https://onlinelibrary.wiley.com/doi/full/10.1111/spol.12205

[5] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/05/cco-lockdown-babies.pdf accessed 9th August 2020

such as additional staff or other resources'. The report notes that 'while Coronavirus may have exacerbated problems with supporting families, those problems already existed', and that 'we need a coherent, joined up plan from Government for children in their earliest years'.

Babies in Lockdown, which is based on a survey of over 5000 families that examined the experiences of parents, babies and the services that support them found that families already at risk of poor outcomes had suffered the most, and suggests that urgent action is now needed to ensure that the pandemic does not 'cast a long shadow on the lives of some babies'.[6] The recommendations include 'a one-off Baby Boost to enable local services to support families who have had a baby during or close to lockdown; a new Parent-Infant Premium providing new funding for local commissioners targeted at improving outcomes for the most vulnerable children; and [...] investment in core funding to support families from conception to age two and beyond, including in statutory services, charities and community groups'.

Based on data from the NSPCC helpline and Childline, and case studies collected from practitioners working in their service centres, the NSPCC found increased child vulnerability during the pandemic, as a result of the increase in stressors for parents, but also a reduction in the normal safeguards available to protect children.[7] They recommend 'comprehensive and long-term funding for children's services with at least £2 billion a year invested in early intervention and therapeutic services.

Limitations of the research

A main limitation of the research was the small sample size of each group of practitioners. While data saturation was reached and there was consensus across the survey (N=905) and interviews (N=20) with regard to the key themes, caution is necessary in terms of applying the findings to the wider body of practitioners including midwives and community paediatricians. There is also a possibility of self-selection bias in that only practitioners and commissioners who included their information in the online survey were contacted to take part in an interview.

As these finding confirm and extend those of the survey of 905 respondents, our study represents a rigorous evaluation of the perspectives of professionals regarding the realities of safeguarding vulnerable children since March 2020, and the changes that are needed going forward.

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[6] https://parentinfantfoundation.org.uk/babies-in-lockdown/ accessed 9th August 2020
[7] https://learning.nspcc.org.uk/research-resources/2020/social-isolation-risk-child-abuse-during-and-after-coronavirus-pandemic accessed 9th August 2020

Appendix 1 – Interview schedule

INTRODUCTION

- o **Thank you very much for completing the survey, and for agreeing to take part in an interview.**
- o Before we start, I want to make sure that you understand what the project is about. We asked you take part because you very helpfully responded to our survey, and our focus now is hearing your views about what could and should be done coming out of lockdown to best support vulnerable families and professionals and your views will help shape future policy and practice with regard to lockdowns.
- o I also just want to check that you are aware the interview will be recorded, and I will let you know when the recorder is put on and when it is switched off.
- o What you say may be used in a report but will be completely and totally anonymous,
- o You don't have to answer questions if they don't want to
- o You can stop the interview at any point without explanation.
- o <u>Can you confirm that you consent to take part?</u>
- o Can I clarify how much time you have got?

Probes FOR PROFESSIONALS

Role: What is your current role?

Context: In what ways if any did the austerity measures impact your practice?

The pandemic:

- Can you tell us about a **family where things have gone** well in terms of supporting them during the lockdown? Please don't mention any of their names.
- Can you tell us about a **family where things did not go well,** and the situation has meant they have not been adequately supported?
- What are you views about the use of virtual care with these families?
- What do you think these families would have liked in terms of support?

Emergence from the pandemic:

- It is anticipated that there will be a surge of newly vulnerable families emerging over the coming weeks and months as we move out of lockdown. What are the **key issues** that you face in the coming months in terms of your **case load and the delivery of services to these vulnerable families;**
- What are the most **urgent and immediate things** that could be done to support you to safeguard the children in these families.
- Which **if any services should be prioritised in terms of supporting vulnerable families** over the coming months; which vulnerable families should be prioritised in the coming months; how should this be done?

- Can you tell me what your thoughts are about who should be visited going forward and how can this best be done: **Probes** – which services; practitioners; home versus clinic;
- **What are your views about the use of virtual visits going forward?**
- Are there any **new ways of working that you have established during the pandemic** that you would consider continuing a) as we transition out of lockdown; or b) once completely normal service delivery is resumed.
- What in your view could **managers/commissioners do better or differently** going forward?
- How could **local data** best be used to inform what services are provided going forward?
- What needs to be done to improve **co-ordination of services** supporting vulnerable families going forward?
- **What planning** is needed to address the issues that are going to emerge over the coming months.

Probes for COMMISSIONERS

Role – Can you tell me a bit about your current role and past experience?

Context – Can you tell me about the ways in which, if any, austerity measures have affected your commissioning of services;

Early stages of the pandemic – what were the issues for you as a commissioner in the early stages of the pandemic?

Ongoing problems due to the pandemic -

- One of the findings of the survey was that commissioners believe that there is going to be a **surge of vulnerable cases identified** as we move out of lockdown. What sort of additional services would you like to be able to commission going forward to enable that their needs are met.
- Health visitors want to be **able to return to delivering universal services,** partly because they believe that this enables them to identify need arising specifically from the pandemic, of which we suspect there is a lot. **From a commissioning perspective, what are the issues;** what could be done to help with this?
- There is already a lot of **pressure on core funding** as a result of austerity with some suggestion that any additional funding is just offsetting existing deficits. What, if anything, could be done to enable you to commission services that meet all of the needs of vulnerable families with preschool children?

From a commissioning perspective what are the **longer-term key issues going forward** in terms of a) safeguarding vulnerable families; b) enabling services to address the needs?

Appendix 2 – Interim recommendations from Stage 1 of the research

Contact with families

In-person visits are perceived to be essential for adequately protecting children known to be vulnerable both during a pandemic, and going forward. We recommend that practitioners should be able to provide safe, assessment, ongoing support, and safeguarding activities to vulnerable families, using in-person visits in the home or the clinic through the provision of adequate PPE and strategic use of existing community spaces and appointment times. More work is needed to ascertain whether support for in-person contact with vulnerable families is as strong across England as it was among these survey respondents.

To protect children whose vulnerabilities are not currently on the radar, universal contacts should be recommenced as soon as possible for health visitors with a focus on the new-birth and 12-month visits.

Virtual delivery of face-to-face services using online platforms may have a role in the delivery of services with no known vulnerabilities, or where vulnerable families are self-isolating.

Training and support (both technical and emotional) should be provided to key frontline practitioners, particularly in regard to the delivery of virtual services.

Evidence is now needed regarding the benefits of in-person contacts for families including those experiencing risk, in order to support decision making about its use in the future.

Families with a preschool child should be sent an update regarding the services and support available going forward, to encourage re-engagement.

Planning and coordination of services

Joint needs assessment and action plans should be conducted with regard to vulnerable preschool children in each locality across key agencies (Healthy Child Programme, Early Help, Midwifery, Children's Centres, Early Years, Children's Social Care) and should be used to guide service provision going forward.

In order to ensure that at least one professional is in contact with families with known and serious vulnerabilities, action plans should include a lead practitioner for each case.

The childcare offer for key community-based practitioners should be extended to enable them to reduce their home working.

Lead practitioners should be consulted going forward, to establish the local challenges and the changes that are needed to enable them to provide the level of care that is needed. This should include discussion between practitioners and commissioners as well as providers.

Channels are needed for lead practitioners to communicate directly with commissioners and not just providers.

Direct line managers of practitioners should adopt a more collaborative approach with practitioners that includes consulting them about the best approaches going forward.

All communication with staff, and particularly those using email, should provide a) transparency with regard to decision-making processes; and b) the opportunity for staff to be listened to with regard to key changes going forward.

Preparation needs to be made to identify and support the 'missed cohorts' of vulnerable children resulting from this pandemic, including those with newly emerging need.