Learning Summary: Multi-agency audit on Children with a Disability

Overview:

In May 2017 Oxfordshire Safeguarding Children's Board commissioned an audit to review how effective multi-agency working was for children with a disability. The audit was selected in relation to issues arising in two recent Serious Case Reviews and in a separate Partnership Review.

The purpose of the audit was to review practice in relation to multi-agency assessment, information sharing and planning, and to identify the structures and tools that might help practitioners in assessing information which informs decision making.

Five families were involved in the audit with a total of fifteen voices from four children, seven parents and four siblings. Cases were chosen on the basis that all had the involvement of health, children's social care and education and presented high risk, complex and challenging decision making. They were a mix of cases where the child was subject to a child protection plan and those who were not. Agencies included Children's Social Care, Oxford University Hospitals, the Clinical Commissioning Group, Oxford Health and Education and Learning.

There was very strong take up, indicating that people wanted to give feedback and have their voices heard.

Themes in common with other audits in Oxfordshire:

- Normalising and misinterpreting behavior linked to Special Educational Needs but pleasingly minimal evidence of this in the 4 deep dive audits which was encouraging
- Identifying the increased safeguarding risks for children with disabilities and Special Educational Needs
- Children 'not being brought' to primary and secondary healthcare appointments by parents/carers
- The importance of school attendance

Findings:

Overall the findings for the audit were positive and considerable good practice evidenced. The following strengths were identified:

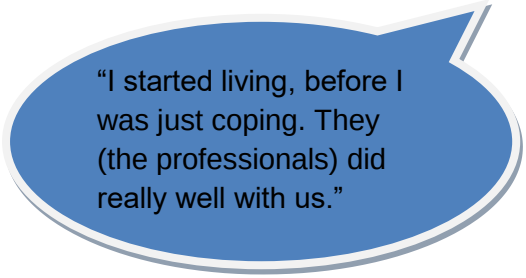
- Overall multi-agency working was very strong across all agencies
- Services had made a good or excellent difference and adapted service delivery to meet the needs of children and families
- Use of relevant tools evident in all cases

- Children and families all identified how much they valued the input/support and persistence of the key workers who worked with them closely: school staff, some key health professionals and social care staff were all identified by children/families as 'going the extra mile' and helping them understand how to safeguard their disabled child and other children who were all vulnerable to poor outcomes before professionals became involved. Direct work from the right professional/s at the right time is critical to this work. Safeguarding work with some disabled children and their siblings will be ongoing throughout their childhood because of their complex needs and the impact this has on family functioning

- Good evidence of information sharing and professionals working hard to engage with others and gather information

- Strong evidence of whole family approach

- Parents and children broadly felt listened to



Key areas for improvement:

- The need for more active engagement and communication with GPs was identified

- Child protection planning could sometimes have been identified earlier although it was noticeable that Child in Need/Early Help Planning can also be effective at safeguarding children where the risks are lower because parents have capacity and are proactively addressing their child's needs

- There could be greater knowledge of what a specific disability means and how this might impact on safeguarding

- Consideration of specific barriers to overcome where the child is non-verbal. Always speak to disability experts who can help with this. Consultation is always available.

- Parents and children were sometimes not sure about how their views impact on plans

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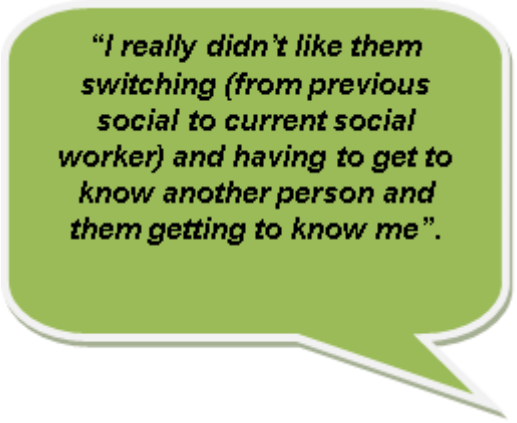

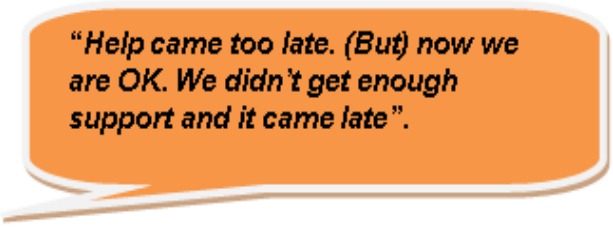

Learning points for managers

- The need for child protection planning could sometimes have been identified earlier and parents reported timing of help and support was 'too slow'
- Children not being brought to appointments should be identified early across all agencies and escalated as a risk factor where there is a concern about neglect and needs to be cross-checked across different health professionals
- Promote importance of schools sharing information with other education colleagues who may be less centrally involved. Also important for schools/settings to make sure appropriate safeguarding information is shared with all front-line staff who work directly with the child on a regular basis e.g. teaching assistants, lunchtime supervisors etc.

Action points for practitioners and managers

- Ensure practitioners keep a clear record of 'was not brought' episodes to identify any patters or gaps and work with partners to ensure this is collated
- Ensure neglect is identified and named at an early point through active use of the Child Care Development Checklist and Practitioner Portal
- Raise awareness of the importance of understanding how a child's impairments may impact on and contribute to their safeguarding vulnerability
- Work with GPs to ensure active engagement and communication in safeguarding processes; remind GPs of the importance of submitting a report and ensure they receive minutes even if they have not attended meetings or contributed reports
- Provide clarity to children, young people and parents on how their views and opinions impact on plans
- Be aware of the specific barriers where the child is non-verbal

Key messages for inter-agency learning

- The importance of good, effective communication between services
- The importance of early identification of neglect and recording and responding to children 'not being brought'
- Promote training for practitioners to understand and identify increased safeguarding risks for children with a disability

If you do one thing, take the time to

Listen to children, parents and siblings – do you understand what a specific disability means and how this might impact on safeguarding? Children reported that they relied on parents to bring up their views and opinions and one sibling reported her insight could have been used more, have you thoroughly considered and paid enough attention to children's views? Have you recorded and acted on them? Are you providing them with feedback about what is being done? Are you keeping them in the loop?

Remember to use the resources available….

Seek advice and support from other agencies – If you have any queries or questions you can contact other agencies for advice and information, or reassurance on concerns.

Reminder to practitioners: Information, tools and links to support for those working with disabled children

- **NSPCC: 'We have the right to be safe, Protecting disabled children from abuse** https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-report.pdf
- **Ofsted: Protecting Disabled Children: Thematic inspection** https://www.gov.uk/government/publications/protecting-disabled-children-thematic-inspection
- **Action for Children: Safeguarding Disabled Children in England** https://www.actionforchildren.org.uk/media/6902/safeguarding-disabled-children-england.pdf
- **Eleanor Schooling: Social care commentary, protecting disabled children** https://www.gov.uk/government/speeches/social-care-commentary-october-2017
- **OSCB: Neglect Practitioner Portal – Tools and Interventions** http://www.oscb.org.uk/themes-tools/neglect/neglect-toolkit-tools-and-interventions/
- **OSCB online training –** the OSCB offers a variety of face-to-face and online courses to suit most safeguarding needs. If there is a course you feel we should be running, tell us! http://www.oscb.org.uk/training/