

# Speech: Social care commentary:

## October 2017

In this commentary I want to highlight the main ingredients for effective practice in protecting disabled children. I will look at this from a strategic level for local authorities and their partners, and at a practice level for the regulated settings we inspect.

Research on protection of disabled children indicates that they are more at risk of being abused than non-disabled children. In fact, it is estimated that [disabled children are over 3 times more likely to be abused or neglected](#) than non-disabled children. This analysis of the risk to disabled children covered a wide range of types of disability, including physical and sensory impairments, mental illness, mental or intellectual impairments and long-term health problems.

As an inspectorate, we continue to challenge ourselves on how we can improve the way we inspect the experience and progress of disabled children. Similarly, leaders across agencies must challenge themselves on whether they are doing enough to protect disabled children.

The questions we, as leaders, need to ask ourselves are:

- are we giving disabled children a level of priority that reflects the risk of abuse?
- is there a thorough understanding of how well children are being protected?
- do practitioners have enough knowledge and skill in this area of practice?
- are we maximising the benefits of multi-agency working?
- why are disabled children more vulnerable to abuse?

According to the NSPCC publication, [‘Protecting deaf and disabled children’](#), some of the reasons that make disabled children more vulnerable to abuse include the below.

### **Dependency**

Some disabled children are dependent on a wide network of carers and other adults to ensure that their medical and intimate care needs are met.

### **Isolation**

Disabled children may need support carers to take them out. They may not have the same network of relationships with their peers as other children.

### **Communication barriers**

Some disabled children have difficulty reporting concerns or abuse. Many of

the ways open to children, such as telephone helplines, are not accessible to all disabled children.

## **Problems identifying the signs of abuse**

A lack of understanding and training about safeguarding disabled children can result in professionals not recognising signs of abuse or neglect. This is important because research indicates that identifying abuse of disabled children is most likely to come from observations of physical signs, behaviour or changes in mood. Research shows that disabled children are less likely to disclose abuse and more likely to delay disclosure.

## **Issues with understanding healthy relationships and how to be safe**

Accessible programmes to explore sex and healthy relationships and understand what abuse is are not always available to all disabled children. As a result, a disabled child may not know how to recognise when they are being abused or who to tell. Research has found that children who have special educational needs have a poorer understanding of bullying and inappropriate touching. This means that disabled children are less able to keep themselves safe.

## **Do we sufficiently prioritise disabled children, given the risk?**

Ofsted's [2012 thematic survey report on protecting disabled children](#) found that disabled children who were also identified as children in need often had unidentified child protection needs. It also found that the majority of Local Safeguarding Children Boards (LSCBs) and local authorities were not robustly assessing the quality of work to protect disabled children.

Since the publication of the report, there has been no significant change to the proportion of disabled children with a child protection plan.

The number of children on child protection plans who have a disability is around 1,600, or just over 3% of all those on a child protection plan. This figure based on the most recently available unpublished data for March 2015. However, there are around 820,000 children who have disabilities in England. This represents around [7% of all children](#). The number of children in need who were recorded as disabled was [13% at the end of March 2017](#).

The proportion of disabled children identified as being in need, or on protection plans, varies a lot among local authorities. We do not know what the right number or proportion is, but the significant variation cannot be right.

Only a minority of LSCBs' annual reports include any analysis of why there are low numbers of disabled children on child protection plans. They need to understand how effective they are at identifying and responding to child protection issues. And we all need to constantly challenge ourselves about how we can do more.

The [National Working Group on Safeguarding Disabled Children](#) undertook a

[survey of LSCBs](#) to assess progress against the recommendations made in our 2012 thematic report. It is concerning to see that responses to the survey indicate that not enough consistent progress has been made on these recommendations. A significant number of LSCBs that responded were not reflecting the risk to disabled children in how they set their priorities, or implementing measures to ensure that the thresholds for child protection were understood and applied.

Overall, there is a lack of preventative strategies to protect disabled children. Thresholds for child protection need to be understood and applied. We have seen delays in recognising child protection thresholds for disabled children. This needs to be closely monitored to ensure that professionals:

- have enough of an understanding of child protection issues for disabled children
- understand the increased vulnerability of disabled children
- take timely and effective action

I am also concerned about some findings from the local authority SEND inspections. They indicate that some local authorities are not using joint working effectively. This is most apparent in education, health and care plans, where in too many local authorities the child's education needs are the main focus. The result is that disabled children's health and care needs are not fully assessed or met.

## **Learning from good practice**

Despite the concerns that we have found, there is good and excellent practice taking place in frontline work. We need to look at that and learn from it.

In Wigan disabled children receive effective services from experienced and knowledgeable professionals. Staff undertake detailed and sensitive assessments with the support and input of partner agencies. They regularly review packages of support for families to ensure that they meet the child's and family's changing needs. Skilled staff build relationships with children at their own pace, ensuring that the voice of the disabled child and other children in the family inform planning and intervention.

In North Tyneside staff are developing holistic approaches for disabled children. Childcare social workers have been transferred to adult services as part of a 'whole life' approach to supporting disabled people and to improve transitions between children's and adult services.

We have also identified examples of good practice in transition planning. For example, in Wakefield planning starts early, with the engagement of adult services. Young people are involved in all the main decisions. Care packages are personalised to meet the specific needs of individuals.

The LSCB in Bedford has made safeguarding disabled children a high priority. Actions taken to respond to concerns about practice include a thematic review, practitioner briefings and training, and a spotlight event on safeguarding disabled children. The Board receives regular assurance reports

on the work of the children with disabilities team. It triangulates information from other sources, for example the chair of the Board 'walks the floor' and speaks directly to social workers. This keeps up the challenge to improve the quality of services. It has led to greater capacity in the team and improvements in the quality of assessments.

Partnerships should gather and evaluate information on disabled children to understand their needs and how effective interventions are. We have seen some good examples of this.

In York there is an effective response to disabled children, delivered by a well-managed partnership. Children, parents and their carers have influenced many service developments. The impact can be seen in the improved short-breaks offer.

Hounslow identified that the number of disabled children living with domestic abuse was lower than expected. Staff are now working to understand the reasons for this.

West Sussex LSCB undertook a focused audit after introducing new assessment tools to identify neglect. It realised that these tools needed to be adapted for assessing disabled children to ensure that risk could be identified effectively.

## **Keeping children safe in residential care**

At the end of March 2016 there were around 1,300 disabled children in residential care. Around 2,000 additional children were in receipt of short-break or respite care during the year 2015 to 2016.

The importance of the child's whole experience in a residential service and the impact this has on their safety cannot be overstated. A positive whole experience will help disabled children to overcome some of the barriers that make them more vulnerable to neglect and abuse.

Good practice in residential care for disabled children should include:

- supporting disabled children to communicate
- dedicated staff, with the necessary skills and experience, who work in partnership with parents and other agencies
- opportunities for children to build self-esteem
- supporting disabled children to take some part in the development of plans for their care (co-production)
- teaching disabled children how to recognise when a situation or someone's behaviour is inappropriate and giving them skills to manage social situations safely
- supporting access to advocacy services
- high-quality assessments that are updated regularly
- supporting children and their relationships with important individuals, including their parents

We have less evidence from our inspections about how well children are

supported to try new things so that they can take appropriate managed risks and learn from experience. Given this is such an important part of becoming more independent, we will give this more attention in our inspections.

## **Supporting disabled children to communicate**

Outstanding residential providers share common characteristics in their approach to how disabled children communicate their choices and preferences. The best providers use innovative approaches to make sure children take part in planning their own lives and the way the services are delivered. This helps children to be assertive, to make choices, exercise control over their bodies and lives, and be safer.

In the North West there is a residential school for blind and partially sighted children who have complex health needs. The school uses a 'total communication' approach to support children. Staff know that listening and responding to children, however they express themselves, are vital to promoting their rights and protecting them from harm. The multi-disciplinary team around the child places children and their families at the centre of their practice. Staff focus on the children in the room and communicate in the most effective way with each child so that they are included. The environment is specially adapted to support clear communication and independence: areas are identified through sensory landmarks and smells. Staff are trained in augmentative communication (the use of other forms of communication other than speech) strategies and understand their children so well that they can pick up on the smallest of signals to help understand their needs.

## **Skilled and experienced workforce**

Increasingly, we inspect schools and children's homes where training in child protection relates directly to disabled children and their particular vulnerabilities. Managers ensure that they use knowledgeable trainers and work with them to create a bespoke package for their particular setting. This is how it should be. In this way, staff are better equipped to do the right thing.

## **Building self-esteem**

If children participate in decisions about their care and have good self-esteem, they are more likely to be able to keep themselves safe.

Good and outstanding residential providers make it a priority for children to have experiences that build their sense of self, confidence and self-esteem. Children are empowered by learning new skills, being supported to communicate their wishes, and being involved in decisions about their daily lives.

For example, at a short breaks service in the East Midlands staff have supported young people to undertake work experience in a hotel. Young people have taken part in several fund-raising events for local and national charitable organisations. They have also taken part in consultations on

national issues for disabled children.

At a children's home in the West Midlands young people's physical and learning disabilities are not seen as barriers to independence. Staff assess their skills and abilities and devise programmes that assist them to be as independent as possible. The children's guide has recently been updated following feedback from young people. It is personalised to meet their individual communication needs.

## **Supporting disabled children to participate in their own care**

Providing the best residential care means more than just the quality of direct care for disabled children. Our inspectors have seen a range of innovative and creative approaches that help children to exercise control over their lives and have increased capacity for making choices. These approaches include:

- staff involving disabled children in creating their plans and reviewing the quality of their placement and the care they receive
- supporting children to communicate when they are unhappy about the care they are receiving

At a children's home in the West Midlands, staff take time to build their relationships with young people, getting to know and understand them. This means that staff are able to interpret body language and facial expressions so that they can determine when young people are upset or distressed. As a result, young people are able to influence their care arrangements. For example, one young person with very restricted movement has been able, with staff support, to develop a meaningful communication system using eye blinks to request changes to her feeding patterns.

At a residential resource centre in Yorkshire, whatever their level of communication, children and young people's right to influence the care they receive is actively promoted and respected. Young people actively contribute to selecting new staff, enhancing the centre's already rigorous recruitment procedures. Using their preferred communication methods, young people ask their chosen questions of applicants. 'Which superhero would you be?' and 'what will you do if I say to you that I am being bullied?' are questions that help children to decide who is going to care for them in the way they want to be cared for.

## **Helping disabled children to develop personal safety**

It is essential to help children and young people to learn about what helps to keep them safe. They must see and experience safe and effective care. They should regularly and meaningfully contribute to reviews of their care plans. Access to appropriate learning about relationships, sexuality and personal care helps them to develop an awareness of risky and harmful behaviour. In

the better providers, we see elements of this work being threaded through the practical support that staff give to disabled children. For example:

- effective role modelling of safe relationships
- protecting personal space
- teaching children about safe relationships
- teaching children to keep themselves safe online

## **The importance of high-quality assessment**

Staff should be knowledgeable about the range of physical and emotional signs and symptoms that a child may experience as a direct result of their complex needs. This helps them to identify any signs that may need further consideration, including potential child protection concerns.

## **Access to advocacy services**

Access to advocacy is important for disabled children. This means having independent visitors and listeners in schools who make clear evaluations about how well children are cared for and kept safe. They can then share this information directly with governors and leaders.

## **The challenge for all of us**

We all need to challenge ourselves about whether we have fully taken account of the heightened risk to disabled children. Are we doing enough to ensure that we overcome any barriers to protecting them? It is critical we have a workforce that has the skill and knowledge to protect disabled children. We need to understand how well disabled children are being protected and take timely and effective action to improve this. The wider experience and progress of disabled children, in our view, is essential in safeguarding them.

At Ofsted, we can improve our focus on how disabled children learn to keep themselves safe, so that we better reflect the impact of this work. We could do more to highlight where we find excellent practice and resources in sexual and health education. We know that disabled children must receive the right kind of information to help them to be safe and we need to do our bit to make that happen. What can you, as agencies and professionals do, to improve the safeguarding of disabled children?