Oldham Safeguarding Children Partnership

Child G
Local Practice Learning Review

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1. Introduction

1.1.1 This Local Practice Learning Review (LPLR) was commissioned by Oldham Safeguarding Children Partnership (OSCP) in accordance with Working Together[1] (2018). The LPLR took into account this guidance and the principles of the systems methodology recommended by the Munro review[2].

1.1.2 The case was referred by Children Social Care (CSC) for rapid review in November 2020. The panel agreed that there were failings by local agencies and that a LPLR should be undertaken as, there was clear evidence of a risk of harm that was not recognised by organisations or acted on appropriately at the time.

1.1.3 LPLRs provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The review should be proportionate to the circumstances of the case, focus on potential learning, and establish the reasons why the events occurred as they did.

1.1.4 It was felt there was learning to be gained by conducting this review.

2. Summary of Learning Themes

2.1.1 The following are the main learning themes:

- Ineffective Child in Need process
- The need to remain focussed on the child
- Importance of listening to and communicating with parents
- The need to place yourself in a child/parent's shoes
- Importance of escalating concerns and interprofessional challenge
- Impact poor communication has on providing timely services
- Resource issues – gap in mental health services for 16-18
- Insufficient capacity in the learning disability nursing service
- The need to provide funding panels with contextual information to inform how funding can be allocated to meet need

3. Analysis of the key focus areas

9.1 Escalation

9.1.1 In this case advice and supervision were sought on many occasions. Practitioners followed the advice given and either referred the case through the Multi-Agency Safeguarding Hub (MASH) or escalated the case when advised. There is no evidence that escalating the case to line or more senior managers resulted in improved outcomes for Child G or his family. When no improvement was achieved there was a lack of further escalation or challenge by line or senior managers.

9.1.2 The reviewer learned that within CSC there was a lack of stability within the leadership team. This coupled with a lack of stability and experience amongst

[1] Working Together to Safeguard Children (2018)

[2]The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).

professionals working within the learning disabilities team, lead to issues being managed at a low level.

9.1.3 What was missing in this case was the right level of experienced people to case manage, drive, and take responsibility. Line manager and supervisors, whilst they provided advice, did not take responsibility for ensuring progression of the case. All the issues remained with frontline practitioners to address. Both frontline practitioners and their managers lacked creativity to find solutions to address the problems they encountered. Some of the practitioners indicated that they had reached the end of their level of expertise, and felt quite despondent that they had not been able to elicit any meaningful change in circumstance for Child G.

9.1.4 When cases were escalated the practitioner was right to anticipate action would be taken. However, when no action followed on from escalation, there was often no attempt to escalate further. The lack of strategic direction to manage complex cases was identified as an issue within, a local thematic review[3]. A complex case forum was developed: practitioners were clear that it is yet to function effectively.

9.1.5 In August 2020 following escalation to a senior manager the case was taken to the newly developed complex case forum, resulting in a renewed effort to get the case on track. Whilst progress has been made recently, with a more cohesive multi-agency approach and an increased package of care, Child G's situation has proved challenging and remains largely unchanged.

9.1.6 The OSCP delivers professional challenge training however, delivery of the training has stalled due to this needing to be delivered face to face. PCT have held a lunch and learn session on resolving professional differences which is on the intranet for staff to view.

Learning point 1: Escalation processes were not resulting in improved outcomes for children. There was a lack of follow up to ascertain what actions had been taken, and challenge when the situation did not improve. An escalation and resolution pathway, revised in September 2020, provides clear guidance to staff including timescales and next steps. This has the potential to provide greater clarity to frontline staff, however, they will require greater support by line managers that has not been in evidence in this review. Professional challenge requires further development.

Recommendation 1: OSCP to seek assurance and evidence from partners that escalation and professional challenge is promoted in supervision and line management when cases are not progressing. If no evidence is available identify the steps that are being taken to improve this

9.2 Systems and processes

9.2.1 Child in Need

9.2.2 Practitioners indicated they were not always clear what the remit of the meetings they were attending was. When the case escalated to CIN this was an opportunity to co-ordinate agencies and gain progress. However, when the SW escalated the case to a team manager, rather than working to produce an effective CIN plan and increase the effectiveness of CIN, Multi-Disciplinary Team (MDT) meetings were held. This produced confusion with some practitioners indicating they hadn't known whether they were attending a CIN meeting or an MDT. Multiple changes in SW appears to have led to a lack of coordination and drift in planning. Whilst the case was open to CIN there was reduced CIN activity. The outcome being Child G's case

[3] Child Q/R Local Child Safeguarding Practice Review (2021)

entering CIN made no significant positive impact. Lack of capacity within services means that health staff do not routinely attend CIN meetings. In this case the GP was unaware the case was in CIN; the GP knew the family well and could have provided useful information. Lack of coordination and planning had the consequence of reducing the effectiveness of CIN meetings.

9.2.3 Education, Health, and Care Plan (EHCP)

9.2.4 Child G was subject to an EHCP. An EHCP is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHCPs identify educational, health and social needs and set out the additional support to meet those needs. The last revision of Child G's EHCP until 2020 was made in 2016/17 and does reference the issues he was having in relation to his fear of the stairs. What is less clear is the plan to address the issues. School did refer Child G to the relevant services on numerous occasions ensuring they were aware of what staff had encountered visiting the family home. School also escalated the case to the Assistant Director of Education at the time and the Enhanced Designated Clinical Officer for SEND. Whilst the SEND team don't have a duty to update an EHCP every year, they will update it if something has changed in relation to learning. SEND report that as Child G wasn't accessing education they didn't know if his learning needs had changed and were not in a position to update his plan. Child G wasn't in school, therefore there was no information to update the plan. This proved problematic in terms of Child G needing to overcome his fear of stairs in order to access learning and revise his plan; this situation has flagged up a limitation to the process. School was of the opinion that there were far bigger concerns evident and barriers to assess Child G's educational needs created by his inability to leave his bedroom.

9.2.5 Care Education and Treatment Reviews (CETR)

9.2.6 Child G was at risk of admission as a result of seizures and toe infections. CETRs are designed for anyone with a learning disability, autism or both who is at risk of admission. There is no evidence that Child G was subject to a CETR until the case was escalated to senior managers in October 2020, suggesting it is underused and not understood by frontline practitioners and middle managers.

Learning point 2: There is a lack of connectivity/interaction between frameworks and processes in Oldham. Practitioners were not making best used of the frameworks and processes available to them. When practitioners and the case became 'stuck' these processes could have been used to further inform thinking and assist practitioners to formulate plans that would bring about change. Management of the case was disjointed. These factors negatively impacted on services working together and achieving a holistic approach to the presenting problems. Increasing the connectivity and understanding of frameworks and processes has the potential to increase their effectiveness.

Recommendation 2: OSCP to develop guidance on pathways between frameworks and processes and partners ensure frontline staff are clear regarding the circumstances when each should be used by sharing the guidance and utilising in supervision. The OSCP to review its effectiveness following implementation.

9.2.7 Leadership and multi-agency working

9.2.8 Parents report a massive lack of communication and that at times they felt overwhelmed by the number of different people involved. There is evidence of groups of professionals coming together to share information and discuss concerns.

What is less apparent is the effectiveness of any of the discussions to produce and advance a plan that had the potential to elicit positive changes for Child G.

9.2.9 Treatment for a phobia is usually through Cognitive Behavioural Therapy (CBT) delivered by a psychologist. CBT works by helping an individual replace their fearful thoughts and behaviours with more rational alternatives. Relaxation exercises are used to help the individual remain calm, whilst the object of fear is slowly introduced to desensitise the individual. Whilst CBT might not have been a viable option for Child G, there is no evidence this or alternative approaches were attempted.

9.2.10 Practitioners either reached the end of their expertise, weren't commissioned to provide a service, or were waiting for someone else to complete an action before they could or would intervene. Practitioners reported the lack of a mental health service for Child G's age group had a significant impact. When Child G's behaviours were considered to relate to a mental health issue the Learning Disability (LD) nursing team completed a comprehensive discharge letter and withdrew.

9.2.11 Up until then the LD nursing team had been suggesting strategies to manage Child G's behaviours in the context of his learning disability and autism. Parents were expected to put these strategies in place and manage the situation themselves rather than a more proactive approach of working with the family. When the strategies did not work, some professionals felt the family were not engaging and not complying. From the family's perspective they felt "forgotten about" and that "practitioners were disinterested and did not give them confidence that they knew what to do".

9.2.12 At the beginning of the review period family support workers were going into the home and taking Child G out, this seemed to be encouraging Child G to come downstairs. However, parents indicated that practitioners were only using half of the two hours to take Child G out, and parents didn't feel sitting with Child G in the home was beneficial, so stopped the visits. The reviewer has reflected that if this service had remained and completed the work tasked, there might have been potential if coupled with some mental health intervention, to overcome the issues.

9.2.13 School did visit the home on occasion but did not always gain access. They provided Child G with an iPad so he could access music lessons online. Unfortunately, Child G had never used an iPad previously, showed no interest or understanding, so this did not have the positive impact intended. School was limited in what they could provide by environmental factors

9.2.14 Parents indicated they didn't feel that they were being listened to and their suggestion to sedate Child G to bring him down was not enacted upon. So, although the perception was that professionals were working together, the reality was that there was significant silo working. Escalation to line-managers was evident but the actions taken did not result an improvement in circumstances for Child G. Leadership within CSC until February 2020 was not demonstrated. Escalating the case on one occasion led to a manager's decision to close the case despite significant concerns and no improvement. When the case was taken to the complex case forum in February 2020 this brought about renewed focus and energies and in the months that followed there is evidence of a more focussed plan. However, this did not bring about change. A change in SW in October 2020 brought about a more comprehensive assessment which has produced a clearer picture of Child G and his family's needs emerged. Plans are in place to renovate the property so Child G will have single storey living and , once Child G is brought downstairs there is a plan for further assessment of his health and wellbeing needs.

Learning point 3: The CIN forum should have been the right forum in this case. Development and actioning of a CIN plan built on the EHCP and CETR should have been sufficient to bring about change. It is concerning that the CIN process was ineffective in this case. It is acknowledged that multiple SW changes and gaps in service provision likely prevented the case gaining traction. Despite a significant level of activity this case has drifted with Child G spending 3 years isolated in his bedroom without his health, education and social needs being met. As time went on and the case remained stuck, it was likely to need to be progressed by more senior practitioners through a complex case forum. A complex case forum has recently been developed as a result of a recommendation from an as yet unpublished local thematic review. Practitioners identified that the complex case forum remains underdeveloped and underutilised; practitioners identified that they did not have the capacity to meet the needs of increasingly complex cases.

Recommendation 3: OSCP partners to conduct a review and audit of CIN, to test the effectiveness of CIN and make recommendations to strengthen practice. The OSCP to review its effectiveness following implementation.

Learning point 4: Line managers have not demonstrated leadership or provided sufficient guidance and support to frontline practitioners working this case.

Recommendation 4: OSCP and its partners to seek assurance regarding the effectiveness of case supervision and multi-agency oversite, in guiding and supporting staff, in cases that are challenging.

9.3 Decision making

9.3.1 Child G met the criteria for statutory intervention prior to and during the entire period of this review. Parents had identified that they were struggling with Child G's behaviours from 2010 with request being made for social care support. The support offered was intermittent with the case being closed and reopened on a number of occasions with no clear rationale. Child G's case was often directed to early help but should have remained in CIN. In 2019 health professionals were clear in their belief that the case had reached the threshold for child protection (CP) as Child G remained unable to come downstairs, was confined to his bedroom limiting his life experiences and preventing him being able to attend school, medical appointments and undertake the activities that had previously brought joy to his life. There was also potential for risk to life if Child G was to become seriously unwell or in the event of fire. The reviewer cannot comprehend the thinking behind the decision within CSC to close Child G's case. At best this demonstrated a lack of recognition of the severe impact Child G's circumstances were having on his and his parents lives and showed little consideration of his and their need for support and services, that was tantamount to organisational neglect. Towards the end of the review period, there was greater ownership from senior managers across the partnership which has led to an increase in activity to try and improve Child G's circumstances.

Learning point 5: The rationale behind decisions in this case have not been fully evidenced. Managers lost sight of Child G and his family. CSC in their learning summary have expressed a confidence that the recently refreshed continuum of need document, the now permanent management structure within CSC, improved relationships between CSC and its partners, and an increase in inter-agency challenge means that this situation would not arise again. The reviewer is less confident.

Recommendation 5: The OSCP partners to amend the escalation policy to incorporate escalation of complex cases to the complex case forum and, monitor the effectiveness of the Complex Case forum to ensure that case is being referred at the earliest opportunity and the pathways are understood.

9.4 Voice of the child

9.4.1 Across services there is evidence that professionals had some understanding of Child G's lived experience. However, Child G's parents indicated professionals had not spent enough time observing Child G, since he has been confined to his bedroom, to get to know him or to fully appreciate the limitations this had caused until a SW assessment in 2020. From parents' perspective, they felt that practitioners were disinterested and did not spend enough time with themselves, to understand Child G or their daily lived experiences. Child G's parents indicated that at no point did practitioners give them any confidence that they knew what to do. Child G went from a boy whose greatest pleasure and calming place was outside, to a boy who was confined to the upstairs of his home. The limitations brought about by his difficulties with stairs cannot be overstated. Initially there were discussions as to whether Child G might be being confined to his room against his will; however, if this were the case, there was no consideration that this might constitute a deprivation of his liberty (DoL) and therefore a need to conduct a DoL's assessment. During this period Child G turned 16, at which point professionals should also have been considering mental capacity in line with the mental capacity act.[4] Within records there is no evidence to suggest a mental capacity act assessment has ever been undertaken.

9.4.2 Child G's inability to come downstairs is cited as the reason an annual review of his EHCP was not completed. The plan was not adapted to address the fundamental issue that was limiting Child G's life experiences. Father indicated that he had suggested Child G be sedated to bring him downstairs, but this suggestion was not pursued. Instead, practitioners tried to work around Child G's behaviour with no coherent plan. Parents indicated there were problems in getting Dr's to visit the family home to assess Child G.

9.4.3 Child G and his parents had significant unmet needs throughout the review period. Agencies did not work collaboratively to acknowledge or address those needs. Not all partners were invested in a multi-agency approach. GPs are currently not contributing to the EHCP process which reduces the breadth of information being drawn upon to complete the assessment, potentially reducing its effectiveness. At time CSC withdrew their involvement (see section 12.3) creating a significant void. Child G was not able to attend school; research conducted in Scotland with parents of autistic children who had missed school found 71% had missed school for reasons other than common childhood illness in the two years of the review period.[5] This is lost time when they could have been developing further skills. Sadly, the lack of a fully invested coordinated approach to identify Child G's unmet needs, lack of

[4] Mental Capacity Act 2005

[5] Children in Scotland, the National Autistic Society Scotland, and Scottish Autism (2018) Not included, not engaged, not involved: A report on the experience of autistic children missing from school https://www.notengaged.com

understanding of the cause and work with the family to address it at speed, has meant Child G spent the two years of the review period shut off upstairs.

9.4.4 Child G's parents were best placed to articulate his voice if Child G had not got mental capacity to do so. Parents were clear that Child G's voice was not being listened to. A recent attempt to get Child G downstairs has been unsuccessful. Parents felt that had they been involved in developing the plan there might have been success. Parents indicated the time of day was wrong for Child G and that the sedation level was insufficient. Constraints on services restraining patients was raised as an additional issue.

Learning point 6: Parents of non-verbal children, and those 16-18 who lack mental capacity, are usually best placed to articulate the needs and likely reactions of their children to any planned intervention. This case has demonstrated that parents' views are not being taken into sufficient account when planning interventions.

Recommendation 6: OSCP to seek assurance from partners that parental views and wishes are being sought and acted upon whenever possible, and that all decisions to exclude or discount parents expressed wishes are accompanied with a clear rationale as to why it would not be in the child's interests to do so.

9.5 Transitions

9.5.1 Child G was 15 at the start of the review period. Transition planning should commence at age 14 for children who will need additional support from adult services after the age of 18. The reviewer has had an opportunity to speak with Child G's parents who were not positive about their experiences of how Child G's case has been managed during the transition period. Child G's parents feel that his age meant that he fell between the categories of child and adult. However, Child G was a child during the whole of this period, and it was incumbent on commissioners to ensure services are available to provide support and services to all children.

9.5.2 From an education perspective Child G transitioned early to a learning establishment assessed as better able to meet his needs and manage his behaviours. This transition took account of Child G's parents' wishes.

9.5.3 In relation to mental health services within Oldham, there is insufficient service provision for 16–18-year-olds with learning disabilities and/or Autistic Spectrum Disorder (ASD). Current commissioning arrangements mean LANC are not commissioned to provide the wrap around care that a Child and Adolescent Mental Health Service (CAMHS) team offer.

9.5.4 Child G was closed to the mental health service before he was sixteen. The reviewer learned cases referred to mental health services after the child is 15 years and 9 months, even where there has been previous involvement, will not be accepted. The service is currently holding over 200 cases that they are not commissioned to provide a service too, as they have been unable to close the cases as there remains a need and there is no service to transition them too. This gap in service impacted on the partnerships ability to adequately devise a plan to address Child G's complex needs.

9.5.5 The children's learning disability team identified they have not got the capacity to meet demand. There is no scope currently for the adult learning disability team to work with the 16-18 age group, as they are not commissioned to work with people until they are 18 years of age. Whilst there is no additional capacity within the adult learning disability team, they work in a different way taking a multi-disciplinary team approach not evident in the children's learning disability team . The consequence of

a lack of both capacity and multi-disciplinary team approach, meant there was not an appropriately skilled team working with Child G to introduce early help interventions and develop strategies to assist Child G and his parents as concerns escalated.

9.5.6 A previous thematic review, which overlaps the review period in this case, identified that transition was underdeveloped within Oldham; it purported that autistic children, at the stage of transition to adulthood, were likely to struggle with the Adult services approach due to their individual circumstances. As a result of the finding Oldham LSCP were required to seek assurance that changes to the transitions policy and process were resulting in children and families being better prepared and supported to manage the change.

9.5.7 A multi-agency work stream has been looking at the strategic approach to transition, as well as revising operational processes and policies for transition support – it suggests the creation of a multi-agency transition hub to track young people's transition from the age of 14.

Learning point 7: Oldham are aware transition is underdeveloped and work is in hand to strengthen processes. What remains are significant gaps in service provision relating to mental health and the learning disability nursing service.

Recommendation 7: OSCP to share the learning in relation to transitions with the Health and Wellbeing Board and the Mental Health Board and invite them to provide assurance that they are also taking the necessary actions to enable OSCP to address these issues.

9.6 Commissioning

9.6.1 Most people with learning disabilities or autism will need more support from a range of sources. The transforming care agenda[6] places responsibility on commissioners to plan for local needs, purchasing care that meets need, and on providers to ensure their services meet the individuals needs and put systems and processes in place to provide effective, efficient high-quality care.

9.6.2 Oldham are aware there are gaps in service provision and whilst commissioners have a pathway in place for commissioning bespoke packages, the pathway to do this is not directly from frontline practitioners. When all off the shelf interventions have been tried without positive effect or have been assessed as inappropriate to meet a child's needs, applications can be made for funding for interventions that will address those needs. In Child G's case the need for support was demonstrated. However, whether commissioners were given a clear picture of Child G's circumstances is in question. The package of care approved by the Access to Resource Panel (ARP) was a package of support for residential short breaks in one of the LA's children's homes.

9.6.3 It is clear that intervention would not have a positive impact on Child G, as he would not be able to access it. 16 hours of support was also to be put into the family home, but it does not appear to have been appropriately commissioned and did not commence.

[6] Department of Health (2012) Transforming care: A national response to Winterbourne View Hospital: Review Final Report

9.6.4 The gap in mental health and learning disability provision should have led to a bespoke assessment and appropriate interventions as there were clear outstanding needs; no such assessment was requested.

9.6.5 All practitioners should be supported by their line managers and supervisors to put forward such cases for a bespoke package of care. The referral must provide sufficient information for commissioners to consider how best an unmet need can be met, and so an appropriate package of care can be agreed; one that is achievable. If a child then can't access the support, the package of care should be challenged.

9.6.6 Recently the partnership concluded a report on Children's Mental Health[7] which includes a review of commissioning of support services for children with complex needs. Completion of the recommendations within this report should ensure that there are clear pathways, processes and guidance to practitioners who have exhausted all other options.

Learning point 8: Oldham has managed its gaps in service provision via bespoke packages of care. This is not ideal as bespoke packages can take time to be agreed, delay timely interventions and can be costly. It is not clear that frontline practitioners are fully aware they can escalate such cases.

Recommendation 8: OSCP to seek assurance that following completion of the recommendations from the Children's Mental Health review that there is either sufficient provision to meet the needs of 16–18-year-olds mental health or, if a gap remains, there is a streamlined system to access bespoke packages of care which is accessible to frontline practitioners.

Recommendation 9: OSCP and relevant partners to conduct a review of capacity within the learning disability nursing service.

9.7 Risk

9.7.1 In Child G's case risk has been identified in singular terms; the risks that were identified related to his health, predominantly his weight and the risk of developing diabetes. Services adapted their ways of working to monitor Child G's weight. Preventative interventions were put in place to address Child G's seizures when further exploration was not possible. Currently Child G still hasn't accessed the kind of assessments a child would normally have followed a prolonged seizure.

9.7.2 Whilst there were concerns about prolonged infection to Child G's toes the risks were not fully recognised or addressed within plans.

9.7.3 School had considered risk in relation to the need for a 2:1 staffing ration when doing any form of meaningful work with Child G but had not extended this thinking to whether the 2:1 was necessary in the home.

9.7.4 The reviewer was interested to learn two referrals recognising risk came from the ambulance service. They expressed their concerns regarding the risk of not being able to afford Child G the same standard of care as they would another child having a seizure, and the risks to Child G if there was a fire in the home.

9.7.5 Following those referrals, a risk assessment, in the event of a fire, was conducted. Parents informed the reviewer that a rather rudimentary plan has been developed which involves throwing a mattress out of Child G's bedroom window and manhandling Child G out of the window. It is not clear Child G would agree to this or whether he would have the mental capacity to agree to this course of action. The reviewer is concerned this plan is both unsafe and unachievable.

[7] Children's Mental Health Summit: Overview and Recommendations (2021)

9.7.6 The question posed was how adaptive processes are to managing risk. The reviewer has seen some evidence that they are, but the approach is not holistic. Practitioners are sufficiently focussed on risk but are not utilising risk assessment processes to their full extent. Doing so should assist professionals to take a more proactive approach to managing risk.

Learning point 10: Records demonstrate that practitioners were cognisant of the risks however, the risks in this case were not sufficiently explored, articulated, or incorporated into achievable multi-agency plans. Practitioners exhausted their individual strategies for managing the risks and due to gaps in provision could not engage others to assist. It has taken senior managers to take over management of the case before a cohesive plan was developed. Increasing the effectiveness of CIN should address this learning point.

9.8 Support

9.8.1 Child G's mother sought support from Early Help prior to the review period indicating she felt she needed support in the form of respite care. The case was referred to MASH and allocated for an assessment which was completed by the Children's Disability Team. Child G's parents received no effective support.

9.8.2 Child G's parents were perceived as having differences in receptiveness to professional support. Mother was perceived as more receptive whilst father was seen by some professionals as difficult and someone who had a problem working with professionals. Insufficient exploration of why that might be the case led to a lot of blame being placed on parents. Practitioners were not placing themselves in parents' shoes. If a risk assessment in school advocated Child G needed 2:1 care to conduct any meaningful work, how were parents going to be able to replicate this within the home, as well as continuing to work? Advocacy or peer support might have assisted. The reviewer learned that there is support through Point and local workshops, but the onus is on parents to seek out and access the support.

9.8.3 Practitioners were not considering the impact of Child G's behaviours on parents. Following the introduction of the Children and Family Act[8], no one considered whether a parent carer assessment[9] should be conducted. When parents were taking a long time coming to the door, there was a lack of consideration that this might relate to attending to an urgent need of Child G. When Child G was not taken to appointments, further thought needed to be given to why. Further exploration would have provided the answer and stopped professionals considering that parents were not fulfilling their responsibilities to take Child G to appointments.

9.8.4 Child G's parents indicated it had been difficult to build relationships with workers due to the frequent change in staff. Child G had 7 SWs in three years and on each occasion, there was a change they felt that the process started again; this is not an unusual finding. It is likely that parents were just getting on with the situation they found themselves, adapting their own lives to meet Child G's needs.

9.8.5 Child G's parents indicated that it wasn't until an assessment completed in October 2020 that they felt they were being listened too.

[8] Children and Families Act 2014 (2014 Act)

[9] Parent carer assessment - A parent carer is defined as, a person aged 18 and over who provides or intends to provide care for a disabled child for whom the person has parental responsibility

9.8.6 Child G's parents indicated there were lots of groups of people involved but no one person was taking the lead. It is not clear whether agreed funded support was ever provided.

9.8.7 As a family they had not been able to visit extended family, go on trips or holidays and as a couple they adapted their working lives to ensure one of them was at home with Child G 24/7.

9.8.8 Lack of support and the difficult circumstances parents found themselves in has adversely affected their health and mental wellbeing.

Learning point 10: Despite there being a recognition of the need for support, and agreement for some funded support this was not fully assessed or progressed. Practitioners were not seeing the whole picture and as a result parents were viewed as unreceptive.

Recommendation 10: OSCP and its partners to introduce/review support need assessment tools to ensure they are fit for purpose, being utilised, and leading to agreement of suitably tailored support packages for both child and parents.

Examples of Good Practice:

- Good practice identified in terms of the LD Nurse sharing information with other professionals, including Children with Disabilities Team.
- Social worker completing an assessment in October 2020 took the time, effort, and energy to understand the situation. Parents indicated the SW gave them full attention and approached the problems as they themselves would.
- Early Help Positive Steps appropriately communicated and referred to MASH.
- Community Paediatrics made continued efforts to get appropriate help and escalated the case.
- Regular MDT meetings were held.
- Evidence of joint working with joint visits across health and education.

Appendix i – key to acronyms/ abbreviations

ARP	Access to Resources Panel
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CETR	Care, Education and Treatment Review
CIN	Child in Need
CP	Child Protection
CSC	Children's Social Care
DoL	Deprivation of Liberty
EHCP	Education and Health Care Plan
GP	General Practitioner
LD	Learning Disability
LPLR	Local Practice Learning Review
MASH	Multi-Agency Safeguarding Hub
MDT	Multi-Disciplinary Team
OSCP	Oldham Safeguarding Children Partnership
SEND	Special Educational Needs and Disability
SW	Social Worker