NCC Targeted Early Help

0 – 19 Service including Children's Centres

Mandatory (interim) Operating Model

Working intensively with the whole family
to improve children's lives and life chances

December 2017 (Version 3)

Northamptonshire County Council

Contents

Operating Model documentation and templates available on Sharepoint:

http://ccl/sites/comser/ehpt/ehp%20operating%20model/forms/allitems.aspx

Practice Framework

Allocation and Risk Assessment

Weeks 1 – 2: to include system review, *Signs of Safety* based risk assessment, telephone contact, first home visit, genogram and consent from family to receiving support from the service.

Early Help Assessment and Intervention Planning

Weeks 3 – 6: to include completion of the Early Help Assessment, Intervention Plan (to include the length of any intervention) and supplementary assessments. TM to sign off plan by end of Week 6.

Completion of the Graded Care Profile is mandatory in cases of suspected Neglect and should be competed in this period.

Completion of a culturegram should be undertaken with all families in support of the Early Help Assessment process.

Age appropriate tools, including use of observations of very young children, should be used to capture the voice and lived experience of all children in this period and their views should help determine the intervention plan.

Other assessments to be completed at the discretion of the practitioner/supervising senior and according to family need:

- Dog Risk Assessment
- CSE and/or Gang Involvement Risk Assessment

- DASH Risk Assessment or Young Person DASH Risk Assessment

The Intervention Plan should focus on agreed outcomes for children and the use of any evidence based tools or programmes, together with the likely duration of the intervention, should be included at the outset.

Interventions and the Review Cycle

Weeks 7 – 24: Activities to capture the voice and lived experience of children to be repeated regularly (at least every third contact) throughout the intervention. Where possible, children should be seen alone.

Team Around the Family (TAF) meetings should take place every 4 – 6 weeks with a closure summary detailing completion of actions and improved outcomes for children signed off by the team manager prior to the final TAF.

All supplementary assessments and tools available on the Early Help Sharepoint site:

Introduction

NCC's 0 -19 Early Help Service offers intensive support to children and families with Targeted Early Help needs, that is, where children are at risk of poor outcomes due to problems in the level of care and parenting they receive and where they experience difficulties at home or at school. This can happen for a variety of reasons including inappropriate behaviour management; impaired physical or emotional wellbeing; poor attachment; neglect and substance misuse, all of which leave children and young people at risk of poor educational attainment, poor physical and mental health outcomes and at a considerable disadvantage as they enter adulthood where there is a risk they will repeat a cycle that may well impact adversely on their own children.

The mandatory Operating Model was introduced to ensure the support offered by the 0 – 19 Early Help Service is consistent across the county and is of good quality, with the learning from quality assurance activities, best practice elsewhere and from serious case reviews embedded in practice and processes and where the principles of *Signs of Safety* underpin all interactions with children and their families.

The Operating Model is designed to establish practice standards around timescales and activities but is still flexible enough to be responsive to the voice and lived experience of children so that findings from assessments and direct work with children are utilised to continually review the appropriateness and effectiveness of support provided, as well as the optimum duration of work with a family in order to achieve the best possible outcomes. The operating model ensures the centrality of supervision and peer challenge in case management and guarantees management oversight at key points in the process, to both ensure work is of high quality and is delivering improved outcomes for children. The model's introduction was accompanied by a programme of training, peer support and in-house workshops to improve practitioners' and supervisors' confidence and these will be repeated as we move towards an integrated 0 – 19 offer to include practitioners from the children's centres..

The operating model incorporates a number of 'best practice' pathways to address presenting issues and prioritises the identification of underlying issues so that support and direct work offered can deliver sustainable change for families, build resilience and reduce the risk of problems in the future. From April 2018 the model will utilise the

Family Outcomes Star to measure impact and progress in a way which is accessible to families and which helps them identify and address their own problems, with support where it is needed. Children and families are referred to the service through the *Access to Support* process and will have come through three principal routes:

1. Following a Complex Case Discussion requested by a lead professional who has been co-ordinating single or multi-agency Early Help but where progress is slow
2. Following a MASH referral that does not lead to any involvement from Social Care
3. Following assessment and/or support provided by Social Care
4. Following a direct referral from another professional eg. a health visitor

The operating model is designed to meet the needs of all children, regardless of their route into the service and is regularly reviewed to optimise its effectiveness.

Allocation

Via *Access to Support*

The 0 -19 Early Help Service offers a countywide service with teams working from a number of children's centre bases and also remotely to best meet the needs of children and families. Teams are organised into three areas as part of an interim structure that will be in place until the introduction of the new service model when the Children's Trust arrangements go live in 2018.

Northamptonshire South has two main bases at children's centres in Daventry West and at Towcester and is managed by Julie Sadler who also oversees crèche provision countywide and is responsible for the programme of CC activities delivered by partners.

Northamptonshire North also has a number of bases including larger sites at Penrith Drive in Wellingborough, Montagu Street in Kettering and at Rushden Academy. The area is managed by Louse Moseley and covers Corby (5 – 19 only), Kettering, Wellingborough and East Northants. Other centres remain open in Newton Road, Rushden, Irthlingborough, Oundle, and Highfield Road, Kettering. A separate community interest company continues to run services for 0 – 5s in Corby. Louise is responsible for the development of group work delivered by the 0 – 19 Targeted early help teams.

Northampton itself has main sites at Kingsthorpe, Kings Heath, Blackthorn, Thorplands and Ecton Brook and also has part time centres at Spring Lane, Penfold, and Upton. The manager for the Northampton teams is John Kelly.

The three area team managers will be supported by a fourth team manager, Susan Connor, who will lead on governance and performance issues, including preparation for Ofsted inspection. Susan will also provide support to the Strategic Manager and the other three area managers to increase overall leadership and management capacity.

Staff have been issued with hybrid tablet/laptops to enable greater flexibility and small teams led by a senior practitioner are based at individual children's centres to allow staff to focus on a caseload in a specific geographic area and to develop strong professional relationships with multi agency partners as a result.

Practitioners will hold a caseload of 10 families or 25 children, whichever is reached first. Senior Practitioners will have a supervisory role and will be actively involved in role modelling best practice, planning direct work and support and will provide regular, high quality supervision of 6 - 8 practitioners. Senior Practitioners may hold cases themselves.

Early Help Case Management

Recording on *Capita One* and the Outcomes Star

The introduction of the revised *Capita One* single case management tool for Early Help work from January 2018 will enable the co-location of recording and all key assessments and observations in one place which will facilitate the creation of chronologies and enable workers to see at a glance what has been tried before so they do not repeat actions. Supervision and management oversight, as well as adherence to timescales, is tracked through *Capita One* reporting functions.

Where 1:1 support is needed, families will be built in *Capita One* by Business Support colleagues prior to allocation to a practitioner through the *Access to Support* process. 0 -19 Early Help practitioners will be expected to record all assessments and support provided in the single Early Help case management involvement. Training has been made available and ongoing support is accessible through Capita super users.

Additional support and training around good quality recording and in the expectations around the format for documenting supervision discussions; case discussions and the recording of internal and external communication is to be provided through the peer support programme once initial workshops to embed the model are complete.

The 0 – 19 Early Help Service is to begin use of the Family Outcomes Star (or similar) from April 2018 to measure progress and impact and this will be built into *Capita One* to enable the extraction of outcomes data. Training and Support will be provided to staff to support its implementation.

Presenting Issues

The Early Help 0 – 19 Service 'Menu'

The 0 – 19 Early Help Service is able to offer assessment, support and direct work with children and families in a number of areas. Families may present with one or more issue and the duration and type of support should reflect their particular needs with one or more presenting issue pathway selected to meet need and manage risk. In all cases, assessment should seek to uncover underlying issues which should be addressed before or alongside the presenting issues to avoid superficial or short term improvement that lapses once the practitioner withdraws from the family.

1. **Parenting Capacity and Capability** – including attachment; inappropriate behaviour expectations; lack of behaviour management/boundaries and lack of emotional warmth/stability or basic physical care; lack of understanding of children's needs and/or development.

2. **Challenging Behaviour** – including special educational needs and disability; 'missing' episodes; crime and anti-social behaviour; school exclusions; school attendance and family relationships; inappropriate physical chastisement; sleep difficulties; routines and boundaries.

3. **Neglect and/or Emotional Abuse** – Poor home conditions/inadequate housing; poor diet and lifestyle; lack of support for school attendance and achievement; family conflict; poor attachment; lack of supervision; internet safety and protective behaviours; lack of support for children in developing confidence and self esteem; lack of emotional warmth/stability; failure to prioritise children's needs.

4. **Domestic Abuse** – Access to support for victims and perpetrators; reduction of risks to children and support for trauma related to experience of domestic abuse (current or historic).

5. **Substance or Alcohol Misuse** – (Parents/carers and children/young people) Enabling Access to Support and Treatment; Young Carer Support; Reducing Associated Risks and trauma and/or addressing inadequate care for children.

6. **Mental Health and Emotional Wellbeing** – (Parents/carers and children/young people) Enabling access to support and treatment; Young Carer support; reducing associated risks and trauma and/or addressing inadequate care for children.

7. **Disability** - (Parents/carers and children/young people) – access to appropriate support; with or without formal diagnosis; Young Carer support.

Interventions can last for anything between 6 and 26 weeks and an estimate of likely duration should be made by the Senior Practitioner on receipt of the referral. This is reviewed after 4 - 6 weeks on completion of the Early Help Assessment. To enable the model to be flexible and responsive to the needs of children and families, the likely duration can be changed at any time provided the need for a change in duration has been discussed in supervision and then the team manager has agreed any extension in advance.

The Voice and Lived Experience of Children and Young People

Our Commitment

Listening to children and young people, empowering and enabling them to speak out and ensuring their voices are heard and their lived experiences are understood is central to the approach of 0 – 19 Early Help Service in NCC. Practitioners work with the whole family but their principal role is to understand the needs of children, to manage any risks they may face and to advocate for them. Supervisors and team managers are expected to identify any over-emphasis on adult needs and preferences in casework or action plans and will challenge where children's needs are not prioritised.

Children and Families referred for support will be assessed through a Signs of Success approach and this will be recorded on the Early Help Assessment. Some supplementary assessments may be undertaken on specific presenting issues (depending on pathway) to ensure appropriate interventions are identified and delivered. Early Help practitioners will always assume the role of Lead Professional and keyworker and will ensure children's views and experiences are central to the Early Help Assessment and will identify professionals who will become members of the Team Around the Family who draw up and implement any Action plan co-produced with the family.

Children's voices are to be captured in age appropriate ways and practitioners should use their judgment to choose the most appropriate methods and match them to every individual child. Where possible, children and young people should be seen alone and regularly throughout (at least every third contact), at school, at home or in another appropriate setting. Children who are pre-verbal (babies and toddlers) or unable to communicate due to disability or other difficulties can be observed and an understanding of their lived experience drawn from these observations.
Children's voices should feature in every Early Help Assessment review and best practice will be to involve them in Team Around the Family Meetings where possible. Methods for capturing children's voices can include:

1. My Life, My Way : any age
2. Observational Assessments : 0 – 5
3. All About Me : 5 - 11
4. Self Assessment : 12 -16
5. Feedback at closure.
6. Customised approaches for individual children (with supervisor oversight)

Stage One

Risk Assessment

Mandatory Actions - What does a good risk assessment and risk management process look like?

1. The Senior Practitioner completes a **full risk assessment** to consider any risks to children and young people **within one week of allocation** to the team using a 'Signs of Safety' approach - interrogating available NCC systems and by considering the referral to the team and the nature of the work requested and, wherever possible, through direct discussion with the referrer. The home environment; cultural background of the family; presenting issues and the ages of individual children should be considered in this initial assessment and any strengths and protective factors considered alongside risks and unknowns (grey areas). The risk assessment should be **recorded on Capita One.**

2. Alongside the identification of risks to children within the family, the Senior Practitioner considers worker safety and gathers together any relevant information about the home environment (or relating to family members) that may require mitigating actions to reduce risks to the practitioner **prior to the first home visit** and this is **recorded on Capita One.** Following the first visit, this information should be reviewed and any changes discussed with the practitioner and recorded.

3. On completion of the full risk assessment and prior to the first home visit, the Senior Practitioner discusses any identified risks to children with the practitioner and together they review the **Signs of Safety risk template** based on the research completed by the Senior Practitioner and to provide a baseline against which risk can be reviewed throughout the intervention. The signs of safety approach is then used to facilitate the initial discussion with the family about their needs and any risks. Template to contain Family Strengths, anything they and professionals are worried about and what needs to happen (an outline action plan).

4. The **Signs of Safety risk template** is to be reviewed at *every* supervision; *any* planned or ad hoc case discussion; *any* peer supervision discussion and in response to *any* incident or escalation and the **outcome recorded on Capita One**. Should risks increase and a referral to Children's Social Care be necessary at any point in the intervention, the Senior Practitioner should review the Signs of Safety narrative before seeking management oversight of the decision to make a referral.

5. If the family have a dog or dogs, an **NCC dog risk assessment** (which specifically considers risks to children) should be considered if there are concerns about the care of any dog(s) around the children and the results and any necessary actions discussed with the family. RSPCA guidance about signs of poor dog welfare is available on Sharepoint. Information should also be added to the environmental risk assessment as it relates to the practitioner.

Stage Two

Initial Contact and Home Visit

Mandatory Actions – What does a good initial contact look like? How tenacious should practitioners be in attempting to make contact?

1. **Telephone contact** should be attempted by the Senior Practitioner **within 5 working days** of allocation to introduce the team, explain the service being offered and to give the name of the Key Worker (practitioner) to the family. A first home visit should be arranged for both the practitioner and supervising senior practitioner to visit the family **with the referrer** within 10 days of allocation to the team. Every attempt at a telephone call should be **recorded on Capita One** with the day, date and time of the attempt and the number used.

2. Where telephone contact cannot be achieved after 5 days, **the referrer should be approached to assist in making contact** (to attempt to arrange a joint visit or 'warm handover'). If this is unsuccessful the practitioner and senior practitioner should attempt up to **3 unannounced visits** (at different times of day and on different days) to try to make contact with the family. On the **first attempt, a welcome letter** should be left asking the parent(s) to contact the practitioner.

3. If allocation to the team is following assessment by the First Response Team the original referrer (into MASH) should be approached to assist in making contact, rather than the assessing Social Worker who will already have closed their involvement.

4. Where contact cannot be established, the outcome of the risk assessment should be discussed with the team manager and a **decision taken as to next steps.** These may include a further discussion with the referrer; a referral into MASH or

case closure with a letter to the original referrer to confirm we have been unable to engage the family. Closure should be a last resort and requires careful consideration of ongoing risks to children. Any decision should be **recorded on Capita One.**

Mandatory Actions – What does a good first visit look like?

5. The **first home visit** should always be undertaken by **the practitioner (key worker) and their supervising senior** together with **the referrer,** wherever possible.

6. The visit should take place **within two weeks of allocation** and should consist of an **explanatory discussion** around the **Early Help Assessment** process and the **reasons for the referral** and **to obtain signed consent** to the Assessment process. **Completion of a genogram** should begin at this visit to ensure all family members are identified and consent and engagement secured from anyone living elsewhere (eg an absent parent or grandparent carer) and should be completed **no later than Week 4** with any adults resident in the home identified and they, as well as additional parents or carers living elsewhere asked to consent to work with EHP. The follow up visit would be to begin completion of the Early Help Assessment and to meet the children if this has not happened at the first visit. Best practice would be to meet and talk to the children at this visit but it is recognised this is not always possible if they are in education.

7. The completion of a **Culturegram** should also be considered and completed alongside the Early Help Assessment to ensure that all aspects of the child and family's lived experiences are considered and understood as they may relate to the intervention planned. The Culturegram should be completed **no later than Week 6** and relevant findings should be included in the EHA Action Plan.

8. The visit should be written up in a standardised format and **added to Capita One**. The **Signs of Safety risk template** should be reviewed as a result of the visit and a **dog risk assessment** undertaken if necessary.

9. Following the initial visit, consideration should be given to the completion of the **Child Sexual Exploitation risk assessment** (as contained in the Northamptonshire CSE toolkit) for any child aged 11 or over (in secondary education) or for a younger child if the presenting issues give cause for concern. The practitioner should do this under the supervision of the Senior Practitioner.

   The purpose of the CSE risk assessment being part of the mandatory operating model is to pick up on *vulnerability* to CSE so that potential harm can be *anticipated* and *prevented.* Children and young people with needs at Level 3 are inevitably vulnerable and may possess a number of the 'push and pull' factors that put them at risk. There are a number of possible outcomes to doing the CSE Risk Assessment:

   9.1 Risks appear low and there is no indication that children and young people are at risk or have been harmed. It is at practitioner discretion as to whether further discussion with parents is necessary and individual outcomes may require

some discussion, for example, around a lack of parental supervision or access to the internet.

9.2 Risks are low - medium and children could be vulnerable to exploitation in certain circumstances but there is no evidence they have been harmed or are at risk. The outcome of the assessment should be discussed with parents/carers so that they understand the risks their children may face and this can form part of ongoing discussions around the changes to their parenting that are required to improve outcomes for their children and keep them safe. Additional interventions such as internet safety, protective behaviours or self esteem work can be considered as a result of the completion of the risk assessment.

9.3 Risks are medium - high and there is a concern that children and young people are at imminent risk of harm or have already been harmed. The risk assessment should be discussed with the team manager and the child or young person referred to MASH. If this does not result in a referral to Tier 4/RISE and the case is retained in the team, additional work to manage potential risk will be necessary and may require access to more specialist services.

For any case with medium to high risk factors present but where the threshold for Tier 4 intervention has not been met, the team manager should be aware of progress in all cases where there are potential vulnerabilities to CSE and the supervising senior should make note on the Capita Communication log for each case at least once a month and titled 'Management Oversight' to say they have reviewed the case and if further action is required.

Stage Three

Early Help Assessment

Use of the Early Help Assessment by the 0 – 19 Early Help Team is mandatory. The assessment should be completed **within 4 - 6 weeks of allocation** to the team. The assessment; review forms and closure forms are all to be used in accordance with countywide procedures and timescales and copies uploaded to the Early Help Case Management Involvement on **Capita One**.

Mandatory Actions – What does a good Early Help Assessment look like?

1. The **views and lived experience of every child** in the family should be captured in the assessment and separately to that of the parents or carers.

2. **All relevant individuals**, including both parents and any other carers, **should be included** in the assessment. This includes anyone not living in the family home such as an absent parent or grandparent carer. Where a parent is not included in the assessment for good reason (for example they are considered to pose a risk) that reason should be recorded clearly on Capita One. Every effort should be made to involve fathers in the assessment and intervention plan. Visiting in the evening or at weekends may help achieve this.

3. The **cultural background** of the family should be fully considered and any ‘‘protected characteristics’ * under the Equality Act be given special attention in terms of the potential impact on the work with the family. Behaviours detrimental to children that are explained as ‘cultural’ (for example inappropriate physical chastisement; female genital mutilation; forced marriage or honour based violence) should be challenged and our response should be compliant with any legal responsibility we have to raise concerns. Where culture is impacting adversely on children but is not illegal, the key worker/practitioner should be an advocate for the child and ensure this is addressed in the intervention plan.

4. The assessment process should **identify all relevant professionals** needed to form the *Team Around the Family* who will work together to address issues raised. Where possible, their views should be included in the assessment.

5. **Historic, chronic difficulties** such as poor school attendance or neglect/poor home conditions should be raised through the assessment and included in the intervention plan, even when the parent does not raise them as a concern or when the referring professional has not expressed any concern about them. Our role is to advocate for children and challenge existing behaviours and lifestyles that are not in the best interests of children.

6. The assessment should **consider previous support and intervention** the family have received and seek not to duplicate this but to find alternate approaches suitable

for the child and their family. Understanding how the family has responded to intervention previously will assist in adding value through our involvement and helps bring about sustainable change.

7. The assessment should seek to **identify underlying issues or causality** giving rise to the presenting difficulties.

8. The commencement (or continuation) of a **chronology** is mandatory in every cases and should be completed by the supervising senior utilising the SC agreed template (available on Sharepoint along with a completed, anonymised exemplar). An existing chronology should be reviewed when the case is allocated within 0 - 19 or a new one started where there has been no previous chronology and reviewed and **updated by the supervising senior at every supervision (or case review where not discussed in supervision).**

*Protected characteristics under the **Equality Act** (2010) include Age; Disability; Gender: Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion and Belief; Sexual Orientation

Stage Four

Additional Assessment or Interventions

Additional Actions based on Presenting Issues to ensure our assessments and intervention plans are of good quality:

1. **Parenting** - engagement of other professionals (eg Health Visitor or Parent Support Advisor) and/or a referral to group work eg Solihull/Incredible Years; Triple P; Escape or 123 Magic as appropriate.

2. **Challenging Behaviour** – **Three Houses/House of Worries or Ecomap** Activity; Engage **School** or **EIP** in *Team Around the Family* to understand issues. Consider any assessments undertaken in **SEND** or **Social Care** relating to Disability or Family Relationships.

3. **Neglect** – Completion of the **Graded Care Profile** with outcomes used to help populate the EH Action Plan. In cases where neglect is suspected, completion of the Graded Care Profile is mandatory.

4. **Domestic Abuse** – Complete **DASH** Risk Assessment or **Child/YP DASH** Risk Assessment.

5. **Substance or Alcohol Misuse** – Refer to appropriate **support and treatment programme** (parent or child) and **engage relevant health professionals** in the *Team Around the Family*. Where the issue is parental misuse, consider involving **Young Carers** Support.

6. **Mental Health & Wellbeing** - Refer to appropriate **support and treatment programme** (parent or child) and **engage relevant health professionals** in the *Team Around the Family*. Where the issue is parental mental health or wellbeing, consider involving **Young Carers** Support.

7. **Disability** – Engage Health and Education Professionals in the *Team Around the Family* and consider assessments undertaken elsewhere (eg. Education and Health Care Plans) to understand how the disability is impacting on the child and family. Where the issue is a disabled parent, consider **Young Carers** support.

   All additional assessments and actions **should be completed within 6 weeks of allocation** of the case and **no later than 2 weeks** after the Early Help Assessment is agreed.

Stage Five

Intervention Planning and Delivery

Issues related to a **lack of school place**; being **NEET** or in relation to **access to Early Years provision** should be picked up at the first visit and prioritised *while the Intervention Plan is being finalised*. Referral to **Prospects**; the **Education Inclusion team** or completion of the 2, 3 or 4 year old **Early Years' Funding Eligibility Checker** should be undertaken as a matter of urgency.

What does a good Intervention Plan look like?

1. A good intervention plan has the child's voice and lived experience as central to agreed actions. Where possible, children have their own plan presented in an accessible format relevant to their needs and with their individual actions clearly identified.

2. Planned actions and interventions address underlying or causal issues as a priority, with presenting issues included but sometimes addressed later on in the intervention.

3. All areas of need identified through the Early Help Assessment (and any additional assessments) must be reflected in the plan. The plan is agreed with all family members and professionals at the first *Team Around the Family* Meeting.

4. The concerns of adults in a family may feature on a plan but should not take priority over the concerns of children.

5. All relevant adults and children are included in the plan, including those living away from the children's family home.

6. Actions are allocated to named individuals and details of what good progress will look like can be clearly identified.

7. The plan reflects the unique characteristics of the family and takes into consideration any protected characteristics and their cultural background. The plan is provided in an appropriate format if there are additional access needs and they are supported by an interpreter if needed.

8. The plan enables clear identification of the likely duration of the intervention. Following an 8 week assessment and planning period during which time work is ongoing in building a relationship of challenge and support with the family and in getting to know the children, the delivery of interventions identified can last for 4; 14; 32 or 44 weeks depending on the level of need and complexity in the family.

All Intervention plans **MUST be reviewed by the Team Manager** and their agreement with the plan should be recorded on Capita One.

Delivery of **interventions** will vary according to the need of the child and family (some examples are included in the model diagram) and these should always be **evidence-based** and **documented or uploaded on Capita One**. Senior Practitioners should agree any planned interventions in advance and should also review their effectiveness. Direct work with children and families can occur in the home, school or setting or in other appropriate community venues.

Stage Six

Progress Reviews, Closure and Evaluation

Progress Reviews and **Team Around the Family** meetings should take place every 4 to 6 weeks in accordance with best practice guidelines for an Early Help Assessment.

Every family supported by the 0 – 19 Early Help team should close to the service with the identification of a new Lead Professional from the **Team Around the Family** who can continue to co-ordinate services and support and help to sustain changes brought about by the work undertaken by the 0 – 19 team. Very rarely, the Early Help Assessment will close at the same time but this should only be if, for example, the family are moving away or have had another significant change in their circumstances.

All Reviews and *Team Around the Family* Notes must be agreed by the Senior Practitioner before being uploaded to Capita One.

Feedback from children and families will be captured through **Outcome Star (or similar)** and the findings from this analysed and fed into reviews of the Operating Model and used to develop practice.

Permission to **extend the duration of the intervention** should be sought from the **Team Manager** who **MUST agree to any extension BEFORE** it is agreed with the TAF and family

When a family are approaching closure a draft EHA closure summary (utilising the headings from the full closure summary) should be provided to the Team Manager to review and should describe how needs will be met and risks managed in the future and should also identify the work completed, progress made and the name of the Lead Professional identified to take over. The Team Manager will make any necessary recommendations and **authorise any closure (transfer to a new lead professional) on Capita One BEFORE** it is agreed with the TAF and family

When families are referred for Social Care support through the MASH, some co-working is possible but should **not take place while a family are subject to a Section 47 investigation**. The case should remain open on Capita One but it should be noted that our actions have ceased pending the outcome of the Section 47 Investigation. If the outcome is that we should continue to support the family, work can resume. During **Single Assessments** it may be appropriate to remain involved and deliver support and direct interventions with families but this should always be with the agreement of the assessing Social Worker.

Quality Assurance

0 -19 Early Help teams are committed to continual improvement through learning captured via Quality Assurance activities. Auditors will continue to be drawn from senior practitioners and team managers in the service and will audit across all the areas of work and in teams that are geographically separate to the teams where they are based so they have had no 'footprint' on cases audited. This work will feed into the NCC Quality Assurance Framework and the QA Manager will work with the Strategic Manager to refine the audit programme..

The NCC audit tool is to be used to capture reflective discussion and auditors will benchmark case work against the practice standards that make up the mandatory operating model. The reflective audit involves the practitioner in a face to face discussion with the auditor in which all aspects of case management including supervision, assessment, decision making and intervention planning are reviewed and key areas of good practice are considered, including

the voice and lived experience of the child. Senior Practitioners also observe home visits and other direct work with families whilst team managers observe supervisions and feed back to supervisors. All these activities are documented and uploaded to Capita One.

Completed audits are shared with the practitioner and their supervisor as well as the team manager. The practitioner's supervisor is responsible for ensuring any necessary actions on cases still open are completed. Where cases are closed, consideration is given as to whether they should be re-opened as a result of the audit so that any further work required can be completed. Team managers re-audit a number of cases each quarter to ensure recommended actions are being completed.

A programme of workshops and support will be rolled out between December 2017 and the end of March 2018 to embed any learning and improve practitioners' and supervisors' confidence to use the assessment tools that are mandatory within the Operating Model. These sessions are part of regular peer support activity. In addition, during 2018, all staff will have the opportunity to receive training in the Signs of Safety approach and to attend regular bitesize sessions on a range of themes and to enable continuous improvement in our practice.

The Operating Model will continue to be reviewed regularly and feedback from children, families, partners, practitioners and supervisors used to improve its efficacy.

All enquiries about the Operating Model should be directed to:

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