

**Families First Operating Procedures**

**PLEASE NOTE : THESE PROCEDURES ARE IN THE PROCESS OF BEING REWRITTEN – IN THE INTERIM PERIOD PLEASE ALSO REFER TO THE FOLLOWING DOCUMENTS**

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**INITIAL STEPS FOR THE SOCIAL WORKER FOLLOWING ALLOCATION**

Following allocation the Social Worker has the following key responsibilities:

* Ensure that the referrer has been notified in writing of the outcome of their referral and your contact details (where they are a professional).
* Speak to the referrer to check the facts of the referral and fully understand their concerns.
* Ensure you are clear about the agreed timescales for the completion of the assessment and that a new single assessment has been opened and linked to the referral on the case recording system.
* To arrange to meet the child and family within a maximum of 5 working days from allocation. In cases which identify Child Protection concerns; practitioners should visit within one working day and the child must be seen.
* Take introductory pack on first home visit and cover all elements of the “checklist for practitioners on initial home visit” (Appendix 1) and ask parent/carer to sign to confirm receipt of this information. This will include:
* Explain the reasons for your involvement to the child and family and ensure they understand this.
* Establish who has parental responsibility for the Child/Young Person
* Ensure the consent form is signed by the relevant adults/parents ([Appendix 2](#Appendix6)) .
* Explain the process of planning and information sharing.
* Ensure that all relevant information has been shared with parents including complaints procedures; access to records information etc. using the checklist in this chapter.
* Complete basic information sheet for all family members including names/dates of birth/addresses/ethnicity/language/religion.
* Introduce the family worker to the family where one is identified.
* Establish with the family which professionals they are involved with and contact them to gather information for the assessment.
* Where a case is to be open for more than 25 days, by day 10, invitations must be sent to the family and all professionals to attend the first TAF (must be held by day 25). This will usually be agreed with the Team Manager at the 10 days management checkpoint.

Where the adult family members are known to Durham County Council contact the worker involved and ensure you as the social worker are logged as co-worker on the case and they know of your involvement. This will enable you to view adult information on SSID.

Where necessary, contact the SSID team to request access to read historical adult information.

As a minimum those to be invited to the Team Around the Family meeting should include:

* The parents (including those who may not live in the family home. On occasion this may require the meeting to be run in 2 parts).
* Extended family that they choose to invite and who will be a support.
* Social Worker
* Family Worker - One Point / Families First
* One Point Practitioners (Early Help Advisors and Early Help Practitioners)
* 0 – 19 Community Family Hub Practitioners
* Health Rep (Health Visitor, School Nurse, GP, Specialist Health Services).
* Education Rep (School, Nursery, College).
* Appropriate Specialist Adult Service Workers.
* Other relevant agencies who play a role in the family e.g. housing, Police Community Support Officer, Anti-Social Behaviour Team, Voluntary and Community sector workers.

Ensure that all basic information collated from the family is transferred onto the case recording system and that the case recording system accurately reflects the key family information.

The Assessment timescales for Level 4 cases begin on the date of referral and the assessment needs to be completed within a maximum of 45 days. The assessment will be proportionate assessment to meet the needs of the child and family, based on the referral to Children’s Sevices and as such it is expected a large number of assessments will be completed in 25 days or less.

First steps within the assessment process include re-reading the referral information to ensure you have a full and comprehensive understanding of the presenting concerns. It will then include the completion of:

* A genogram.
* The start of the multi-agency chronology.
* Review of all historical records on the case recording system including all previous referral and any information known about the adults in the family. (This may include them as children).

The assessment process will run alongside an outcome focussed plan. Support should always be offered to the family whilst the assessment is ongoing. Often, support offered at this stage of intervention will be based on the child and the parent’s priorities and what they feel they most need support with.

The priorities and intervention at this stage should be agreed with the family at this visit. The final outcome focussed Care Plan and support to be offered will be agreed at the first TAF (within 25 days).

**FIRST TEAM AROUND THE FAMILY (TAF) MEETING AFTER ALLOCATION**

For all cases that are to remain open to the team for 25 working days or more a TAF meeting must be arranged by day 25.

The social worker is responsible for arranging these meetings with the support of the team co-ordinator.

The social worker will ensure that the family understands who will be attending the meeting and why. All Families must receive the ‘Single Assessment and TAF guide’ for parents and carers.

The social worker will ensure that the child/young person understands who will be attending the meeting and why.

The social worker should discuss whether the child/young person requires an advocate and where appropriate make a referral.

The social worker will ensure that the family and child/young person can attend and support them to do so.

Wherever possible, introductions by all professionals should have been made to the family beforehand and this is the responsibility of individual professionals and agencies to arrange.

The social worker have responsibility for chairing the meeting.

The social worker will be responsible for ensuring that there is a record of this meeting which will be circulated to all that participated. This may mean that another member of the TAF takes the minutes whilst the social worker chairs.

The purpose of the meeting is:

* To lay out clearly to the family what the issues of concern are for the child/ren and whole family functioning.
* To lay out expectations from professionals for the family.
* To be clear about what they would need to see in terms of change for the child and family and what a good outcome will look like.
* To be clear about what the family can expect of all of the professionals sitting around the table in terms of support to effect positive change.
* To clarify what support extended family members are able to offer to the family.
* To explain to all present the process of the Assessment and Review process and the expectations of all professionals in terms of ongoing contributions to this.
* To explain the process of pulling together the multi-agency chronology and agree what information will be returned to the social worker and when.
* Identify at this stage whether other professionals need to be a part of the multi-agency meeting process.
* Agree a multi-agency work plan for 4-6 weeks of intervention (up until the date of the next meeting at least). The plan should also specify visiting arrangements between professionals (i.e. dates each professional intends to visit).
* Agree the final outcome focussed Care Plan.
* Set out a schedule of meetings at 4-6 weekly intervals until at least the formal 3 month review so that all partners and the family have the dates set.

The multi-agency work plan should be included in the child’s family plan and subsequently typed up. It should identify clearly what each session with the family will look like and how it will link to the overall goals in the care plan. It should provide evidence of visiting patterns and frequencies and should identify tools which staff plan to use with families. Overall, the plan should ensure all professionals and family are clear about when visits will be made and any specific tasks planned which will contribute to the overall intervention plan. The plan should to be linked to the goals and outcomes agreed with the family.

Copies of the hand written notes can be copied and shared at the meeting to assist in providing all members of the TAF with the agreed actions of that meeting.

Copies of the Outcome Focussed Care Plan should be sent to the family and all professionals in attendance at the meeting along with the typed minutes of the meeting and recorded on the case recording system within 10 working days of the meeting. The minutes should be quality assured by the relevant team manager or social work consultant.

All TAF meeting minutes should be recorded on the case recording system.

**DELIVERING SUPPORT AND INTERVENTIONS TO FAMILIES**

A key focus of the Families First Service is to ensure that families have an opportunity to build up a good relationship with their social worker and practitioners within the team, which in turn will support the process of creating change with families. Social workers should not underestimate the importance of their positive relationship with a child and a family in helping them to make change and should see this as a key part of their early work with every family. A relationship-based approach provides the skill base and the environment from which social workers are enabled to help families to change, helping them to find solutions, so that the safety, development and well-being of their children is enhanced.

Positive relationships in this context are warm; open; honest; supportive; challenging and assertive, where appropriate. All practitioners need to work honestly and openly with families, discuss any concerns with them and ensure that they are involved in decision making. It is important that they acknowledge and respect the contribution of parents and other family members.

Practitioners have a responsibility to ensure that they spend time with the child and family to enhance their own understanding of the family’s functioning and what life is like for the child living within that family unit.

Practitioners need to work directly with children and young people and ensure that this work is evidenced within the assessment and plan. The [Single Assessment Guidance](http://www.durham-lscb.org.uk/wp-content/uploads/sites/29/2016/06/Single-Assessment-Practice-Guidance.pdf) provides a range of tools to assist practitioners with this. Whilst much of this work can be seen as part of the ongoing assessment process (e.g. use of scales, questionnaires, home conditions checklist; alcohol screening tool), if done well can really help the family to understand themselves better and what support they may need and should be seen as tools for change in families.

All work with families will be based on a **solution focused** approach using the Signs of Safety framework for assessment and intervention.

Practitioners also have a responsibility to develop detailed support plans with families which indicate what needs to change within families and how this will improve life for the child; what help and support each member of the family needs and why. Every plan needs to be include specific actions for individual family member and professionals and each must indicate what the change is that is required.

The focus of the Families First Service is to provide **direct help and intervention to help families** to make the changes that we are asking of them. This will be done in conjunction with other agencies and other services. Part of the role of the social worker is to both coordinate this and ensure that the family understands who is doing what and to deliver relevant parts of the support plan themselves.

Whilst referrals to specialist services should continue to be made where children, young people and families have specific needs, where appropriate and possible support to families should be offered by practitioners in the team who know the family. The benefits of this approach are that TAF meetings are kept to a manageable size and families know who is visiting them and why; the social worker can use the opportunities to deliver support as a means of getting to know the family and building up positive relationships; the family see the practitioner as someone who is helpful to them and not simply critical or monitoring them; the practitioner spends more time in the family home which aids their assessment and enables them to determine whether the family can make the sustainable changes that have been identified; and resources are used more effectively.

Families must understand why professionals are concerned and what changes need to happen to reduce those concerns.

All plans will be based on the premise that support may need to be intensive at first but that any outcome focussed care plan will aim to gradually reduce support to ensure that families can demonstrate they can sustain change. Part of the ongoing assessment of the Social Worker is to determine how well the family can function with low levels of sustainable support in the longer term. If a family is unable to do this, then careful monitoring and evidence gathering is required as this may suggest that the parents will be unable to meet their children’s needs in the long term.

All support plans should include a contingency plan.

Families should understand clearly what support they will receive and what may happen next if they are unable to make the changes that have been identified as necessary.

All support plans should include an ‘exit plan’ out of the Families First Service either into universal or other targeted services as required or into Looked After Children teams as a result of the strength of concerns and risk for the child.

The use of community and voluntary organisations as well as volunteers and befrienders should be routinely considered for families who are moving down the continuum of need.

All families should know who they can contact if they need support – both whilst an active case to a Families First team and once the case has closed to this service. A critical role of the social worker is to identify this source of support for each family.

**WHAT DO WE MEAN BY DIRECT SUPPORT AND INTERVENTION?**

A key element of our work to support families to make positive changes is the offer of direct support. An initial focus on direct help, such as overdue repairs, rubbish clearance or obtaining crucial items such as beds for children or a functioning washing machine is important in starting to build the relationship needed to bring about change. Seeing some practical and quick results can signal to families that the worker intends to keep their promises and is there to help. This may be the point where families begin to see this support as different to what they may have experienced before and begin to trust the social worker and become more willing to work with them.

Direct support involves workers working alongside families, showing them how to clear up and improve home conditions. As one study put it, ‘…it also meant being able to help the family see that change was possible, sometimes by identifying an important change where positive results could be seen fairly quickly, for example in improving the physical environment of the home’. Small improvements such as a cleaner house or garden are often a critical first step forward for families. These improvements can reduce other problems such as depression or difficult family relationships that can be exacerbated by poor living conditions as well as improving a family’s motivation to make bigger changes. Workers help to provide a routine for those living in chaotic circumstances, showing parents how to get children up and fed in the morning, how to prepare meals and how to put children to bed are important. Family’s day-to-day skills such as cooking, hygiene and daily routines may often have been taken for granted by other agencies and they may need to learn these things for the first time. Parents may not have much knowledge about the development needs of their children and may need information regarding this as well as help in mirroring how to play for example. The focus needs to be on workers who do much of the work ‘on the job’ showing the family what to do, teaching them, sometimes for the first time, basic household skills such as shopping and cooking rather than referring them to a ‘food skills course’ run by another agency.

The objective is always helping families learn to do things themselves. Workers are clear on the need not to slip into doing things for families, allowing them off the hook. As families achieve things that were previously beyond them, this builds up their self- esteem, creating a ‘feel good factor’ which builds their confidence and resilience. Practitioners need to slowly pull back on this direct support over time to ensure families don’t become dependent on this support and ensure that any changes that are made are sustainable.

The type of direct support offered will be dependent on the needs of the family and should be tailored to the assessment of their needs. All support should be evidence based and based on what we know works to support change in families.

Below is a list of examples of the types of support that may be offered to children, young people and families to ensure that outcomes are improved. This list is not exhaustive.

* Direct work with children (talking, playing, completing activities with them; use of worksheets and questionnaires with a view to getting to know them and enabling them to speak to us so that we can understand their experiences and lives);
* Direct work with parents to aid assessment and understanding of their issues and experiences (use of checklists, questionnaires);
* Genogram with the whole family including the use of photographs;
* Support with family routines - using stickers, photos, making posters to aid understanding and memory, supporting and helping families use reward charts effectively and consistently;
* Showing and helping the family to undertake basic day to day household tasks such as shopping, preparing meals, hygiene and daily routines;
* Showing parents and young people how to clean a bedroom or kitchen for example, by doing it with them initially and then gradually reducing the amount of direct support to ascertain whether the family are able to do this in a sustained way themselves;
* Modelling family routines - attending houses at critical times - e.g. mornings and evenings in order to observe what is happening and support the family to make a plan. Plans of work to attend at critical times to support parents and show them how to make the changes needed;
* Showing and helping the family how to get the children up and fed in the morning or how to put children to bed;
* Increasing knowledge and understanding of a range of issues for children, young people and parents - about domestic abuse; substance misuse; healthy eating;
* Support with family budgeting - access to debt management if required and helping family apply for appropriate benefits; this may include a plan which includes support with shopping; then a reduction in support to help with a shopping list; then support with preparing and cooking healthy meals; and then positive reinforcement and motivation for the family to do these tasks independently;
* Support to help to get the child to school with a view to modelling how the parent/young person will move towards doing this independently;
* Support to get family members to key appointments( e.g. health, housing) and meetings with other services;
* Support to get family members to access an appropriate Parenting Programme, Family Learning activity at Children’s Centre or School;
* Helping the family tackle overdue repairs, cleaning projects, rubbish clearance or obtaining crucial items such as beds for children or a functioning washing machine;
* Helping and supporting the family address overcrowding- sorting out storage/providing beds etc;
* Support with housing needs, addressing rent arrears, applying and bidding for new tenancy if required;
* Support to build positive relationships in families by helping members of the family to talk to each other; identify each other’s strengths; talk about difficult issues; find ways of addressing difficult conversations without arguing, negotiate, agree and maintain appropriate boundaries;
* Facilitating family mediation sessions within the family home either in response to a crisis - e.g. a young person who is being threatened with having to move out or in a planned way;
* Facilitating a Family Group Conference with the support of the Supporting Solutions team;
* Supporting parents to plan a family day out and give them the confidence to do the trip in order to improve family relationships;
* Educating parents about child development through the use of DVDs; work sheets, activities (e.g. pre-birth toolkit – some materials are appropriate for a wider age range of children);
* Supporting young people and parents to access higher education or training by for example, ensuring they have access to support for their CV; accompanying them to an open day;
* Support engagement with positive activities outside the home such as sports, educational and recreational activities;
* Work with young people who have been missing from home to help them understand risk; how to keep themselves safe on social media; develop keeping safe strategies;

**OUTCOME FOCUSED PLANS**

The [Family Outcome Framework](http://www.durham-lscb.org.uk/wp-content/uploads/sites/29/2018/10/Family-Outcome-Framework-Reviewed-Oct-2018-SW-KD-FS-v3.pdf) sets out an agreed approach to Care Planning and evidencing when a family has achieved significant and sustained progress, ensuring our work with children and families is focussed on achieving measureable positive outcomes.

The key purpose of any type of child’s or young person’s plan is to help focus and target professional involvement with them and their family steering activity towards **agreed goals and outcomes.** A good plan therefore needs a clearly defined overall aim or goal, and a brief summary of the key issues and reasons why additional support, protection or care is needed.

The plan should include sufficient information to allow anyone reading it without prior background knowledge of the child or their circumstances to understand broadly why it’s needed at this time, and should include reference to all family members and their needs.

A good plan will be clear about what the child’s ***unmet* developmental or care needs** are and what is required for the child’s improved circumstances, wellbeing or safety, based upon rigorous and up-to-date assessments. Having a clear understanding about what the child’s or young person’s unmet needs are is always the starting point for developing a good plan.

Plans will consider the needs of all members of the family in the context of Think Family practice, but will always have a focus on how improving outcomes for parents will impact positively on the child and their unmet needs.

Plans must also be clear about the services or support that will be offered to the child/young person or their family, and/or the actions which are required, to help meet the child’s needs. The plan should identify clearly who will be responsible for providing or doing what and should set reasonable timescales for this – which should reflect the *child’s* own needs and rate of development. All plans will be reviewed at 4-6 weekly intervals at TAF meetings to measure progress against the intended outcomes.

Importantly, effective plans set clear **‘planned outcomes’** for each of the child’s unmet needs. Planned outcomes should:

* describe what change will ‘look like’, making it easier to tell whether or not the plan (or individual aspects of it) has been successful, i.e. whether an unmet need is now sufficiently met, or a risk factor sufficiently reduced.
* be child focused,
* achievable
* easily measurable.
* timely

The most successful plans ‘take people with them’; they have been **developed *with* families, not for them**. Parents – and young people, when appropriate – should be integral to their development and implementation, firm partners from the outset. To assist in this process, plans should therefore be written in clear, straightforward language that can be easily understood by anyone outside of social care and in particular by the family (and child/young person when appropriate) that plan has been made for. They should be explicit, **jargon free**, and avoid abbreviations.

In accordance with the principles of evidence-based practice, all plans for children should include clear, built-in mechanisms to help measure their progress and success.

Traditionally, success has often been evaluated in terms of *processes –* “have we done what we said we’d do?” However, this often tells us little about the consequences for the child. To know about these, we need to measure outcomes – by **asking “what *difference* has this plan made for the child *-* and how do we know?”**

Therefore, unless the child’s plan includes clear ‘intended’ or ‘planned’ outcomes which relate to each aspect of risk or unmet need, it’s virtually impossible to know whether (and when) the plan has achieved what it was designed to do. When planned outcomes are clearly defined, measurable and explicitly child-focused, it becomes much easier to evaluate a plan’s real success *for the child*, in a more reliable and objective way.

Planned outcomes also help parents/carers and involved professionals know where the goal posts are – i.e. what ‘success’ will look like and what the expected changes/requirements are. This in turn makes it much easier to focus in upon what changes have been achieved *for the child* at review meetings or before decisions are made about their cases.

Like the entire plan itself, plans need to be **SMART** (i.e. specific, measurable, achievable, realistic and timely).

They should **relate *specifically* to the child and family and their identified unmet needs** (and to any risk factors, if these have been identified).

Planned outcomes should ***not***relate to ‘Interventions’ – i.e. to the services offered, actions or tasks agreed, etc. (This is a crucial concept. Planned outcomes which relate to ‘Interventions’ won’t usually help to measure success *for the child*, only success of providing a service or achieving a tasks, etc. So, a parent may receive support to attend a ‘positive parenting’ group and may complete it, but what matters in terms of outcomes for the child is whether this results in improved quality of care and/or developmental progress.)

Planned outcomes need to be ***Measurable*** and so should incorporate a clear and objective ***measurement of success***, preferably something which can be independently observed, recorded, counted, weighed or otherwise evaluated without requiring personal judgements or values. However, this is not an exact science, and can be especially difficult when the child’s needs relate to their emotional development or to the quality of their attachments or family relationships. In such cases, changes in the child’s observed behaviour or their own views may be the only means of independent evaluation.

Planned outcomes also need to be ***Achievable* and *Realistic***. For example, in the case of CiN plans they should help demonstrate whether the child’s needs have been *sufficiently* met so that they are no longer “a vulnerable child with complex and multiple needs”. In the case of child protection plans, they should help demonstrate whether the likelihood of significant harm has *sufficiently* reduced to a point where the plan can be replaced with a Child in Need plan.

Planned outcomes should also be ***achievable within reasonable timescales*** – which themselves should be determined by the child’s own needs and developmental timescales, or the anticipated/likely timeframe of the plan or review period (whichever is less).

It should be recognised that there are sometimes unintended impacts which can and should also be planned for:

e.g. a child’s school attendance improves but they worry more about what is going on at home as they are not there. This would need an additional plan to support the child’s emotional needs as well as their school attendance.

**STEP–BY–STEP GUIDE TO DEFINING MEASURABLE ‘PLANNED OUTCOMES’**

* **Step 1: Identify the unmet needs**: Before anything else, it’s necessary to be clear about the child’s *unmet* developmental and care needs *and* any difficulties their parents/carers have in meeting these needs *and* any risk factors that must be reduced. This is the key function of the assessment process.
* **Step 2: Agree the changes that are needed or the ‘Planned Outcomes’:** Once the child’s needs are identified then the practitioner needs to be clear about what the planned outcomes are for the child and their family. What changes are needed in this family in order to improve outcomes for them?

e.g. *If a child has poor school attendance then the overall planned outcome would be for them to improve school attendance so that their attendance improves to at least 90% for 3 consecutive terms*

* **Step 3: Identify the services/support/activities which will help the child and family to achieve the outcomes identified**: Once the child’s needs are clearly defined, the services, support, actions (or non-actions) etc. can be identified, which will help to meet each of the child’s needs or reduce risks, etc. These are usually agreed at a planning or review meeting, Child Protection conference etc. They should focus on the direct support and help that will be provided to the family that will help them to make the changes identified
* **Step 4: Ask a few questions** about *each* identified need/risk factor:
  + - * If this need was being met sufficiently (or if this risk was sufficiently reduced), how would I *know*?
      * What would I see/measure/count etc. that would tell me?
      * What would be tangibly different about or for **the child**?
      * In other words, ***how would I determine that the child’s development / wellbeing / care / safety has really improved*** and that the services provided or the actions taken have really made any difference?
      * Here’s an example of a need I have:
* **My Need**: I need to lose some weight, because I can’t fit into my outfit for my sister’s wedding.
* **My problem**: I keep eating too many cakes and biscuits and I never exercise.
* **What action is required**: I’m going to eat fewer cakes and biscuits and I’m going to the gym every week.
* **By When**: September (date of the wedding).
* **Planned outcome:** I’ll have lost enough weight to fit into my outfit.

*(If I defined my planned outcome as simply “I’ll have lost weight”, I couldn’t be sure that this would result in my need to fit into my outfit - I might not lose* enough *weight. Similarly, if I set a planned outcome simply to have visited the gym every week, I couldn’t be sure this would meet my need either - I might go to the gym and eat the cheap Wagon Wheels they sell there. The only way I’ll know my plan has worked is if I lose* enough *weight to fit into my outfit before September.*

Defining measurable planned outcomes is not an exact science and it’s recognised that **some needs are much harder to measure objectively** in clear and quantifiable terms - particularly those relating to a child’s emotional development – for example, the quality of attachments and relationships, or the degree of self-esteem.

* The key question to be answered, however, is “how will we know whether things have improved?”
* Sometimes a child’s longer-term developmental or care needs can only be determined by other assessments being made (such as a risk assessment, psychological/cognitive assessment or a parenting assessment). In such circumstances, the initial ‘planned outcome’ might be simply that “there will be enough information about X from Y assessment to make future plans for the child”.

**TEAM AROUND THE FAMILY (TAF) REVIEW PROCESS**

The social worker is responsible for planning and coordinating TAF meetings with support from the team co-ordinator. These meetings will act to review the family’s outcome focussed plan, for the work carried out to date and plan sessions for the next phase of work over the following 4-6 weeks period.

TAF meetings should be planned in advance. Every TAF member should know the dates of the meetings and if unable to attend, their absence recorded.

The meetings should aim to include both parents/carers. In cases where it is not appropriate that parent/carer(s) attend together; the meeting should be co-ordinated to allow parents/carer to attend separate parts of the meeting.

The purpose and process of each meeting should have been explained to the family members beforehand along with an explanation of who will be attending and why. Members of the team have a responsibility to speak to parents/family members prior to meetings and ensure they are fully prepared and know what information will be shared. No new information to the family should be shared at TAF meetings.

The social worker should gather the views of the parents/carers/children and young people, in the week prior to the meeting, as part of their ongoing work. Parents/carers/children and young people should be encouraged to represent their views at each meeting and ask questions. Where they are unable to attend, their views should be recorded and then represented at the meeting. These views should be clearly stated on the minutes of the meeting.

Where a social worker and a family worker within Families First are working together with a family, they should meet at least once prior to each TAF meeting to discuss and plan the next pieces of intervention work with the family.

Each TAF meeting should use the outcome focussed care plan as the basis for their discussion. The outcome focussed plan should be updated at each TAF meeting; clearly demonstrating when outcomes have been achieved and are outstanding. All work should be agreed and recorded in the child’s family plan, showing the tasks for each TAF member.

As a minimum each meeting should consider and record the following:

* The actions agreed at the last meeting and how these have since been progressed?
* A review of the work plan to date; how effective is the plan? What work is outstanding and what is the planned schedule of interventions for the next 4 – 6 weeks.
* Whether any referrals need to be made to other agencies or professionals.
* The progress has been made towards the overarching care plan outcomes for the child/young person, whether the plan continues to be relevant and what amendments, if any, are required.
* Events which should be added to the chronology.
* Patterns of concern evident from analysis of chronology.
* A review of the levels of engagement and cooperation from parents with the plan and evidence of progress and change.
  + - The risks to the child and any further action required.
    - The protective factors present within the family to mitigate the risks.
    - The views of the child.
    - The views of each parent and relevant members of the extended family.
    - The views of each member of multi-agency TAF member.
    - The make-up of the multi-agency TAF and whether other professionals should be co-opted onto the team.

• The social worker will chair TAF meetings.

• Record taking in the form of TAF minutes will be a responsibility shared by all TAF professionals. TAF minutes should be recorded on the child/young person’s case file using the agreed recording format in the child’s electronic case file.

• The minutes should be typed and quality assured by the relevant team manager/social work consultant.

* A copy must be securely circulated to all TAF members including those who were not able to attend, within 10 working days.
* It is the responsibility of TAF members to identify any disagreements/inaccuracies within minutes of meetings and alert the chairperson.

**ESCALATION AND DE-ESCALATION OF CASES TO AND FROM FAMILIES FIRST**

The Durham Continuum of Need (see page 3 of the [Threshold Document 0-19 Level of Need](http://www.durham-lscb.org.uk/wp-content/uploads/sites/29/2016/06/0-19-Level-of-Need-Final-2016.pdf)) is designed to support Families appropriately depending upon their level of need. As a family’s needs change, they will move between the levels of need on the Continuum. Families deemed at level 2 or higher on the Durham Level of need Continuum, must have an appointed lead professional. Families deemed at level 4 need must have an allocated social worker as lead professional.

**ESCALATION AND DE-ESCALATION OF CASES BETWEEN ONE POINT SERVICE AND FAMILIES FIRST**

One Point Service and Families First teams work closely to ensure that families receive the right support at the right time; escalating and de-escalating cases according to level of need.

**WEEKLY ALLOCATION MEETING**

All Families First Teams and One Point Service locality managers should hold a weekly allocation meeting. This meeting is an opportunity for practitioners to meet and discuss cases identified for escalation and de-escalation. The meeting will discuss the family level of need, consider what options of support have already been offered and agree a course of action.

Where a decision is made to de-escalate a case Families First Team Co-ordinator will take responsibility for completing the de-escalation form (Appendix 3).

**In instances where a One Point professional/family member believes a child may be or is at risk of suffering significant harm; it is not appropriate to delay action by waiting to discuss the case at a weekly allocation meeting**.

The professional/family member should act immediately and make a referral to First Contact detailing the key concerns and risks posed to the child following [Child Protection Procedures](http://www.durham-lscb.org.uk/professionals/) .

All decision making and actions must be recorded on the case recording system.

**De-escalation of a Case from Families First to One Point**

Families First social worker identifies case requires de-escalation.

Discussion should take place with relevant TAF practitioners, Family Members and the team manager/social work consultant. A record of all discussions and rationale should be kept on the child’s file including what support is required.

Recommendation

Team managers agree de-escalation to One Point Service

Famiiles First team manager completes transfer summary. Case note added to case recording system, and record made detailing rationale and further support required.

Case re-allocated in case recording system to relevant One Point team.

Team managers do not agree de-escalation

Record made on child’s file. Case remains with Families First. Support from social worker and TAF following Outcome Focussed plan.

Agreement

Needs may be met by One Point Service

Case is presented to the Allocations Meeting for discussion between Families First team manager and One Point Service team manager.

Case presented to allocations meeting attended by One Point Service team manager and Families First team manager

Case discussion which includes what support has been offered and provided, including the rationale for de-escalation recommendation.

Needs may be met by Universal Services / voluntary and community sector

Rationale for decision must be recorded on child’s file.

The identified Lead Professional details should be recorded on the case recording system and case closure procedure followed.

**Escalation of a Case from One Point Service to Families First**

**Urgent**

**Child Protection**

Immediate referral to First Contact. First Contact will progress the escalation ensuring the MASH process is utilised.

Case in need of escalation identified by One Point lead professional

**A referral is made to First Contact by One Point team manager.**

First Contact will progress the escalation ensuring the MASH process is utilised

One Point complete transfer summary and puts case note on case record, and record on child’s file detailing rationale and areas of concern

Team managers agree escalation

Record made on child’s file. Case not escalated to Families First and remains with One Point supported by lead professional and TAF following Outcome Focussed plan.

Team managers don’t agree escalation

Case presented to allocations meeting attended by One Point team manager and and Families First team manager. Case discussion which includes what support has been offered and provided including the areas of concern which have led to escalation recommendation.

Escalation of level of need to Level 4

Escalation to Families First

No change to level of need/escalation of level of need 2/3

Needs can be met in One Point Service

Review recommendation

**Non Urgent**

One Point lead professional undertake assessment review and consult with family and TAF members

**JOINT WORKING ARRANGEMENTS WITH THE YOUNG PEOPLE’S SERVICE**

The Young People’s Service (YPS) works with young people who are Children in Need (at Level 4 on the continuum of need) where they are aged 16+ and have completed Year 11 at school (30 June each academic year). The Service also provides support to care leavers, Looked After Children aged 15+.

The close working relationship between the YPS and Families First team is important for this group of young people as it ensures that they get the right support and expertise that is available to meet their particular needs. Many young people will receive support from the One Point Service and will not need the support of the YPS as they leave Year 11.

Where a young person is 16 years old, have left Year 11 of school and require social work support; they should be referred to the Young People's Service (YPS) in line with the transfer protocol.

Where a Young Person is already an open case to Families First; in the summer term prior to finishing Year 11 a planned transfer process will take place between the two services. Where the young person is part of a family group who have children of different ages, a co-ordinated 'whole family' team approach will be in place and the worker in YPS will be a part of the TAF support plan.

Any young people who are on family plans with younger siblings should remain with FF teams.

The Families First social worker and team manager will ensure that the YPS and appropriate One Point Service are invited to all TAF meeting planned for April, May or June of Year 11 where a 16 year is part of the family group and will be an open case on the 30 June of that year.

A TAF meeting must have taken place prior to the 30 June and the two appropriate services must have been invited. Relevant team managers in both services should be notified of the planned meeting date with at least 3 weeks’ notice so that they can identify a member of staff to attend the meeting.

The meeting will consider the current care plan for the whole family and also look specifically at the needs of the young person about to leave year 11. Depending on the support needs of the young person a decision will be made at the meeting, with the family and ideally the young person present, whether the YPS or the One Point Service is best placed to meet the needs of the 16 year old young person.

This appropriate service will then become an active part of the TAF (if they are not already) to specifically meet the needs of the young person whilst the rest of the care team continue to meet the needs of the rest of the family. YPS will only work with the young person leaving year 11. The social worker for the family will continue to have responsibility for ensuring that the needs of all other children in the family are met, as well as arranging regular TAF meetings and inviting the relevant support services for the young person. The principle of one family plan and one TAF meeting should continue unless it is not in the interests of the young person to do so.

Once it has been agreed who will provide support to the young person, a joint visit will be arranged following the TAF and prior to the 30 June that year to introduce the new worker to the young person and prepare the case for transfer within two weeks of the 30 June.

Where the YPS will provide the ongoing support to the family, the social worker can add the new worker’s name as a provision on the case recording system pending full transfer of the case. This will enable the newly identified worker to access the case information and add case notes.

**CLOSURE OF CASES OPEN TO FAMILIES FIRST**

One of the key objectives of the Families First Service is to reduce the re-referral rate of Families by ensuring that the right support is offered at the right time. This requires rigorous and careful attention to de-escalation processes and case closures.

Practitioners should always consider what support is required for the family upon case closure/de-escalation from Families First. Resources within Universal services, the One Point Service and the voluntary and community sector should always be considered.

All cases that are due to de-escalate or closure must be discussed with the team manager or social work consultant in the first instance and a case note should be added to the child’s file reflecting key discussion and decisions.

There are some referrals received within the Families First Service which require no further follow up action or support from other services and therefore can be closed. Case recording is important; the social worker must always demonstrate why this is the most appropriate decision, who has been consulted and include what evidence, if any, has been found in response to the initial issues of concern.

In preparation for case closure, the social worker will:

* Complete the closure summary on the case recording system which must identify the initial reason/family need, what progress has been made and if there are any outstanding tasks.
* If a lead professional is identified at the point of closure or de-escalation, add the contact details of this person onto the case recording system.
* Prepare the child/young person’s file for closure, ensuring all key documents are be updated and included on the file prior to passing to the team manager/social work consultant for sign off.

The team manager/social work consultant will check that closure procedure has been followed and where appropriate approve case closure.

The social worker is responsible (in conjunction with the team co-ordinator) for ensuring that a letter is sent to TAF members, referrer and family confirming that the case has been closed to Families First. Where there are outstanding tasks/actions, the letter must also include what arrangements are in place to support the family to address their needs.

Wherever a lead professional changes for a family who are engaged with the Stronger Families programme; the lead professional is responsible for ensuring that this information is passed to the Stronger Families Team.

When all relevant parties are informed and the closure process is complete, the team manager/social work consultant will close the case on the case recording system.

**QUALITY CLINICS**

**Quality clinics chaired by the social work consultant**

Themed quality clinics are designed to provide space to offer in-depth reflective case discussion to social workers, in addition to management oversight which is offered within supervision. The clinics provide the opportunity to discuss progress towards good quality outcomes and avoid drift and delay for children, young people and families.

Social Work Consultants should hold monthly themed clinics with case workers on the following areas of concern:

* Cases where [Neglect](http://www.durham-lscb.org.uk/wp-content/uploads/sites/29/2016/06/1458036245-Neglect-Practice-Guidance-2016-Final.pdf) is a concern
* Children/young people on the edge of care
* Children/young person who have been open to the team for 6 months or more

The focus of each clinic is to provide opportunities for reflective case discussions aimed at improving the quality of case work, minimising drift and improving outcomes for children, young people and their families. These sessions aim to provide an opportunity to explore cases, challenge ideas within a supportive and reflective process.

Gibbs (1988) provides a model for reflective practice:



Gibbs (1988) reflective cycle provides a process of reflection which encourages:

* ***Description:*** a clear description of the situation
* ***Feelings:*** analysis of thoughts and feelings (worker, child, family, professionals)
* ***Evaluation:*** what was good/bad about the experience
* ***Conclusion and Analysis:*** make sense of the experience/situation
* ***Action plan:*** reflection upon experience to examine what needs to happen in the future

The social work consultant should support practitioners to discuss case work using the model of reflection.

Cases should be identified by social workers as suitable for the clinic. Social workers should consult the team manager or social work consultant if they are unsure if the case meets the criteria for discussion in any clinic.

Some cases may be specifically selected for discussion in a clinics by the team manager or social work consultant.

The social worker must prepare for the clinic and attend with relevant information, including the genogram and update of the case.

A record must be made of discussion on each case using a discussion/decision sheet. Every case discussion written record must, as a minimum, include the following:

* Child’s name, age and PID
* Overarching plan
* Current Issue
* Reflective discussion
* Action required

As part of discussions, appropriate reference should be made to policy, procedures, research and tools

The social work consultant will ensure accurate records are made, to reflect each case discussion, using discussion and decision sheets. The social work consultant will ensure completed discussion and decision sheets are recorded on the child's file.

The social work consultant should provide the team manager with an overview and feedback from each clinic.

Decisions and actions should be linked to case discussions held in supervision between social workers and the relevant team managers/social work consultant.

Families should be informed that their case is discussed in quality clinics.

Decisions from quality clinics should be shared at TAF meetings and included in the Family care plan.

**Neglect Clincs**

The neglect clinic aims to ensure that children who live in neglectful circumstances are robustly and regularly reviewed to ensure that the circumstances they’re living in are good enough and that there is evidence of parental capacity to change.

[Neglect](http://www.durham-lscb.org.uk/wp-content/uploads/sites/29/2016/06/1458036245-Neglect-Practice-Guidance-2016-Final.pdf) can be an event (one-off incident) and a process (number of events/incidents) and either can be as equally serious as the other. Neglect can be life threatening and also has the potential to compromise a child’s development significantly, across multiple domains.

In assessing neglect, it is important for practitioners to be able to distinguish between a *risk factors* of neglect and *indicators* of actual neglect. The presence of risk factors (such as social isolation, poverty, substance misuse) doesn’t automatically mean the neglect will occur however factors can increase the likelihood. Indicators of neglect suggest that the child is experiencing actual neglect and can feature in their behaviour and development. These indicators are more often ‘seen’ and should be taken seriously.

Because neglect frequently coexists with other forms of abuse, it can be difficult to understand and identify. Neglect is considered to be at least as damaging, if not more so, than other forms of maltreatment because its impact is the most far-reaching and difficult to overcome (Gilbert *et al.*, 2009), in particular from the point of view of long-term mental health or social functioning. Given the lifelong impact that neglect can have upon an individual; early intervention and support for families is therefore of priority in safeguarding children from harm.

Neglect is defined in UK statutory guidance as:

*The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:*

* *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
* *protect a child from physical and emotional harm or danger*
* *ensure adequate supervision (including the use of inadequate caregivers) or ensure access to appropriate medical care or treatment*
* *be responsive to the child’s basic emotional needs*
* *provide consistent guidance and boundaries*
* *failing to provide stability of physical and emotional environment (e.g. frequent short-term house moves)*

The challenge for practitioners is to know when, with whom and how to intervene and with what degree of urgency. In this process, we should be able to make a clear distinction between those acts of omission for which good parents know that they are sometimes responsible, and child neglect. Furthermore, identify the impact that the child’s experience is having upon them and the child’s timeframe for change. Timely and reflective discussions provide the opportunity to discuss these complex cases in order to recognize patterns, identify areas of concern and form analysis.

***Criteria for the clinic:***

* Children at level 4 where there are concerns about neglect
* Practitioner/TAF concerned that the child is likely to experience neglect or is actually experiencing neglect

***Points to consider when exploring neglect (also refer to Guidance on*** [***Neglect***](file:///C:\Users\cath.heron\Desktop\•%09http:\www.durham-lscb.org.uk\wp-content\uploads\sites\29\2016\06\1458036245-Neglect-Practice-Guidance-2016-Final.pdf)***)***

* CHANGE - Has there been an assessment of Parental capacity to change? Does the parent demonstrate ability to change or are there signs of avoidance / ambivalence / relapse? What does this mean for the child and how can practitioners support the parent?
* AGE of the child - Although older young people are more at risk of neglect overall (Schumacher *et al*., 2001), pre-school aged children and babies are innately more vulnerable and can suffer severe harm from neglect very
* DISABILITY – young children with disabilities are identified as a vulnerable group
* INTERACTIONS between parent/child
* BIRTH FATHER – NUMBER of referrals to Safeguarding services about the child/family
* Are there PATTERNS in referral concerns– featuring similar themes such as poor supervision, neglect of child’s health and educational needs
* Are there a VARIETY of professionals concerned about the child/family?
* PRE-BIRTH risk factors such as parent failing to attend appointments, failure to follow medical advice, Misuse of illegal or prescription drugs or alcohol while pregnant.
* RISK FACTORS such as maternal mental health problems, learning disabilities, drug and alcohol misuse and living with domestic violence.
* CHILD’S PRESENTATION is of concern; changes in physical weight changes/clothes/hygiene
* CHILD’S VIEWS and comments which causes professionals / others to be concerned
* PARENT’S and professionals views

**References:**

[Working Together 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

[Missed Opportunities](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379747/RR404_-_Indicators_of_neglect_missed_opportunities.pdf)

**Children/young people on the edge of care**

Children/Young people can be edging towards care (likely to require Local Authority care) for various reasons for example; family crisis, neglectful parenting, or parents struggling to cope. There is an extensive body of evidence which shows how factors such as domestic abuse, parental substance misuse, mental health problems and learning disability undermine parenting capability and increase the likelihood of the child experiencing significant harm, particularly when they occur in combination. The growing evidence shows how the experience of abuse and neglect may have a long-term, negative impact on children’s physical, cognitive, social, emotional and behavioural development that can last throughout the life course.

“In cases where there is clear evidence of significant harm or its likelihood, multiple risk factors that are known to be associated with future harm, no mitigating protective factors and no active engagement or evidence of parental change, there is a strong possibility that children’s life chances will be seriously compromised unless they are placed away from home. The negative impact however for children being separated from their birth family is well documented with evidence of them facing poor outcomes” (DfE Assessing Parental Capacity to Change when children are on the Edge of Care). Therefore, Local Authority Care should be the only option after all possible avenues to keep the child safe at home have been explored.

Early intervention is therefore pivotal to ensuring children/young people receive the right services to address family challenges and difficulties to support them to remain together safely. Professional decision making is crucial to input the right services at the right time. When there are serious child protection concerns and the child is likely to require Local Authority care, social workers need to be able to assess and make informed decisions about the parent(s) being able to meet their children’s needs and why, what aspects of parents’ behaviour need to change and whether parents have the capacity to make such changes within a timeframe that is appropriate for the child/young person.

Judgments concerning the risks of significant harm, need to be based on; evidence, the child’s outcomes and professional knowledge.

In all cases where children/young people are on the edge of care, a referral must be made for a Family Group Conference

***Criteria for the clinic:***

* Children residing with a parent subject to an Interim Care Order
* Relationship Breakdown between child and parent/primary carer
* The child/young person is beyond parental control
* The child/young person is engaging in criminal behaviour
* Parent/Primary Carer is seeking to relinquish care of the child/young person
* Child/young person is at risk of Child Sexual Exploitation
* Frequently missing from home

***Points to consider when exploring issues concerning child/young people on the edge of care:***

* RISK FACTORS: What are the risk factors which are contributing to the child/young person being on the edge of care?
* VIEWS: What does the child/young person say, what are their views?
* What do the parents and other professionals say, what are their views?
* CHANGE? Has there been an assessment of Parental capacity to change? What does this mean for the child and how can practitioners support the parent?
* SIGNS: Are there signs of false compliance, resistance, failure to cooperate and denial; what are the possible reasons?
* STRENGTHS AND VULNERABILIES: What resources do the family have which can be utilised? What are their strengths? Can the support network help or be strengthened?
* SUPPORT SERVICES: What services have been explored? Community / Voluntary Services, Family Group conference and family mediation. If these haven’t been explored, why?
* SAFETY: Who is keeping the child/young person safe and how?
* DANGER: What are the actual risks posed to the child, from whom?
* PLAN: Can risks be managed safely without the use of care? If so, how? And if not, why
* CONTINGUENCY PLAN: Who have the family identified (if appropriate) as a carer for the children in the event that emergency care is required? What assessment is needed?
* LEGAL: Should legal advice be obtained?

**References:**

[Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/330332/RR369_Assessing_parental_capacity_to_change_Final.pdf)

**Children/young person who have been open to the team for 6 months or more**

The purpose of this clinic is to review cases which have been open longer than 6 months within the Families First team. These reviews are undertaken by the social work consultant on a monthly basis. The review aims to consider the care plan; whether there is evidence of progress and improved outcomes; whether the plan needs to change or whether the case needs to escalate or de-escalate.

This clinic does not consider cases whereby Children are subject to a Child Protection plan or Looked After Children.

***Criteria for clinic***

* Child/young person whose case has been consistently open for over 6 months
* Child/young person is not subject to a child protection plan
* Child/young person is not Looked After

***Points to consider when exploring issues concerning child/young people with cases open 6 months or more:***

* PLAN: What is the plan and purpose of current social work involvement?
* RISK FACTORS: What are the current risk factors?
* SAFETY: Who is keeping the child/young person safe and how?
* DANGER: What are the actual risks posed to the child, from whom?
* CHANGE? Has there been an assessment of parental capacity to change? What does this mean for the child and how can practitioners support the parent? Are there signs of disguised compliance, resistance, failure to cooperate and denial; what are the possible reasons?
* STRENGTHS AND VULNERABILITIES: What resources do the family have which can be utilised? What are their strengths? Can the support network help or be strengthened?
* SUPPORT SERVICES: What services have been explored? What additional work is needed?
* DE-ESCALATION: What needs to happen to de-escalate this case?
* ESCALATION: Arrange a case review using case file audit template and consider 1) what additional case work is required to evidence concerns 2) should Operations Manager be consulted? 2) Should legal advice be obtained? 3) Is PLO/Child Protection appropriate?
* VIEWS: What does the child/young person say, what are their views? What do the parents and other professionals say, what are their views?



**Checklist for Practitioners on Initial Home Visit**

Appendix 1

**Complete as appropriate to confirm that this information has been shared with you and explained:**

|  |  |  |
| --- | --- | --- |
| **Information shared with Parent/s** | **Y/N** | **Comments** |
| Consent to share information discussed and signed |  |  |
| Representations Procedure  (Complaints or Compliments) |  |  |
| Access to Records Information |  |  |
| Relevant contact numbers for your lead professional |  |  |
| Information Sharing Discussed |  |  |
| Transporting Children Policy  (if appropriate) |  |  |
| Information on referral to Children’s Centre |  |  |

|  |  |  |
| --- | --- | --- |
| **Signature of Parent (s)** | **Print Name** | **Date** |
|  |  |  |
|  |  |  |
| **Signature of Child/Young Person**  **(as appropriate)** | **Print Name** | **Date** |
|  |  |  |
|  |  |  |



Appendix 2

**Durham County Council**

**Children and Young People’s Services**

**Families First Service**

**Consent Form**

*(Consent means giving your permission for something to happen or making an agreement to do something)*

Child/Young Person’s name: ……………………………………………….

Date of Birth: ……………………………………………….

Address: ……………………………………………….

It is Durham County Council’s expectation that your social worker/lead professional will always strive to work in partnership with you and will fully explain the assessment process and why they are involved with your family. The social worker/lead professional will explain the issue of 'consent' and seek your permission to contact other agencies and share information in order to better understand what support your child and the rest of the family need.

Social workers/lead professionals have a duty to promote the welfare of your child in accordance S17 of the Childrens Act which states ‘tIt shall be the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and to assess circumstances where concerns have been raised about a child’.

**Please read the following statements and discuss any questions you have with your social worker/lead professional. You will be asked by your social worker/lead professional to sign this consent form when they first meet with you and you will be able to have a copy for your own records.**

I/we understand that it may sometimes be necessary for Children’s Care staff to transport my/our child in their own car or act as an escort with another driver. Where this is necessary I/we agree that Children’s Care staff may transport (enter name).

* **I/we give permission for this to happen according to the Service’s procedure for Transporting Children.**

I/we understand that information gathered regarding my family is recorded and will be stored and used for the purpose of providing services to my family. This may include a package of support/services delivered to me and my family.

This Information will not be shared for other purposes without my consent unless there are clear child protection reasons for doing so or there is a legal requirement to share the information e.g. the prevention or detection of crime.

* **I/we agree to the sharing of information, between professionals working with me and my family.**
* **I/we do not agree to share information with: …………………………………………………………..**

Please state if you have been given information about the Service’s complaints and compliments procedure:

**Yes No**

Please state if you have been given information about your right to access personal records:

**Yes No**

**Please use block letters**

Parent(s)/Carer(s) name(s): ……………………………………………….

Signature: ………………………………………………. Date: ……………………………………………….

Social worker/keyworker name: ……………………………………………….

Signature: ………………………………………………. Date: ……………………………………………….

……………………………………………….……………………………………………….……………………………………………….…………

**Young Person’s Consent**

* I **agree** to take part in the assessment and give my views as well as talking about my wishes and feelings to the social worker.
* I understand the social worker will need to speak to people who know me e.g. my teacher

Or

* I **do not consent to an assessment or to any agencies being contacted.**

Name: ……………………………………………….

Signature: ………………………………………………. Date: ……………………………………………….

Please place copy on child’s/young person’s case file

**Appendix 3**

**DE-ESCALATION FORM**

Families First – One Point

UNDER TAF PROCEDURES

**Child/Family:** Name/s:

DOBs:

Address: ­­­­­­­­­­­­­­

**DATE TRANSFER HAS TAKEN PLACE:**

**Name of Social Worker/Lead Professional in Families First:**

Name:

Team:

Contact number:

**New Lead Professional in One Point:**

Name:

Title:

Contact Details:

**Next TAF Meeting:**

Date:

Time:

Venue:

Member’s details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Following TAF Meeting:**

Date:

Time:

Venue:

Member’s details:

**Information to be shared with One Point Manager and Families First Manager**

**Date:**

**Signed:** ………………………………/……………………………...

Families First New Lead Professional