One Point Operating Procedures

Information for DCC internal staff

November 2023

Durham County Council

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Chapter 1

Using these Procedures and Useful Links

Durham County Council

Using these Procedures and Useful Links

The purpose of these procedures is to give clear guidance on working practices within Durham County Council One Point Service. It aims to support managers and practitioners to provide an efficient and effective service to children, young people and their families. The procedures should be regularly referred to by managers and practitioners and be an essential resource to new practitioners joining the service.

These procedures should be used in conjunction with a number of essential Government Documents and Durham County Council policies and procedures as detailed below (this is not an exhaustive list).

For quick access hover over the chosen title and click on the link (opens external hyperlink).

Growing Up in County Durham – Children and Young People's Strategy	The Growing Up in County Durham Strategy 2023 - 25 is a high level partnership plan which explains what we are going to do to achieve our vision for children, young people and their families.
A Strategic Partnership Approach to Early Help for County Durham (coming soon/undergoing accessibility checks)	A Strategic Partnership Approach to Early Help for County Durham – This partnership approach recognises that in County Durham, Early Help is not a single service or team, but a way of working with families that all of our key partners and stakeholders working with children and families can put into practice.
Early Help Assessment	The procedure for partners leading on supporting children, young people and families at a Team Around the Family (TAF) level.
The Durham Threshold Guidance 2020	This document provides indicators which are designed to provide practitioners with an overarching view on what level of support and intervention a family might need.
County Durham Family Outcome Framework	This sets out an agreed approach to planning and evidencing when a family has achieved significant and sustained progress, ensuring our work with children and families is focussed on achieving measurable positive outcomes.
Durham's Local Offer Special Educational Needs and Disabilities	The Special Educational Needs and Disability Local Offer webpages provide professionals with guidance on how to best support children and young people with SEND in accordance with government guidelines.
Durham Safeguarding Children's Partnership	The Durham Safeguarding Children Partnership website host a wide range of procedures, practice guidance and training

	relating to safeguarding children.
Children and Families Practice Toolkit (Currently under review)	Provides information resources and tools for assessment and intervention based on the Headline Outcomes of the County Durham Family Outcome Framework.
Working Together 2018	Working Together 2018 sets out the legislative framework for safeguarding children.
Neglect Practice Guidance (Currently under review)	This is the Durham Safeguarding Children's Partnership (DSCP) Neglect Practice Guidance and should be read and implemented by all practitioners undertaking assessments and interventions where there are concerns about neglectful parenting.
Durham Locate	Provides links to local adult leisure and community activities, products and services in County Durham
County Durham Family Information Service (FIS)	Durham County Council's Families Information Service (FIS) is the place to find free and impartial information to support families from pregnancy until a child reaches their 20th birthday, or 25 years old for children and young people with special educational needs and disabilities (SEND). FIS provides information on a wide range of things including childcare, family support, or activities for children and young people and signposting to other services.
Quality Assurance Framework	The Quality Assurance Framework sets out how the service measure and reports on the performance and quality of service support.
Supervision Framework	The framework details the processes of supervision for all OPS staff. (need online link for these resources)

Chapter 2

Children and Young People's Service

Durham County Council

Children and Young People Service

Children and Young People's Service consists of three service areas: Children Social Care, Education and Skills and Early Help, Inclusion and Vulnerable Children (EHIVC). The One Point Service sits within EHIVC along with SEND and Inclusion Service, Youth Justice Service and Aycliffe Secure Unit.

Please see external links below:

Structure Map for Early Help, Inclusion and Vulnerable Children (EHIVC) Service

Structure Map for Social Care and Education and Skills

Growing Up in County Durham Strategy 2023 - 2025 outlines our shared vision for children, young people and families in County Durham:

'Our Vision is that County Durham supports all children, young people and their families to achieve their goals in life, in an environment that is safe, happy and healthy.'

(Growing Up in County Durham Strategy 2023-2025)

Principles of Best Practice across Children's Services

Children and Young People's Service have developed and implemented a set of key principles of best practice, which provide a framework for our work with children, young people and families.

Children and Young People's Service Practice Model

Signs of Safety/Wellbeing

The Signs of Safety/Wellbeing practice model is used across County Durham to facilitate our strength-based approach. A strengths-based approach helps to build and maintain healthy relationships, resolve difficulties and repair harm where there has been conflict. This approach is now being used across Children and Young People's Service from Early Help up to and Childrens Social Care. We use the Signs of Safety/Wellbeing practice model to ensure all practitioners work collaboratively with children, young people and families to create solutions, focussing on strengthening and supporting family resilience. We aim to put children, families and everyone naturally connected at the heart of decision making, assessments and planning and give them every opportunity to come up with their own ideas before we offer or impose ours

We use Signs of Safety/Wellbeing in our work to assess the support needs of the family and put a clear a realistic plan in place to help identify their own solutions and take responsibility for their futures.

How we work together with families

We will work with them to agree what help they need and plan their family goals. We will work on three key questions.

1. What are we worried about?
2. What is working well?
3. What needs to happen?

Whole Family Approach

A whole family approach means taking a broader view by ensuring that both parents/carers and children are able to get the support they need, at the right time, to help their children achieve good outcomes. If any member of the family - a child, young person or adult - has a problem, it generally has an effect on other people in the family. If the whole family is supported, it's more likely that things will improve. We need to ensure that families receive integrated, coordinated, multi-agency, solution focused support. By identifying problems early, all services can work closely together to help prevent a family's needs escalating and requiring more intensive intervention.

Stronger Families

The aim of the national Supporting Families Programme, known in Durham as ‘Stronger Families’ (as it is more of a model than a programme), aims to transform the way the way that public services work with families with multiple problems to take an integrated ‘whole family’ approach and help reduce demand for reactive services.

The Prevention and Early Help Partnership’s collective aim is to help embed better ways of collaborative working to mainstream the 'whole family’ approach and embed the **County Durham Family Outcome Framework (FOF)** across their services to:

1. know and target children and families in communities most vulnerable to poor outcomes;
2. ensure the use of evidence-based approaches to help children and families achieve positive change and,
3. as partners, work collaboratively at the earliest opportunity to maximise impact and reduce duplication and help prevent the need for high cost services.

Chapter 3

The One Point Service

Durham County Council

The One Point Service

The One Point Service provides Durham County Council's Early Help service to children, young people and families living in County Durham.

Vision for effective 'Early Help' in County Durham

All children and young people in County Durham receive Universal Services; however, some children, because of their needs or circumstances will require extra support to be healthy, safe and achieve their potential. **The Strategic Partnership Approach to Early Help for Children, Young People and Families in County Durham (currently being reviewed for accessibility)** sets out our aims and priorities for the delivery of early help across County Durham.

Our vision for delivering effective 'Early Help' in County Durham is to:

'Bring together local partners to provide early support for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future, that builds resilience, prevents difficulties from escalating and leads to better outcomes that are sustained'

Early Help in County Durham is not a single service but a way of 'thinking' and 'working' through a collaborative approach between communities, families and services. Early Help is the term used by agencies in County Durham to describe our approach to providing support to vulnerable children, young people and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future.

Our early help partnership approach in County Durham is twofold:

'The approach for individual children, young people and their families and how to respond to additional or more complex needs as they arise at any point in a child's life; thereby securing better outcomes and avoid more costly interventions in the future.'

(1. Early Help Partnership Approach)

'The approach and practice from research and local intelligence to respond to groups of children and young people who are disadvantaged or vulnerable by known circumstances or environment.'

(2. Early Help Partnership Approach)

Within the One Point Service we do this by ensuring our services are focused on groups of children and families at risk of poor outcomes and on individual children and families with a range of complex needs as they arise at any point in the child's life.

The One Point Service is part of this coordinated community-based provision.

The Early Help System

Acute & Targeted

Universal

Community Support

Stronger Families

A new way of working with families in County Durham

One Point Service

The aim of the One Point Service is to identify and provide timely and effective early help for children, young people and families, that builds resilience, prevents difficulties from escalating and leads to better outcomes, which are sustained.

The One Point Service consists of the following provision:

Seven Intensive Family Support Teams

These teams are based within seven Intensive Family Support Teams. The teams provide intensive family support to children and families who present with a range of complex needs. The team provides a Key Worker model, providing 'whole family, outcomes focussed' support, utilising our collective resource through TAF processes. The seven teams are aligned to the 15 Families First social work teams, many teams are co- located to facilitate seamless service provision.

Fifteen Family Hubs

Fifteen Family Hubs provide a 0-19 early help offer for children, young people and their families with lower level needs, whilst retaining a clear focus on early years in line with the 'Best Start in Life'. The Family Hubs work in partnership with the Community and Voluntary Sector and health partners to provide access to a range of health, wellbeing and family support services including support for a child's learning and development, promoting healthy lifestyle and life skills and support for family relationships to ensure all children get the best start in life. The offer from the Family Hubs includes both time limited one to one support and group-based programmes and activities. Health Visitors and School Nurses are co- located within Family Hubs facilitating integrated working arrangements.

Social Inclusion Team

The Social Inclusion team lead on the VCS Alliance programme, Fun and Food programme and a range of projects that strengthen links with the voluntary and community sector and frontline practitioners, with a clear focus on child poverty to ensure families receive services and support appropriate to their needs.

SEND Information Advice and Support Service (SENDIASS)

Durham **SEND Information Advice and Support Service** is a statutory service supporting parents/carers of children with special educational needs and disabilities (SEND). Durham SEND Information Advice and Support Service operates at 'arm's length' from the Local Authority and the services provided are confidential and impartial.

Please see the **Structure Map for the One Point Service** which sits within the Early Help, Inclusion and Vulnerable Children (EHIVC) Service.

See a brief description of the One Point Service roles (external link).

Intended Outcomes of the One Point Service

The following sets out the intended outcomes we want to achieve through the effective delivery of coordinated early help support across the One Point Service.

1. Families with complex needs in need of early help achieve positive, measurable and sustained outcomes in line with the DCC Family Outcome Framework.
2. Sustained reduction in referrals to statutory services.
3. Sustained reduction in re-referrals to One Point Service.
4. Contribute to improving school readiness for vulnerable children.
5. Children, young people and families have access to a range of VCS services which enable them to achieve positive outcomes.
6. Improved health, wellbeing and developmental outcomes for babies, children and young people.
7. Improved health and wellbeing outcomes for parents and carers.
8. Improved access, connections and relationships within local family services.
9. Reduce inequalities.
10. A stronger evidence base on what works in difference delivery contexts.

Chapter 4

Requests for Early Help

Durham County Council

First Contact / Early Help Triage

All new requests for help into Durham's Children and Young People's Service are made via First Contact. The First Contact Team, including Early Help Triage Workers provide a triage and referral function to professionals and members of the public who require early help or have a concern about a child. First Contact/Early Help Triage will allocate work to the appropriate CYPS team based upon the level of need.

The One Point Service (OPS) will work with partners to provide services and support to families who have early help needs, below safeguarding (CIN/CP) thresholds. The Families First Service have responsibility for working with children, young people and families triaged as requiring safeguarding/statutory service (CIN/CP) or Disabled Children's Team.

When a referral is made to First Contact for a child or young person where there is a potential safeguarding concern, information about the child and their parents/carers can be gathered by all partners in the Durham Multi-Agency Safeguarding Hub (MASH) which is based in First Contact. The MASH functions as a central point for information gathering as part of risk assessment, identifying the level of need and the most suitable service for those children and families. The MASH works in partnership with Durham Constabulary, Harrogate District Foundation Trust, Drug & Alcohol Service, Domestic Abuse Service and Education.

Allocation to One Point Service

First Contact Officers will transfer parent early help requests to the Early Help Triage Workers (EHTW) who will resolve, or re-direct. This can include progressing Family Hub referrals for parenting support as appropriate or where needs are complex and require intensive support, EHTW, with management oversight, will allocate directly to the IFS Managers in-tray via the LiquidLogic Early Help Module (LiquidLogic EHM). As of October 2023, the EHTW will allocate to the appropriate Family Hub or Intensive Family Support Team. Team Managers still have the facility to have a Threshold Conversation with the Senior Early Help Triage Worker as required. Professional requests for early help for families will be made directly to the Early Help Triage Workers via First Contact telephone number or by an on-line digital form. Early Help Triage Workers will triage in the same way, resolve, re-direct or invite the professional to a Locality Early Help Conversation. Where needs are complex and require intensive support, EHTW will allocate families directly into the IFS team via the LiquidLogic EHM Managers In-tray.

As of October 2023, Early Help Triage Workers will have up to 5 working days to progress a request for early help providing them with the time to complete thorough information checks to inform triage decision making.

Where safeguarding referrals have been received into First Contact and triaged as requiring an early help response (if consent obtained), these will be transferred to the Early Help Triage Worker who will consider the best response for the family and, if

appropriate, allocate into the relevant IFS Team Managers.

The Team Manager will ensure support is offered to a child, young person and their family as quickly as possible by either allocating the family to a Key Worker or to an Early Help Practitioner (refer to chapters 5 and 6).

If a challenge to the threshold is initiated, then the Threshold Discussion Procedures must be followed.

Thresholds Discussions

To assist in managing families where the route to allocation is not clear or the threshold not agreed, the following process should be followed. (MASH challenges will follow MASH challenge procedures). **Threshold discussions** should be concluded no later than **two working days**.

▶ Step 1

Thresholds can be assigned by either the First Contact Officer and triaged by the First Contact Social Worker i.e., Safeguarding Referrals triaged as requiring Early Help or by an Early Help Triage Worker. This will depend on the route the referral came through and whether it was by a parent/member of the public or professional. All Early Help requests are triaged by an Early Help Triage Worker and, if appropriate, assigned to the Family Hub or Intensive Family Support Team.

▶ Step 2

In the first instance the threshold conversation will be initiated by the IFS Team Manager/Senior Key Worker or Family Hub Manager to the Senior Early Help Triage Worker **within one working day.** The Senior Early Help Triage Worker would discuss with the First Contact Social Work Consultant (FCSWC) and if agreed that the decision to Early Help should be overturned, then the FCSWC will action this.

▶ Step 3

If agreement cannot be reached on the threshold by SEHTW/FCSWC, the SEHTW will discuss with the IFS Team Manager/Senior Key Worker or Family Hub Manager who will then discuss the family with their Operations Manager **within two workings** days of receipt of the referral. The Operations Manager will review all relevant information. If the Operations Manager upholds the decision that the case is Early Help, the Operations Manager will make a Management Oversight Case Note on LiquidLogic and this will be the final decision. Should the Operations Manager agree that the case is not Early Help and feels it meets Safeguarding thresholds, **move to Step 4.**

▶ Step 4

The Operations Manager will inform the Senior Early Help Triage Worker and will proceed to have a conversation with the First Contact Manager.

It is important that support for the family should not be delayed during the threshold discussion. Managers must reach agreement on how they can support the family until a team and Lead Professional are identified.

▶ Step 5

If no agreement can be reached the OPS Operations Manager will escalate to OPS Strategic Manager who will have a conversation with the First Contact Strategic Manager **within one working day.**

▶ Step 6

The Strategic Manager will reach a decision on the threshold and make a Management Oversight Case Note on LiquidLogic. This decision is final and ends the threshold discussion.

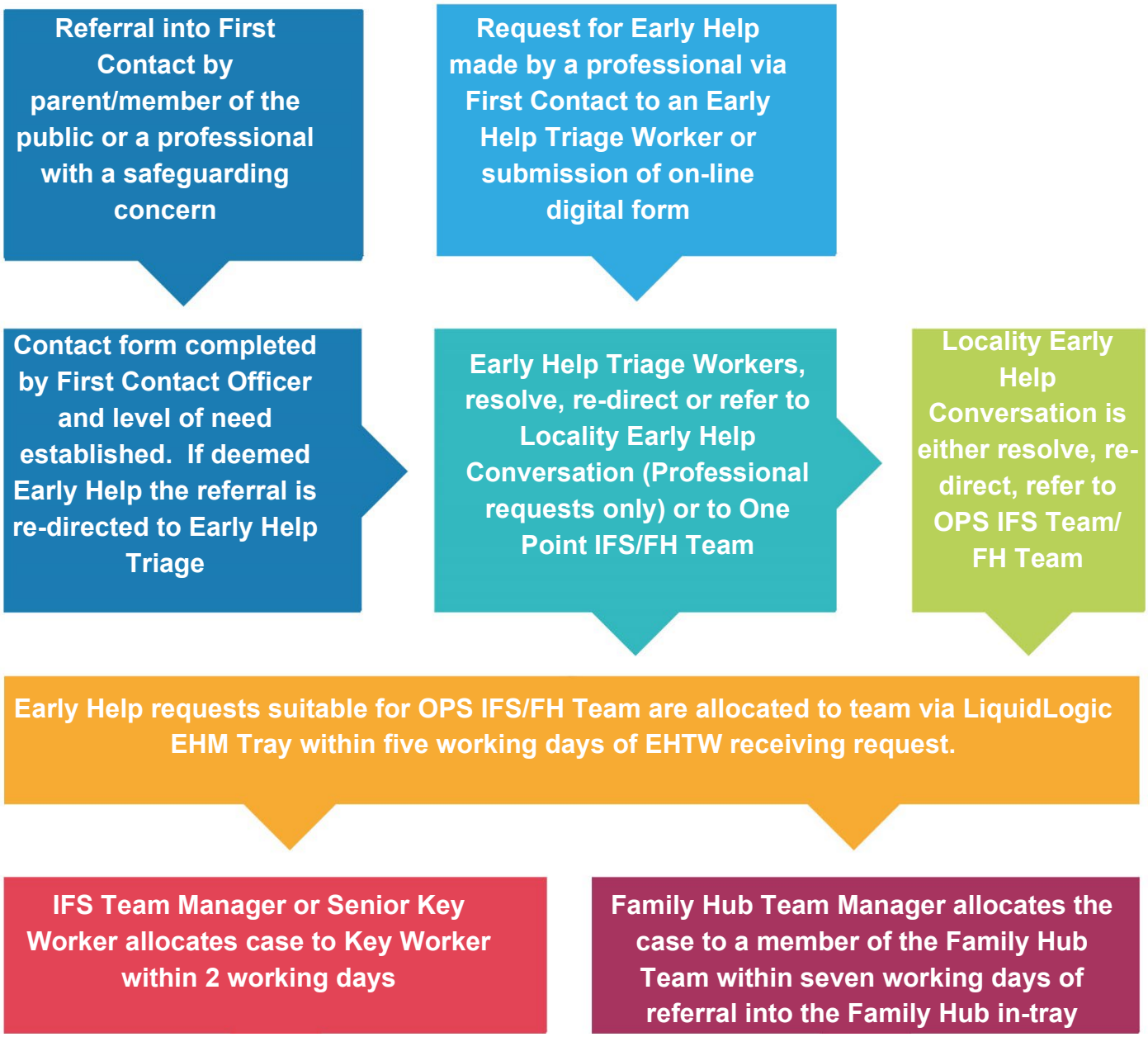
Locality Early Help Conversations

Locality Early Help Conversations facilitate collaborative multiagency decision making. They provide the opportunity for a practitioner who has a worry that a child may need early help to have a quality conversation with a range of partners to clarify the nature of the worries, the needs of the child and their family and the most appropriate way to respond to them.

The Locality Early Help Conversations will:

If further information shared during the Locality Early Help Conversation identifies heightened risk or complexity a referral will be considered for One Point Intensive Family Support Team and referred into the relevant team by the Early Help Triage Workers. If a Safeguarding concern is raised, Safeguarding procedures will be followed.

Child and Family Allocation Process Map



– how requests for Team Around the Community (TAC) are managed go to Chapter 11.

– how requests from a Health Visitor are managed go to Chapter 11.

– how requests for the 'Care' Assessment of Education, Health and Care Plans are managed go to Chapter 11.

Chapter 5

Requests for Early Help Allocated to the Intensive Family Support Team

Durham County Council

Allocating work to IFST Key Workers

▶ Step 1

- IFST Manager/Senior Key Worker read referral and allocate to a Key Worker on LiquidLogic EHM within **two working days** from the receipt of the referral into the Team Tray.
- The IFST TM/SKW will record the initial case summary using the Timeline.
- Where possible, it is good practice to discuss the referral with the Key Worker prior to allocation.

▶ Step 2

- IFST Manager/SKW completes the Allocation Process on LiquidLogic EHM and record discussion and/or actions required on the Allocation Summary
- Managers must follow the Timeline.

▶ Step 3

- Reassign the case to the Key Worker on LL EHM.

Where possible we aim to ensure Key Workers have a caseload of approximately 25 children and young people.

Initial Steps for the IFST Key Worker

Key Workers will be allocated new child/ren and family within **two working days** of receipt of the referral into the Team Tray. They are expected to undertake the following initial steps:

- Read the case allocation summary and referral details on the family.
- Families to be contacted within five working days from allocation and seen within **10 working days from allocation** to obtain their consent.
- Contact the family using their preferred method of communication and ask the family which professionals they are involved with so contact can be made to gather information for the assessment.
- Begin to plan how you will complete your assessment and apply the Mapping Tool principles. Include historical Children's Services information where appropriate. Key Worker to start multi-agency chronology.
- Based on the referral start to think about what tools may be useful for your assessment and how you will measure impact.
- Speak to the referrer to check the facts of the referral; fully understand their worries and ensure they have your contact details.
- Check Potentially Violent Persons register on intranet.
- Complete the Home Visit Risk Assessment (RAPID).
- Key worker to take the introductory pack on the first home visit and cover everything on the checklist and ask parent/carer to confirm they have received and understood the information. Good practice is for the Key Worker/Family Worker to meet the family on the initial visit where possible.
- Agree a date with the family to complete the HEAT tool if not complete during the initial visit.
- Discuss with the family their current support network and who else they could draw on for support.
- All assessments to be completed within 28 days however in some circumstances this can be extended to no more than 45 days with agreement from Manager.
- Arrange to see the child(ren) alone where age appropriate to obtain their wishes and feelings. Observations of the children in a variety of settings including with their parents/carers should also be made.
- Ensure that all basic information collated from the family is accurately transferred onto LiquidLogic **EHM including immigration and nationality status.**
- A Family Network Meeting is to be arranged and carried out within the assessment period, where possible within 28 days and before the first TAF meeting.
- Do not delay the initial TAF if everyone cannot attend as families have the right to a TAF, the initial TAF should take place during the Assessment period of 28 days. With consent from the family agree which professionals and who from the their network they want to attend.

Allocating work to IFST Family Workers

Family Workers will be allocated work by the Senior Key Workers (SKW). SKW will have a good understanding of what work is required dependent upon the needs of the family. All work must have an identified timeline for review/completion.

Work may be allocated in two ways:

- Consideration may be given at point of family allocation by the Team Manager and/or Senior Key Worker as to whether Family Worker support may be necessary.
- Requests for Family Worker support by Key Workers will be by discussion with the Key Worker and Senior Key Worker using the **Timeline.**

- ✓ Once agreement has been reached, the Key Worker will be responsible for giving the Family Worker access to the children's records on LiquidLogic EHM.
- ✓ Family Workers are required to record all their work on LiquidLogic EHM.
- ✓ Family Workers are required to send all completed evidence of their direct work with families, including tools to the central document store. Where appropriate, notes should be typed before sending to the document store.
- ✓ Senior Key Workers will review progress in case management discussion. See Chapter 14 for more information.
- ✓ Where possible we aim to ensure **Family Workers have a caseload of approximately 25 children and young people.**

Initial steps for Senior Key Worker allocating work to Family Worker

1. •Read the **Families Timeline** and discuss with Team Manager (if required).
   •Read case notes on LiquidLogic and discuss with Key Worker if necessary.
   •Allocate to a Family Worker within **3 working days from receipt of request**.
2. •Share **Family Timeline** with allocated Family Worker.
3. •Senior Key Worker to send Family Timeline to Document Store to be uploaded on LiquidLogic. Senior Key Worker to complete case note, as Management Oversight to state Family Worker allocated.

Initial steps for Family Worker

1. •Key Worker meets with the Family Worker **within two working days** following allocation to discuss plan of work.
2. •It is the responsibility of the KW to invite the FW to TAF meetings where appropriate and be prepared to give feedback on their work.
3. •Key Worker to arrange a joint Home Visit with the Family Worker **within five working days** of a FW being allocated a case.
4. •Key Worker and Family Worker to discuss and agree what support each will provide and this will be reflected in the Family Plan. The Weekly Family Timetable can be used to help the family know when and who they have appointments with.

- ✓ It is the responsibility of the Key Worker to ensure that the Family Worker attends TAF meetings and is prepared to give feedback on their work.
- ✓ 'It is the responsibility of the Key Worker to invite the Family Worker to attend TAF meetings and that the Family Worker is prepared to feedback on their work.'

Chapter 6

Requests for Early Help Allocated to the Family Hub Team

Durham County Council

Allocation to Early Help Practitioner

1. •Family Hub Team Manager will read referral and allocate to a Early Help Practitioner on LiquidLogic within seven working days from **when it comes to the Family Hub in-tray.**
2. •Discuss referral with Early Help Practitioner.
3. •Record discussion and actions in the allocation summary in LiquidLogic.

Initial Steps for the Family Hub Practitioner

N.B. All families will have a home visit to decide what support is required.

1. •Read the allocation summary/priority risk and referral details of the family.
2. •Early Help Practitioner to begin chronology when the family is being opened as a case to the Family Hub.
3. •Speak to the referrer if the request has not come from the parent, to check the facts of the request for help.
4. • Check Potentially Violent Person's register on the Intranet.
5. • Consent to be gained within **10 working days** from allocation.
6. • Ask the family if there are any professionals they are involved with and with the agreement of the family contact them to gather information for the assessment.
7. • Complete the Home Visit Risk Assessment (RAPID).

8. •Take the **introductory home visit pack** on the first home visit and cover everything on the checklist and ask parent/carer to confirm they have received and understood the information.

9. •Where a proportionate assessment and Home Visit required, complete the Home Environment Assessment Tool (HEAT).

10. •Offer a Family Network Meeting - record appropriate casenote type

11. •The **assessment** timescales are from the date of consent.

12. •Ensure that all basic information collated from the family is accurately transferred onto LiquidLogic including immigration and nationality status of those living in the household.

13. •The Family Hub Practitioner will submit a proportionate assessment to their manager within **15 working days** from the date that consent was obtained. Assessments must be quality assured by the Family Hub Team Manager and **finalised within 5 working days**.

14. •The Family Plan will be completed by the Family Hub Practitioner and sent to the Family Hub Team Manger to be authorised and then closed. This can be restarted if the plan changes significantly and changes made and then authorised and closed. The Family Plan should not remain open.The Family Plan will also need to be restarted if there is a TAF and this will need to remain open for the duration of the TAF.

Access to Emotional Wellbeing Worker (EWBW) Support

1. •The Family Hub Team Manager will allocate families to the Emotional Wellbeing Worker (EWBW) via routine allocation processes.

2. •Practitioners working across OPS can also request a family access an evidence-based parenting programme (Solihull Approach, Incredible Years, Strengthening Families or Triple P) or another wellbeing /resilience programme as part of their family plan. This will be requested directly to the Family Hub Team Manager by completing the Request for a Family Hub Programme Form. Requests are also to be sent to business support to be saved in TEAMS file.

3. •Record discussion and actions in the allocation summary in LiquidLogic.

Chapter 7

Assessing Child and Family Needs

Durham County Council

What assessment we use and what we expect from staff in IFS Team

All practitioners within the Intensive Family Support Team will follow the Durham Safeguarding Children's Partnership Assessment Procedures which underpin the early identification of need and the provision of early help to support those needs. The process provides the tools necessary to make sure that need is effectively identified, understood and addressed in a timely way so that children get the help and support they need to achieve good outcomes.

All assessments must include a visit to the family home and direct communication with the children and family.

The planning and carrying out of the Assessment is fundamental to ensuring timely intervention. A good assessment provides the foundations for the quality of subsequent Family Plans and interventions aimed at having a positive outcome for the child/young person.

It is the Lead Professional's responsibility to ensure that all children and young people are seen a **minimum of once every 20 working days and be seen alone if 5+ years old.** It is however an expectation that families who are receiving intensive family support will receive this more frequently particularly at the beginning of One Point involvement. Children under the age of one year old, should be **visited once every 10 working days by a member of the professional support network (TAF members and to be noted in the Family Plan). OPS worker to have a face to face or group contact at least once every 10 working days.**

The assessment will be proportionate and based on the needs of the child and family. At the point of allocation, the Team Manager or Senior Key Worker will indicate the expected timescale for the assessment which will be recorded on LiquidLogic. This will be no more than **28 working** days from consent to also include quality assurance by the manager. Assessment timescales should be regularly reviewed to ensure that emerging needs are fully understood, and it is in the best interests of the child, young person and the family.

It is expected that a Family Network Meeting and TAF will take place during the assessment period as these will inform the assessment.

We aim to ensure children and their families have their needs assessed within 28 working days from consent. No assessments should exceed 45 days from the date of consent. Any extension of 28 days must be with Management approval and not exceed 45 days.

Expectations for Assessments

Practitioners can use the Mapping Tool if they choose but must apply the principles of it within their Assessment. This information can be gathered at the

initial TAF which is to take place during the assessment period to inform the assessment.

Practitioners must also follow the DSCP Assessment procedures and guidance when undertaking a whole family assessment.

All tools/direct work relating to CYP should be uploaded onto the LiquidLogic document store. We would expect:

- Signs of Wellbeing model of practice is evident throughout the assessment with SOW language and tools used.
- Support should be offered to the family whilst the assessment is ongoing.
- The purpose of the assessment must be clear.
- The assessment must link to the initial referral.
- Must describe what daily life is like for the child/ren in the family.
- Use of evidence-based tools, including Signs of Wellbeing e.g. HEAT, three columns, Harm Matrix, DASH.
- A chronology of significant events (for IFST's families this should be a 'multi-agency' chronology.)
- Genogram to be completed.
- Must identify all adults with parental responsibility and their ability to parent effectively.
- Must complete Immigration and Nationality Status of those living in the household.
- Must identify all adults attached to the family, including ‘hidden males/Dads/Male Carers’.
- Use of family friendly language, avoiding jargon and easy to understand (an eight year old could understand).
- Strengths of the family are recognised.
- Support available from extended family members and friends.
- Stronger Families outcomes to be identified.

Expectations for gathering information

- All professionals involved with the family should contribute to the assessment. This information can be gathered at the initial TAF which is to take place during the assessment period to inform the assessment.
- Talk to family members and their family network separately. This information can be gathered at the initial Family Network Meeting which is to take place during the assessment period to inform the assessment.

- Must seek to talk to both Mam and Dad alone whether they are together or separated.
- If Mam or Dad have a new partner, must explore what their parenting role is.
- Observe the interaction between parents/carers and children.
- Talk to children over 5+ years old alone.
- Review historical information and presenting issues identify safety, strengths, risks and worries, worry statements and wellbeing goals.

Analysis and professional judgement

The professional judgement of practitioners is valuable and should be clearly outlined within the analysis of the Single Assessment. The conclusions and analysis of the assessment should be presented with reference to the evidence available.

Expectations of the Analysis/Worry Statements

✓ The analysis should clearly set out each of the child's and adult's needs demonstrating the interplay between these, the focus must always be on the needs and risks to the child/ren.

✓ The Worry/Danger Statements (analysis) clearly outlines any areas of risk and what needs to happen to reduce this risk to the child/ren.

✓ The information and evidence held within the assessment information should cross reference with your conclusion and analysis including Golden Thread, scaling questions and information from the Harm Matrix.

✓ References to the evidence used should be used to back up judgements (either what has been told and verified/what has been observed/what others have observed/what has been read in files).

✓ The Key Worker must be clear about the source of the evidence used and if it is an opinion, rather than an accepted fact, ensure this is clearly stated.

✓ The Key Worker must also ensure that they provide a professional judgement within the analysis of risk.

Management Oversight

Upon completion of the assessment the Team Manager or Senior Key Worker must:

- Read and quality assure the final draft. Quality assurance must focus on quality and compliance with practice standards and procedures.
- Challenge and be open to challenge.
- Return any assessments that do not meet minimum standards or where presentation/writing does not meet the needs of the family.
- Provide feedback to the practitioner on good practice and areas requiring further work.
- Whilst the information contained in the assessment will be proportionate to the needs of the family; the assessment must not be finalised without evidence of the key elements of a good assessment: the chronology (on LL not in Assessment); the genogram; mandatory tools; multi-agency information and direct work with parents and children.
- Be signed by the Team Manager or Senior Key Worker.
- Follow LiquidLogic EHM procedures for authorising assessments.

Sharing the Assessment

The assessment must be signed by parents and the child where appropriate and the **family must be given a copy**. Any areas of disagreement regarding the content or conclusions of the assessment must be noted in case notes and the Team Manager or Senior Key Worker made aware of any disagreements. The family will have been part of the assessment process therefore should have seen the assessment prior to manager sign off. With consent from the family, the assessment should be made available to professionals at the next planned TAF meeting and parents must have seen the assessment prior to it being shared more widely in accordance with GDPR. There **should be evidence on the file that the assessment has been shared.**

A signed copy of the assessment should be sent to the central document store for uploading onto LiquidLogic EHM case file.

Reviewing Assessments

There is the facility to update or review an Assessment on LiquidLogic within an open episode. Should there be changes to a family's demographics or changes to the family circumstances that are deemed significant by the Team Manager updates can be made by selecting the option **Second or Subsequent Assessment.** It is an expectation that all Assessments are reviewed annually if the episode remains open to the One Point Service for this duration. In these instances, select **Review Assessment (Annual Review of C&F).**

Guidance on Completing a Family Hub Assessment

The following guidance should be read alongside the flow chart 'Early Help requests into the Family Hub'.

Assessment

1. The Early Help Practitioner (EHP) and/or Emotional Wellbeing Worker (EWBW) will complete the initial visit, recording this in case notes in LiquidLogic.
2. HEAT tool will be routinely undertaken.
3. Use a scaling question with the adults and child(ren).
4. All the boxes in the general note will be completed.

Assessment

Reason for contact

e.g. a referral has been received…

Detailed notes

What does the HEAT tool tell us?

What does the Alcohol Audit Tool tell us?

Voice of the child?

Record the scaling question(s) used

Complete a chronology when the family is open as a case to the Family Hub'

Analysis

In this box please detail worry statements, wellbeing goals and wellbeing scales.

What is the impact on the child?

Management Decision

Outcome of the discussion with the Family Hub Team Manager (FHTM)

Action

Decide in conjunction with your FHTM informed by the proportionate assessment, is this a child/young person/family that requires a group work response. To help you with this think about the Stronger Families Headline Outcomes. If there are 3 or more Headline Outcomes for this child/young person/family, this may indicate that a programme alone may not be enough to help this family. This may require one to one work and would be eligible for inclusion with Stronger Families.

If the recording of the initial visit indicates that a group response would be appropriate to meet the needs of the family, no further assessment will be required.

Tips for a Proportionate Assessment

The guidance in LiquidLogic should be followed alongside the following:

Golden Thread	Be Concise	Mandatory Tools
What was reason for the request for early help? Is this reflected throughout the assessment and in the analysis.	Only include what is relevant to the request. For example, unless it is relevant you do not need to detail the full educational background and employment history of the parent/carer.	HEAT

Voice of the Child

e.g, MOMO

Tools relevant to the referral needs should be used

e.g. Adult Mental Health impacting on the child's wellbeing, use Adult Wellbeing Toolkit.

The following need only be included for the non-subject child:

- All children/young people will be included in the assessment as the VOC is obtained.
- Basic details.
- School/nursery information on the child/young person e.g. do they have any worries?
- Conclude that the child/young person has not been seen as there are no worries and referral was in relation to sibling (unless of course there are worries).

Environmental Factor section	Analysis	Next Steps
• Always reference the HEAT, date and impact if any. • If there are issues these can also be reflected in other sections if relevant, e.g. the impact on the child.	• What is the impact on the child, what are we worried about, what is working well? • Golden Thread – has the reason for request for early help been addressed? • Are we seeing / hearing this from the children and the direct work we are doing with them?	Is the support we are offering the right support at the right time? Are there other appropriate agencies? What will happen next?

Completion of Proportionate Assessment

Upon completion of the proportionate assessment the Family Hub Team Manager must:

- check the family have already had sight of the assessment.
- read and quality assure the final draft submitted by the practitioner to ensure the assessment is finalised by FHTM within 20 working days.
- quality assurance must focus on quality and compliance with practice standards and operating procedures.
- challenge and be open to challenge.
- return any assessments that do not meet minimum standards or where presentation/writing is poor.
- provide feedback to the practitioner on good practice and areas requiring further work.

Sharing the assessment

The assessment must be signed by parents and the child where appropriate and the family must be given a copy. Any areas of disagreement regarding the content or conclusions of the assessment must be noted on the assessment. A signed copy of the assessment should be placed on the child's file.

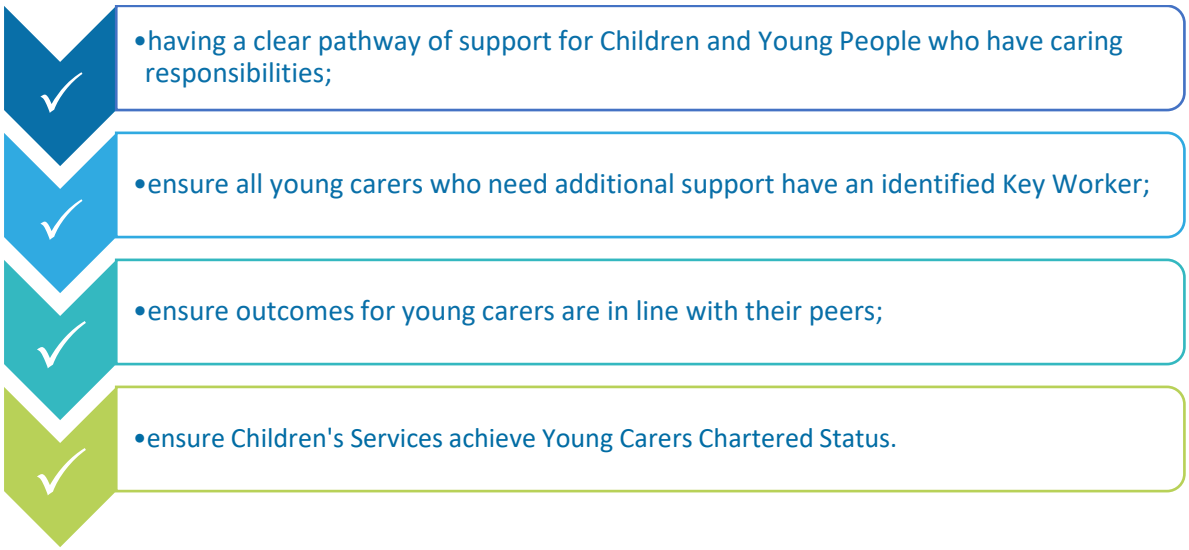
Expectations of working with Young Carers

Young Carers are identified as a young person under 18 years of age who helps to look after a family member who is disabled, physically or mentally ill or has a substance misuse problem.

Caring can involve physical or emotional care or being responsible for someone's safety and wellbeing. The level of responsibility assumed by a young carer is often inappropriate to their age and beyond the level of simply helping out at home as part of the process of growing up.

Durham County Council, have adopted the: **Working Together To Support Young Carers and their Families, Memorandum of Understanding** and agree that the term "young carer" should be taken to include children and young people under 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances.

Children's Services have the identified Principle of 'Be Safe'. The One Point Service are committed to achieving this principle by:



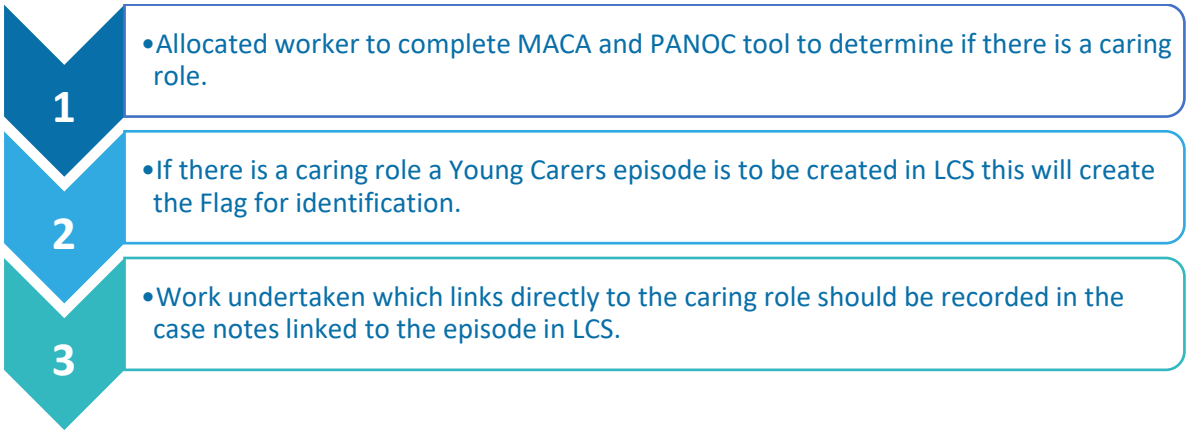
Practitioners working with Young Carers will ensure during assessment their caring role is assessed and analysed, to reduce risk and support them achieve outcomes in line with their peers.

Where a practitioner identifies that a Young Person may have a caring role, they will complete the Multi-dimensional Assessment of Caring Activities tools. If deemed

appropriate to refer to Young Carers Service a copy of the tools are to be shared.

Young Carers are identified on LiquidLogic by a flag entered on the system. This enables swift identification of young carers.

The process for identifying young Carers on LiquidLogic is as follows:



Chapter 8

Child and Family Plans

Durham County Council

The **County Durham Family Outcome Framework** sets out an agreed approach to developing an outcome focussed **Child and Family Plan** and evidencing when a family has achieved significant and sustained progress, ensuring our work with children and families is focussed on achieving measurable positive outcomes.

Child and Family Plan – Quick Reference Tool

The key purpose of any type of child, young person and family plan is to help focus and target professional involvement with them and their family steering activity towards **agreed goals and outcomes.** In order for that plan to be successful it needs the involvement of everyone, especially families, children and their network as we know that services should be temporary in family's lives. A good plan therefore needs a brief summary of the key issues and reasons why additional support, protection or care is needed. In Durham where we operate within a Signs of Safety/Wellbeing framework so this would be our 'worry statement' 'wellbeing goal' and 'wellbeing scale'.

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 (evidence of the worrying behaviours and the complicating factors in a child's life) 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. Applying the 'Mapping Tool' can help everyone understand the sub categories of analysis.

Plans will consider the needs of all members of the family in the context of a 'whole family approach' 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. In addition to being clear about services and support, the plan also needs to include what the family and their network will be doing to ensure that their needs are met. 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 four to six weekly intervals at TAF meetings/Family Network Meetings to measure progress against the intended outcomes. We will do this by using a specific scaling question throughout the journey of our involvement in a child's life.

Importantly, effective plans set clear **'planned outcomes' (Next steps)** 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

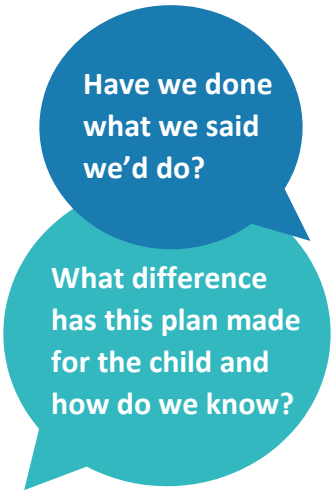
plan (or individual aspects of it) has been successful, i.e. whether an unmet need is now sufficiently met, or a risk factor sufficiently reduced (Use a clear wellbeing goal with a scale so that we can track that progress)

- ✓ be child focused (have an impact on that child's lived experience)
- ✓ achievable (realistic and based on an individual basis)
- ✓ easily measurable (we measure by using a scale)
- ✓ Timely.

The most successful plans 'take people with them'; they have been **developed *with* families, not for them**. Parents and young people should always 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 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.

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 using a wellbeing scale which is linked to the wellbeing goal and to the worry statement, this will enable us to know the work we are doing with the family is making a difference to that child's lived experience.***

Therefore, unless the child's plan includes clear 'intended' or 'planned' outcomes which relate to each aspect of risk or unmet need (worry statement), it's virtually impossible to know whether (and when) the plan has achieved what is 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 (Wellbeing goals) 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. Wellbeing goals clearly describe the behaviours we would like the family to do differently so that we are no longer worried. This in turn makes it much easier to focus in upon what changes have been achieved for the child at review TAFs 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).

S	**- specific**
M	**- measurable**
A	**- achievable**
R	**- realistic**
T	**- 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 (Wellbeing goals) 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 task, etc. So, a parent may receive support to attend a 'positive parenting' group and may complete it, but if nothing in their behaviour changes and therefore doesn't have a direct impact on the child's lived experience then can we say that it has been an outcome?)

Planned (Wellbeing goals) 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, plans should help demonstrate whether the child's needs have been *sufficiently* met so that they are no longer require support and interventions by the OPS and can be safely managed by universal services such as GP, School or Health Visitor.

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, impact should be explicit not assumed.

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.

Measuring Progress and Outcomes

The whole family assessment and formulation of the Child and Family Plan will identify the family needs and outcomes you are working on with the family to achieve. Progress will be measured using consistent scaling questions and through using the range of evidence based, distance travelled tools available to you that are appropriate for the family. Outcomes must be reviewed in accordance with County Durham's Family Outcome Framework and recorded and updated on Liquid Logic, EHM's -Supporting Families module. Please also refer to Signs of Safety/Wellbeing Framework.

Reviewing the Family Plan in the Intensive Family Support Team

The Outcome Focussed Family Plan will be reviewed at each TAF meeting, which will take place **within 30 working days from the last TAF.** The Family Plan will be used to discuss the progress of each of the family goals and any changes they have made and/or been achieved. Scaling questions to TAF members including the family should be used routinely at each TAF meeting to support in measuring progress. The discussion should be recorded in the TAF Meeting notes and the **updated Family Plan** should be shared with the family and TAF members (with family consent) within **10 working days of the meeting**.

Reviewing the Family Plan in the Family Hub Team

Early help offered through Family Hubs will be time limited and this should be clearly indicated in the Family Plan and reviewed during case discussions between the Family Hub Team Manager and the practitioner.

In case discussion meetings, where other options of support have been explored and consideration has been given to step-down to another agency, the Family Hub Team Manager may agree that support needs to continue for a further four weeks and this will be reviewed at the next case discussion.

The progress of each of the family goals and any changes they have made and/or been achieved with the practitioner should be recorded in the Case Supervision Form on LiquidLogic. If there has been a significant change in the plan for the family this can be restarted by the practitioner and then updated by them. This can be done via the decisions tab. This will then be sent for authorisation to the Family Hub Team Manager and closed down.

Chapter 9

Delivering Support and Interventions to Children and Families

Durham County Council

Delivering Support and Interventions to Children and Families

A key focus of the One Point Service is to ensure that children and young people and families have an opportunity to build up a good relationship with their worker within the team, which in turn will support the process of creating change with families. OPS 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 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 including **BOTH Mam and Dad** (where one is available, even if separated and here safe to do so), 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.

All work with families will be based on a **solution focused** approach using the Signs of Safety/Wellbeing 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 include specific actions for individual family members and professionals, and each must indicate what the change is that is required.

The focus of the One Point 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 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.

A family network meeting should be offered at the start of the OPS support to identify the family's network of support going forward.

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 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 Family Plan will aim to gradually reduce support to ensure that families can demonstrate they can sustain change. Part of the ongoing assessment of the 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.

Wellbeing/Safety Plans for families should be tried and tested.

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 One Point Service either into universal services or if needs are escalating, into Social Care for statutory support and this should be recorded within the Family Plan. Consideration of the family network and safety plan need to be included and referenced where to find them. The aim is to hand the responsibility back to the network so that services no longer need to be involved.

The use of community and voluntary organisations as well as volunteers and befrienders should be routinely considered for families at all stages of assessment and intervention.

All families should know who they can contact if they need support – both whilst an active case to a OPS team and once the case has closed to this service. A critical role of the worker is to identify this source of support for each family. This should include a plan with the family which describes who will do what and when? Everyone should have a copy as well as the children in a child friendly version.

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 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 a study identified, '…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.

Convene a Family Network Meeting;

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 the Family Hub, Community venues 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 a 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;

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);

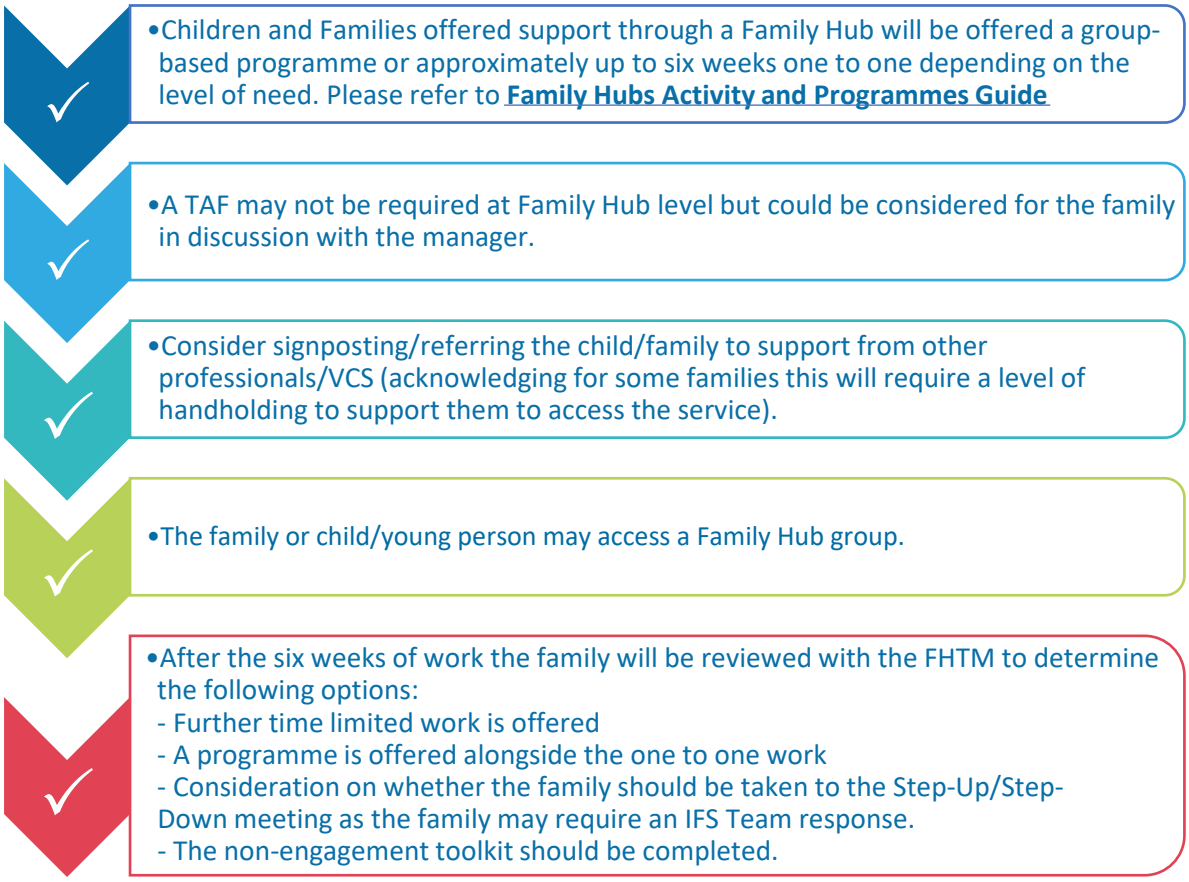
Supporting young people and parents to access higher education or training by for example, ensuring they have access to support for their CV; accompanying them to an open day;

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;

Connect families with their communities through appropriate VCS referrals.

Family Hub Offer



Signs of Safety/Wellbeing Practice Approach Model

Please see the **Signs of Safety/Wellbeing Knowledge Hub** where you can find tools and resources to support your work with families.

Family Network Meetings

The One Point Service is committed to supporting families to build their resilience enabling them to solve their own problems in the future, ensuring that both the wider family and children thrive and achieve positive outcomes. Our aim is to prevent families stepping up from Early Help into statutory services.

What is a Family Network Meeting?

A Family Network Meeting acts as a strengths-based intervention for families which will result in a short-term plan of support being agreed. They can be pulled together quickly and is often sufficient to meet the immediate needs of the family, without instigating the full Family Group Conference process.

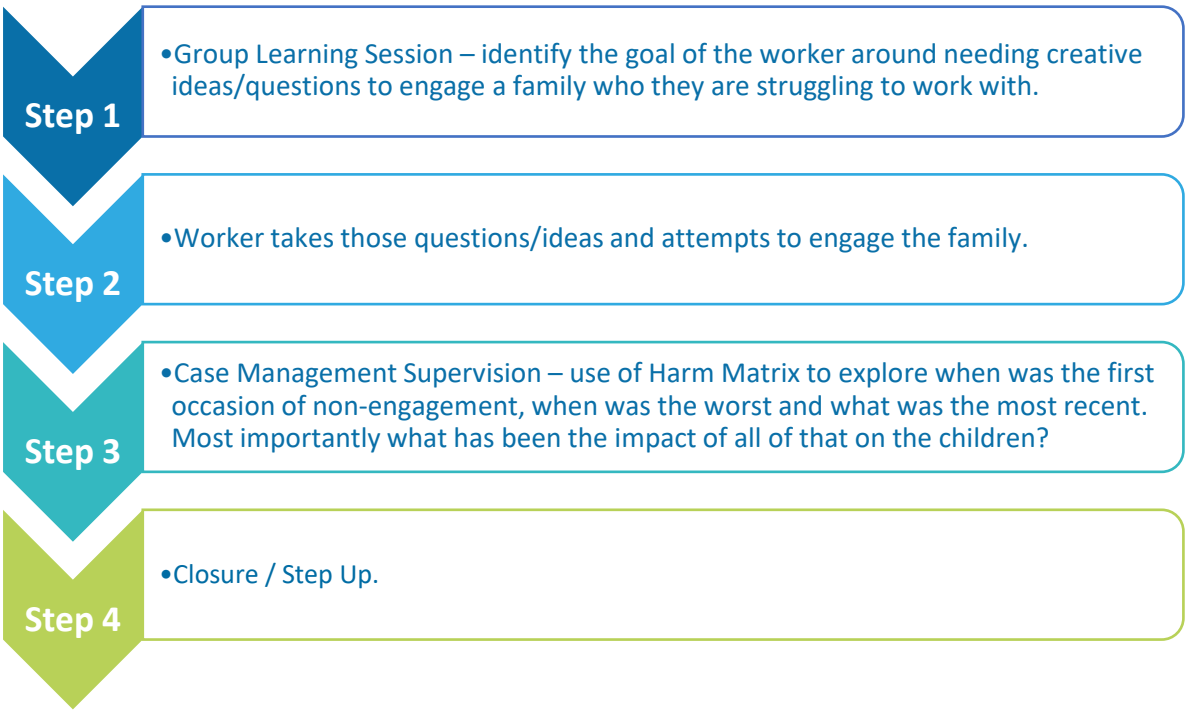
These meetings are held as quickly as possible, and the purpose is to provide an immediate opportunity for the family and the family network to discuss the family situation and collectively agree actions for support.

A **Family Network Meeting Leaflet** for parents/carers is available to help explain what they are.

Engaging Families

All One Point staff must also hold firm the belief that engaging families is the job of the practitioner and not the job of the CYP/Families that we work with and that sometimes in order to 'engage' we need to be as creative as possible.

Where there are any concerns about a lack of engagement the following steps should be taken:



One Point Service Non-Engagement Process Map

Discuss concerns with a manager

When access to a child is denied by parents	Three missed planned appointments	At management checkpoints

Manager discusses the range of engagement activities used with practitioner

Ensure all discussions and attempts at engagements are clearly recorded

In Case Supervision Form / MO Case Note	On LiquidLogic

Gather information from other services known to the family

Inform the referrer of non-engagement if appropriate and consider if other agencies need to be told of non-engagement

Use the Mapping Tool and Harm Matrix

If potential safeguarding concerns plan a professionals meeting to share appropriate and relevant information.

Notify the family this is happening and welcome their attendance.

Include an analysis of your findings in your risk assessment

Chapter 10

Team Around the Family Meetings (TAFs)

Durham County Council

What is a Team Around the Family Meeting?

A 'Team Around the Family' (TAF) takes place when a multi-agency response is required to meet the family's needs. Within the One Point Service Intensive Family Support Team, a TAF must take place during the assessment period as this will *inform the assessment. The main functions of a TAF are:*

- To bring together the child, young person, Mams/Dads/Carers (even when separated and safe to do so), other family members and practitioners from a range of organisations who are/can provide support to help the family.
- Ensure the voice of the child is heard.
- To ensure parents/carers and children/young people have an equal role in agreeing goals and the actions needed to meet those goals.
- Agree with TAF members, including the family and their network, the scaling questions that will be used as a baseline and consistently reviewed by all at each TAF to measure progress.

Purpose of the TAF Meeting

1. To explain to the family what our worries are for the children, young people and the whole family;
2. To recognise what is working well for the family;
3. To be clear about what needs to change to improve things for the children, young people and the family and helping them to identify small goals to achieve;
4. To be clear about what the family can expect from the professionals sitting around the table;
5. To find out what the family's support network can offer to the family;
6. To explain about the assessment process and who will be involved.
7. To explain what a chronology is, what it is for, who will give us information and what we mean by a significant event;
8. To agree which professionals, need to be working with and supporting the whole family and invite them to the next TAF meeting;
9. To agree four to six weeks of support (or up until the date of the next TAF meeting) which will clearly set out who will be working with the family, what work will be done and when. This will ensure that support is co-ordinated, and the family does not become overwhelmed. All work should clearly link to the

goals and outcomes agreed with the family;

10. Agree the outcome focussed **Child and Family Plan;**
11. Review agreed scaling questions to measure progress towards outcomes;
12. To agree the dates for TAF meetings for the next three months so everyone can attend.

Initial Team around the Family (TAF) meeting after allocation

For all families within the One Point Service where a TAF is required, this should be during the Assessment period and after any Family Network Meeting. The OPS practitioner is responsible for arranging TAF meetings with the support of business support and should follow TAF processes on LiquidLogic EHM.

The OPS practitioner must ensure that the family understands who will be attending the meeting and why. All families must receive the Team Around the Family (TAF) Leaflet. The OPS practitioner will ensure that the children, young people and the family can attend the TAF 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 OPS practitioner is responsible for chairing the meetings and ensuring that the meeting is recorded within the Family Plan. This may mean that another member of the TAF updates the Family Plan whilst the OPS practitioner chairs.

The Family Plan should then be updated on LiquidLogic EHM within **5 working days** following the TAF.

If invited, Family Workers will attend Team Around the Family meetings to update the TAF on their work. Where this is not appropriate or possible the Key Worker will update the TAF on behalf of the Family Worker.

Family Workers are not expected to 'deputise' for Key Workers

Requirements for a TAF Meeting

- ✓ Welcome/ introduction/ apologies.
- ✓ Complete sign in sheet or chair notes attendance if virtual TAF
- ✓ Agree who will update the plan. This might be a TAF Member on behalf of the Key Worker (Chair) but it will be the Key Worker's responsibility to update on LL.
- ✓ Review what we are worried about and what is working well using scaling questions.
- ✓ Review previous Family Plan and sign as a true record. It is the responsibility

of TAF members to identify any errors within the Family Plan and inform the Key Worker.

- ✓ Review previous actions and progress from Family Plan using:
  - Review CYP and parent/carer views on progress and/or worries,
  - review family's views on progress and/or concerns,
  - record views of professionals,
  - chronology updates/concerns,
  - review of TAF members required/no longer required.

- ✓ Practitioner summarise key points from the meeting.
- ✓ Record new actions and goals for the family.
- ✓ Date and time of next meeting.

A copy of the updated Family Plan should be sent to the family and all TAF members within **10 working days of the meeting.**

Review Process

The Team around the Family will review the Family Plan **within 30 working days from the last TAF**, depending on the needs of the family, to review progress against small goals set and outcomes on the Family Plan. The TAF will also look at why there has been no progress and help the family identify barriers to making change.

The practitioner should explain the purpose of each meeting to the family beforehand as well as telling them who will be attending and why. All members of the TAF have a responsibility to speak to parents/family members before meetings so children, young people and the family know what information will be shared. No new information to the family should be shared at the TAF meeting.

Review meetings are also used to plan what support is needed for the children, young people and family over the next four to six weeks. Each meeting should use the **Child and Family Plan** as the basis for their discussion in TAF meetings.

The meetings should always include the parents/carers and if appropriate, arrangements should be made for both parents to attend separate parts of the meeting.

The practitioner must make sure they have gathered **the views of the parents and children one week prior to the meeting** if they are not attending the TAF as part of their ongoing work. They should focus on supporting parents to voice their opinions and where this is not possible, ensure their views are represented and clearly recorded in the Family Plan.

If not due for closure, a OPS manager (IFST or FC TM/SKW) will attend every third TAF as part of the review process and management oversight.

Invitations to attend Team Around the Family (TAF) Meetings where a Partner is the Lead Professional

Invitations to TAF meetings from partner agencies should go via the Early Help Advisors either via telephone call or email from the partner. The Early Help Advisor would offer support to the partner or advise them if they should make a request for (additional) early help but will not advise on what the outcome of this (triage) will be.

Where a family has been previously known to One Point (within the last 12 months), the Early Help Advisor will discuss with the family's previous worker and Team Manager and decide on the appropriateness of them also attending the TAF. In both instances the information is not to be recorded on LiquidLogic as consent has not been given by the family.

Process for initiating a referral to One Point following a TAF

Where families require One Point to become the lead agency, the referring agency (who initiated the TAF) should follow the standard referral process for making Early Help requests referencing the agreement of the TAF members.

Chapter 11

Record Keeping

Durham County Council

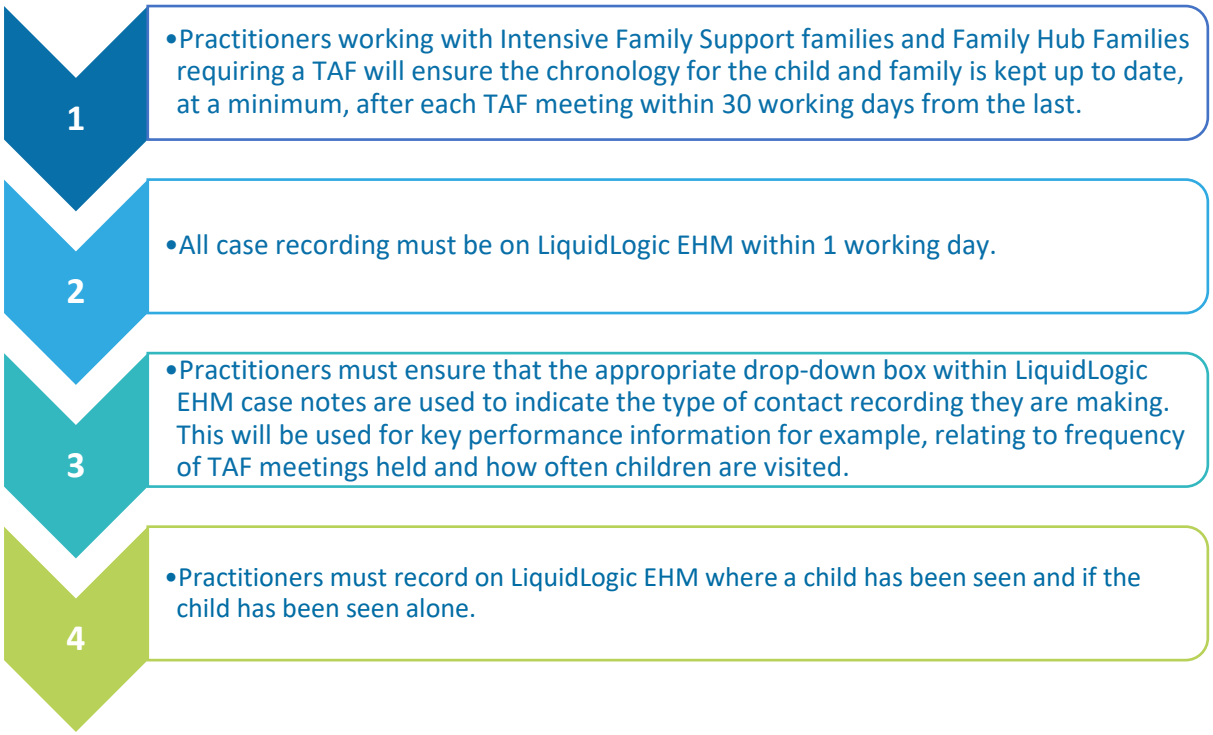
Record Keeping

Practitioners within the One Point Service are expected to undertake **contemporaneous record keeping, this means recording within 24 hours.** All key management decisions must be recorded on the child's file on LiquidLogic EHM including case discussions with managers.

NB: Copying of notes across all siblings is required for family activities, TAF and contact with worker, however there maybe interventions when the worker will complete case notes on individual children for instance, a specific intervention with one child or if a child has made a disclosure which is not relevant to other children and should not be recorded on any other child's records other than the child in question. Generic, nonspecific case notes e.g. TAF attendance, contact with worker are only required to be copied onto children's files and not adults.

Practitioners will ensure that all TAF meetings are recorded and the updated Family Plan circulated within 10 working days.

NB: Please ensure you record the Immigration and Nationality Status of the child and household members.



Practitioners must ensure that all sections of the case note section are completed.

Case Summaries

All children open to the One Point Service will be required to have an up-to-date Case Summary.

See Case Summary Guidance

Recording Early Help in Family Hubs

Recording Non-Lead Work

Family Hub Non-Lead Briefing Note

Family Support Non-Lead Contact Form

LiquidLogic

The following types of work delivered to families who are not open to One Point or where the worker is not the lead, are recorded below:

- Healthy Child Programme -Health visitor or School Nurse referral re behaviour, toileting etc
- Locality Early Help Conversation Family Hub Support- Anything we agree to deliver to a family from an Early Help Conversation
- Enhanced Parent Support Pathway (formerly Vulnerable Parent Pathway)
- Pre-Birth Intervention – record on LCS
- Family Hub Programme -Any referrals from IFS, FF, school etc. Record the first and last session only, unless you feel there is a need for other recording e.g. if a parent talks to you about a worry. If the family is open to One Point (FC and IFS) then record every session.
- Two Year Placements -any contact to support a family to access a two-year placement.
- Domestic Abuse Empowerment Programme e.g. Inspire. Record the first and last session only unless you feel there is a need for other recording e.g. if a parent talks to you about a concern. If the family is open to One Point (FC and IFS) then record every session.
- The exception to recording Family Hub work on LiquidLogic are the Baby and Toddler groups and Holiday Activities which are not programmes but rather ‘play and learning’ and families can ask for a place on these groups.
- Where families are not open to the One Point Service the work detailed above can be recorded in general notes on LiquidLogic unless it needs to be recorded in the case notes or LCS - see overleaf.

If the child has no record on LiquidLogic the following applies:

1. FHTM to ask OP worker to make contact with parent and gain permission (verbal at present) to complete work with the family and record the work on LL.
2. When consent gained FHTM e mails CYPS First Contact Admin to ask them to create a basic demographic for the child. Name , DOB, address, Name of parent(s) who they live with.
3. FHTM to record managment oversight in general notes, indicating that this is a request for early help (saying where it came from e,g EHC) and is not an open case to OP. State which worker you will forward the request to and what the work will look like.

If the family are not open to OP or Families First (FF) and there is a record on LiquidLogic the following applies:

1. FHTM to record a management oversight in genral note indicating that this is a request for early help (saying where it came from e,g EHC) and is not an open case to OP. State which OP worker you will forward the request to and what the work will look like. and that you are asking the worker to gain consent to work with the family and record on LL.
2. OP worker to contact parents and gain consent and record this and subsequent contacts in general notes.

How to record the contacts

To capture the work we deliver with these families we need to use the case note ‘contact type’ drop down which is the contact type you select when you add a general note or case note in LiquidLogic. Regardless of your method of contact for the work e.g. home visit or a telephone call you need to record it as the reason for your involvement e.g. Healthy Child Programme. If for example you use telephone call, we will not be able to report on this data and link it to the Healthy Child Programme. In the notes please write in the method of the contact e.g. if it was a home visit or a telephone call etc.

Recordings should:

- describe the work undertaken and its IMPACT.
- tell the story of what we are worried about and what has happened.
- include feedback from families if appropriate.
- be kept simple and as clear as possible.

Documents can be uploaded and normal procedures for uploading documents apply.

Families open to OPS IFS Teams

If a family is open to the IFS Team any work delivered from a FC Team can be recorded in the case notes (not general notes) to ensure all the notes on an open episode are together.

Families open to Families First

- Pre-Birth Interventions work should be recorded on LCS
- Where a family is being worked with by Families First and the OPS Manager has agreed OP will deliver some interventions, the notes can be recorded in LCS.
- Where we have been delivering one to one or a Programme to a family who are then subsequently supported by Families First due to a Step Up, this work will then be recorded on LCS.
- Where One Point is delivering the Inspire Programme or other programme to a family open to Families First this will be recorded on LCS.

Reporting on the work of the Family Hub

Group work recording on LiquidLogic

All group work delivered by the Family Hub staff or Intensive Family Support Team staff will be recorded on LiquidLogic Group Work. Business Support will create the programmes on the system and the facilitators will be responsible for recording attendance and reflections about the session. This will be used to report the number of programmes that have been delivered, how many people attended and the impact of the work.

One to one delivery in LiquidLogic

Information is being produced in the monthly performance reports on the amount of delivery that is being completed mainly by the Family Hubs on families that are not open to them.

Recording Team Around the Community (TAC)

Practitioners delivering Early Help through the TAC programme must keep records of the sessions using the planning and recording paperwork. This will include names of workers delivering the session, areas visited, plans for the session, feedback and any areas of concern.

Where TAC is delivered using a model of detached youth work, the session will be recorded in LiquidLogic Group Work with anonymous attendance only. Paperwork needs to be sent to the Worker in Charge monthly who will record this on LiquidLogic.

If staff are delivering The Curve this will be recorded in LiquidLogic Group Work. Any contact made with the family directly, either home visits before the programme, or follow up between sessions of after the programme is completed will be recorded in general notes.

Chronologies

Every child we work with in the Intensive Family Support Team should have a working multi-agency chronology of significant events on their LiquidLogic case file. Families who are open to the Family Hub as a 'case' must also have a multi-agency chronology completed by the Early Help Practitioner. Chronologies are the ‘go to place’ for workers to get a quick and accurate understanding of the child’s experiences, the harm they have or may have suffered and to obtain an up to date position of the family.

See guidance on creating an electronic chronology on LiquidLogic

It is the responsibility of the lead practitioner to create the chronology and the responsibility of partner agencies (when family open to IFST) to directly contribute relevant and succinct information to be included.

- ✓ All practitioners within the One Point Service are required to open a new chronology from the point of consent and opening the EH episode on LL.
- ✓ Any previous chronologies recorded on LL may be copied forward onto the new chronology. This functionality is only available in EHM.
- ✓ If there is a pre-EHM chronology (February 2019) and where SSID remains accessible, the worker is to request Business Support type this and the worker is to then input into the LL EHM Chronology.

What makes a Good Chronology?

a) It lists events in the order they happened, not in the order they came to professional attention;

b) They tell the story of the child and family, not of the agencies working with them;

c) They are up to date, accurate and succinct;

d) They are multi-agency;

e) When they are written in plain language with no abbreviations.

What is a Significant Event?

1. Deciding on what is a significant event will often require professional judgement. Some events will be universal and others specific to an individual child and their circumstances. A chronology of significant events will include some but not all social care processes such as Strategy Meetings, Team Around the Family meetings, Private Law Outline Panel (PLO) Family Group Conference etc. Remember to include the 'person centred' part, which could be the reason the meeting was needed, the decisions made, following actions and the impact on the child.
2. When using your professional judgement and practice wisdom in deciding what events are significant, ask yourself, "Does this decision, event, occurrence or omission hold significance for the child, why and what is the impact or potential impact on them?
3. Suggestions for significant events and top tips can be found in the **Practice Guidance Multi-Agency Chronologies**

Genograms

a) Please continue to attempt the genogram on LiquidLogic first as advised by the systems team.

b) If not successful:

c) Draw the genogram by hand and scan and save to your worker file on SharePoint;

d) Send the genogram to your appropriate Business Support email box for typing. It is the responsibility of the Key Worker to ensure that this is completed accurately and uploaded on LL.

Court Statements

There will be times when a One Point Service practitioner is requested to write a statement for court on a child/ren and family they are or have worked with.

In the first instance this must be discussed with their line manager and Operations Manager. It will be the responsibility of the line manager to liaise with Legal Services Manager (Kelsey Clayton – September 2020) for guidance. **One Point Court Report Template October 2021** (witness statement template) must be used at all times. All court statements must be quality assured by the appropriate Operations Manager prior to submission.

Chapter 12

Step-up and Step-Down Procedures

Durham County Council

Step-up and Step-Down Procedures

The Durham Threshold Guidance 2020 is designed to support families appropriately depending upon their level of need. As a family's needs change, they will move between levels of need on the continuum. Families may move from only needing universal support to early help support or more targeted, intensive support. Families who have safeguarding needs must have an allocated social worker as lead professional.

To ensure that children, young people and families receive a seamless service appropriate to their current needs, services will work together, through the Team Around the Family arrangements to ensure that where there remain unmet needs these are clearly identified.

Stepping Up/Down of children and families between One Point Service and Families First/Young People Service

One Point Service and Families First teams work closely to ensure that families receive the right support at the right time; stepping up and stepping down cases according to thresholds.

Weekly Step Up/Down Meeting

All Families First and One Point Service teams will hold a weekly Step Up/Down Meeting with a standardised **agenda**. This meeting is an opportunity for practitioners to meet and discuss cases identified for step up or step down. The meeting will discuss the family's level of need, identify the main Early Help or Safeguarding 'theme' for step up/down, consider what options of support have already been offered and agree a course of action.

Membership & Meeting Structure

Step Up/Step Down meetings are held on a **weekly basis** and has a core membership who are mandated to attend:

- ✓ Families First Team Manager or Social Work Consultant
- ✓ One Point Team Manager or Senior Key Worker
- ✓ Health Service Manager and/or Clinical Lead
- ✓ Family Hub Team Manager
- ✓ Social Inclusion Practitioner

Meetings will be administered by the Families First Team Co-ordinator.

All requests for step up/step down need to be submitted to the appropriate manager on the **Step Up/Step Down Request Form.**

Managers are required to send any request forms to the Team Coordinator who will circulate to the core membership (via a secure network) **1 working day** prior to the meeting.

In exceptional circumstances, managers may agree to consider any late requests. This will be up to the discretion of managers.

Team Co-ordinators will make a record of decisions made in the meeting on the appropriate section of the Request Form.

Stepping Up a Case from One Point Service to Families First

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 discuss with Families First detailing the key concerns and risks posed to the child following **Child Protection Procedures.**

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

See flow-chart

Practitioners may be asked to attend the Step Up/Step Down meeting to present their case if this is appropriate.

Where a family is to be Stepped Up to Children with Disabilities or Young People's Service, the Step Up/Step Down form should be completed as normal. The IFS Team Manager, Senior Key Worker or Family Hub Team Manager should contact the relevant Team Manager/Social Worker Consultant and arrange a suitable time for the family to be discussed, ideally this should be during the arranged Step Up/Step Down meeting. A timeslot can be offered with the option to dial in. If this is not possible a mutually agreed time should be arranged between Managers.

Once agreement has been reached to Step Up a family to statutory services (either through the Step Up/Step Down process or immediately) the Case Step Up Process must be initiated **within one working day on LiquidLogic.** If a One Point Service Practitioner is required to attend an Initial Child Protection Conference for a case that has been stepped up by then, they are to use the **ICPC Report Template**

Case Note Guidance for Step Up/Step Down Meetings

IFS Team Managers/Senior Key Workers/Family Hub Team Managers should add the following case note entry following agreement to step up/step down a family on the day of the meeting: **'Family discussion took place on (date) at the Step Up/Step Down meeting and agreement reached that this family will be stepped up/stepped down to (team)'.**

Stepping Down a Case from Families First to One Point

Stepping Up/Down between One Point Service and ASET Team

Should you be working with a young person who becomes homeless and requires Joint Homeless Protocol please escalate to ASET team .

Contact Laura Broomfield, ASET Manager directly for urgent requests or the ASET Team will hold a weekly allocation meeting. One Point Managers will be able to book a slot at this meeting. Where the ASET Team would like to have a 'Step Down' conversation they will invite the relevant One Point Manager to the meeting. The meeting will discuss the family/young person's level of need, consider what options of support have already been offered and agree a course of action.

Please refer to flow-chart

The weekly Step Up/Step Down meeting will enable managers to consider any families which require ongoing intensive support but where the level of need no longer requires statutory intervention**. FF Managers are required to send a copy of the Step Up/Step Down Request Form for all families to be discussed to the Team Coordinator for circulation to the core members of the meeting at least 1 working day prior to the meeting.**

The initial decision to step down the level of support required should be discussed within the TAF meeting with the family and agreed by the Families First Team Manager.

> **!** **It is important to ensure that the family understand and consent to either Stepping Up or Stepping Down. This should be confirmed in the case discussions and recorded in TAF and/or case notes.**

The IFS Team Manager or Senior Key Worker must agree the family meets the threshold for the IFS Team and still require intensive family support to help the family achieve positive outcomes. Where appropriate the family may step down to the Family Hub for a FC programme, with FCTM agreement, or an offer of support from a partner agency.

Once agreement has been reached to step down a family, the FF Team Manager must follow the Step-Down process on LiquidLogic LCS to transfer the record. The outgoing Social Worker should invite the new worker to the next TAF meeting to transfer the family.

Families being stepped down to the Family Hub Team must be formally done on LiquidLogic including those that are stepped down for parenting and wellbeing programmes.

Stepping Down families from ASET or Children with Disabilities

When the Young People's Service (YPS) or Children with Disabilities (CWD) would like to step a family down to the IFS Team or Family Hub the Step-Down Form should be complete and sent to the relevant Team Manager. Contact should be made with the manager to determine an appropriate time to discuss the family. Ideally a slot should be allocated at the weekly Step Up/Down meeting, but if this is not possible, a mutually agreeable time should be arranged.

Once agreement has been reached to step down a family, the ASET/CWD Team Manager must follow the Step-Down process on LiquidLogic LCS to transfer the family record. The outgoing Social Worker should invite the new worker to the next TAF meeting or arrange a joint home visit to transfer the family.

Please see Step-Up and Step-Down Briefing Note (Liquid Logic)

Stepping Down Families from the One Point Intensive Family Support Team

It is important that once intensive support for children, young people and their families is no longer required, ongoing support is available to help the family build upon the positive outcomes already achieved. The Team Around the Family has the responsibility to ensure that where there remain unmet needs these are clearly identified on the Family Plan.

All families that are due to be stepped down must be discussed with the TAF members, and then agreed by the IFS Team Manager or Senior Key Worker. TAF members should always consider what services are available within the local community to provide ongoing support to families.

Change of Lead Professional within the One Point Service

Where a family held in the Intensive Family Support Team requires Stepping Down to the Family Hub Team, the family will be discussed at the weekly Step Up/Step Down meeting as follows:

1. Any outstanding elements of the Family Plan and any associated risks will be identified as well as specific pieces of work. A decision will then be made on what the Family Hub Team and partners can offer;
2. The Family Hub Team Manager confirms that stepping down the family has been agreed by the TAF members and the family;
3. The Family Hub team can only offer a time limited piece of work. If further support is needed by an other partner the early help practitioner is to agree with the family who will take the 'lead' and work with the child and family plan.

When a family is stepped down to the Family Hub Team, the IFS Team Manger or Senior Key Worker will transfer the family on LiquidLogic EHM to the Family Hub Team Manager who will then allocate.

The allocated Early Help Practitioner/ Wellbeing for Life Worker will attend the next TAF meeting if it has been agreed by the manager, professionals and the family that a TAF is still appropriate.

The new worker and the IFS Key Worker will discuss the family and conduct a joint home visit **within 5 working days** so the family can meet the new worker.

Where a family is open to the One Point Service and is being worked by the Family Hub Team, but needs are escalating, and the family may require more intensive support the first step is to review the Assessment and Family Plan.

Consideration should be given to the development of a Team Around the Family if this is not in place.

1. Support and guidance can be provided by the Intensive Family Support Team via the weekly Step Up/Step Down meeting.
2. Where a family required more intensive support, the Family Hub Team Manager will follow the Step-Up procedures.
3. The Family Hub Team Manager is to ensure the Assessment is finalised prior to Step-Up Meeting and should follow LiquidLogic guidance on transferring the family to the IFS Team Manager.
4. The new lead will be expected to attend the next TAF meeting if a TAF is already in place. A joint Home Visit will take place within five working days by the Early Help Practitioner/Well Being for Life Worker and the Key Worker.

Chapter 13

Case Closures

Durham County Council

Case Closures

Intensive Family Support Team

It is the responsibility of the IFS Team Manager or Senior Key Worker to ensure that the TAF has discussed the possible closure with the family and that everyone involved has thought carefully about whether the needs of the whole family have been met before they agree to close the family. The case discussion must be recorded on the Case Supervision Form in Liquid Logic and the Case Closure Procedure must be followed. Where there remain unmet needs, a clear ongoing plan of support must be in place and the appropriate Step Up/Step Down procedures followed. A family should not be closed until there is evidence of a Family Survey offered; a case note should be recorded to state when this was and to whom.

Family Hub Team

It is the responsibility of the Family Hub Team Manager to ensure that the needs of the whole family have been met or that other partners are able to offer further support, before they agree to close the family. If there has been a TAF they must ensure that the TAF have discussed the possible closure with the family and that everyone involved has thought carefully about whether the needs of the whole family have been met before they agree to closure.

The Early Help Plan will be re started by the worker and updated to reflect the outcomes achieved for the family. This can be done via the decisions tab. This will then be sent to the Family Hub Team Manager for authorisation. The decision to close must either be recorded on a case supervision form or if the case has not been open for sufficient time a case note of management oversight can be recorded. The Case Closure Procedure must then be followed.

Please see **Case File Checklist.**

IFST & Family Hub Team Closure Process Map

1

- Key Worker/EH Practitioner/ Emotional Wellbeing Worker (EWBW) completes case file checklist in preparation for Case Closure.
- Team Manager/Senior Key Worker/Family Hub Team Manager discusses possible closure with member of staff.
- Team Manager/Senior Key Worker to discuss which Stronger Families Outcomes have been achieved and evidenced and Worker to record on LiquidLogic.
- Discussion recorded on Case Supervision Form on LiquidLogic.

2

- Key Worker/EH Practitioner/ Emotional Wellbeing Worker (EWBW) Worker discusses possible closure with family and partners.
- Key Worker/ EH Practitioner/ Emotional Wellbeing Worker (EWBW) (if appropriate) discusses possible closure at the next TAF meeting and agrees a potential date if closure agreed.
- Decisions are recorded on Family Plan.

3

- TAF considers whether on-going support through Family Hub or universal services is required and
- Step-Down procedures followed or
- Key Worker/EH Practitioner/ Emotional Wellbeing Worker (EWBW) discusses case closure with Team Manager/ Senior Key Worker/Family Hub Team Manager and a closure date confirmed.
- Service User satisfaction survey to be sent to children/young people/parents/carers. OPS Practitioner to record case note to state sent.
- Discussion recorded on Case Supervision Form on LiquidLogic.

4

- Key Worker/EH Practitioner/ Emotional Wellbeing Worker (EWBW) requests case closure on LiquidLogic for manager sign off.
- Team Manager/Senior Key Worker/Family Hub Team Manager checks outcomes section and that all case recordings are up to date before case sign off.
- Team Manager/Senior Key Worker/Family Hub Team Manager checks that all relevant documents are complete/evidenced and uploaded on LiquidLogic.

5

- Team Manager Senior Key Worker/Family Hub Team Manager signs case off.
- The standard closure letter is sent to the family. This is the responsibility of the KW/EHP/EWBW.

Chapter 14

Performance and Quality Assurance

Durham County Council

Performance and Quality Assurance

Overall accountability for managing performance and quality of all our work with children and their family sits with the One Point Senior Management Team. However, the quality, timeliness and effectiveness of support we offer requires every practitioner within the service to deliver a quality service to the children and families they are supporting.

A **Quality Assurance Framework** has been developed to ensure a wide range of performance and quality information is captured and shared to help inform quality improvement activity in each team and more broadly across the service. Key Performance Indicators also link to those set by CYPS (which include corporate KPI's). The OPS Performance Scorecard and Quality Improvement Reports are shared with teams on a monthly basis.

The OPS has developed an annual **Plan on a Page** which also includes our Quality Improvement Plan and focuses on which focuses on key priorities and quality improvement activity for the service. Quarterly Performance and Quality Improvement Reports are presented to Children Social Care and Early Help, Inclusion and Vulnerable Quality Improvement Board.

However, improving performance is a shared responsibility and processes should be in place to ensure that all staff have the opportunity to reflect upon their own performance and identify actions for improvement, particularly through supervision and Performance and Development Review (PDR). **See Supervision Framework.**

Management Oversight

It is the responsibility of the team manager to ensure decisions about children are timely, safe, effective and lead to positive outcomes for children and their family.

The management oversight 'footprint' must be evident across all decision making and easily found on the child's case file. Management oversight should demonstrate a clear rationale and evidence base for decisions, including the perceived impact upon the child, backed up by SMART planning to ensure effective implementation. Where relevant, case records should also contain evidence of how the manager has challenged the case worker's views of the case, both through supervision and day-to-day case planning.

Effective management oversight will always be built on the relationships between the manager and worker as well as effective use of supervision, performance data and quality assurance processes. All workers within the OPS will be provided with regular supervision and Group Learning as per Supervision Framework. Managers will have access to a range of performance and quality data as per **Quality Assurance Framework.**

Child and Family Allocation

To assist Team Managers and Senior Key Workers effectively implement the case management procedures, separate Management Oversight Checkpoints for IFS Team and Family Hub Families have been developed. **See Management Checkpoint Flowchart.**

This includes a manager's responsibility regarding case summaries and ensuring management oversight of any case considered for closure, Step Up, Step Down.

Informal Case Discussions

It is expected that One Point Service Managers may have **informal case discussions** with staff. As a **minimum**, all informal discussions and decisions must be recorded on LiquidLogic case notes by the Manager (using the management oversight code) and where appropriate on Case Supervision Form in LiquidLogic.

Formal Case Supervision

Formal case supervision will be undertaken by the Team Manager or Senior Key Worker (as per supervision framework).

> All formal case supervision must have a Case Supervision form on LiquidLogic complete and the Case Summary reviewed and updated.

Signs of Safety/Wellbeing Group Learning

All practitioners will have the opportunity to participate in Signs of Safety/Wellbeing Group Learning on a monthly basis within their team. For part time staff the frequency will be bi-monthly. The purpose of group learning is to build strong team habits of analysis and judgement in order to foster more agile, confident decision making and practice. It also promotes a learning culture within the service.

A good group learning process for thinking through cases will lead to more energy and dynamism in practice because it builds a shared sense of carrying risk within the whole team which dissolves the isolation and sense that so many practitioners have: 'if this goes wrong, it is my fault'. Teams that use this process consistently report greater use in the Signs of Safety/Wellbeing framework and their Signs of Safety/Wellbeing/ practice.

Bi-Monthly Operations Manager Case Clinics

In line with our Quality Assurance Framework, Operations Managers will hold bi-monthly **Case Clinics.** These clinics will be set for the calendar year and the purpose of the clinics 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. The clinics aim to provide an opportunity to explore cases, challenge ideas within a supportive and reflective process.

Children and families which may be selected for bi-monthly case clinics may include:

- CYP of most concern
- long-standing neglect of CYP
- unborn babies and children under one
- CYP cases open over six months.

Team Managers and/or Senior Key Workers are all required to attend the bi-monthly Case Clinics arranged by the Operations Manager. The monthly Locality Performance Outcomes Summary prepared by the Team Managers will help to inform which families will be discussed/reviewed. Where possible Operations Manager will plan for the bi-monthly Case Clinics to be held following the Performance Meetings. Operations Manager will review:

LiquidLogic Case Recordings.

Locality Performance and Outcomes Summary (Exceptions Report Template) **and Re-Referral Template**.

Operations Managers will make an 'operation management oversight' case note on the CYP record to evidence discussion with any key points/actions.

Operations Managers will be involved in audit activity as and when required (more information about audit activity can be found in the **Quality Assurance Framework.**

Use of LiquidLogic Dashboard

A number of management reports are available to assist with effective case management. All One Point Service Managers/Senior Key Workers are expected to use these tools on a **weekly basis** including oversight of:

- All open assessments
- Children where there is no case recording for 20+ working days
- Families where no TAF information is recorded (IFST).

Monthly Performance and Quality Clinics

The OP&TFS Strategic Manager and/or Locality Operations Manager will hold **monthly performance clinics** with each locality team manager and will focus on performance measures and within the OPS performance scorecard. The OPS scorecard will include both performance and quality measures which will demonstrate the impact of work with children, young people and families. Performance measures will include compliance with supervision and attendance management procedures. The performance reports highlight performance exceptions to help the manager to investigate reasons for the performance being outside service standards.

All Team Managers will be provided with their team's performance report and exceptions a week prior to prior to a monthly performance clinic with Operations and OPS Strategic Manager. Managers will be required to prepare by completing both the **Locality Performance Outcome Summary** (exception Report Template) and **Re-Referral Template** Quarterly Quality Improvement Reports outlining feedback from quality improvement activities such as collaborative audits, service user feedback and compliments and complaints will also be shared.

Locality Management Meetings and Monthly Team Meetings

Systems should also be in place within each locality and teams to ensure that key targets and indicators are regularly reviewed, and it is expected that Performance will be a standard agenda item on monthly Locality Management Meetings and monthly Team Meetings.

Each OPS team will be responsible for developing and implementing a team Quality Improvement Plan which will focus on key priorities for Early Help, Inclusion and Vulnerable Children Service, the One Point Service and individual teams.

Weekly Team Briefings

- All Team Managers should have a weekly Team Briefing with their staff team with the purpose of:
- Welfare check-up
- Manage cover arrangements
- Manage Team resource to meet Assessment deadlines / contact with families
- Share performance information
- Share what is working well/what are we worried about?

Learning and Development

One Point Service Workforce Strategy

This strategy looks at the Early Help Workforce as a whole and identifies the current position of the workforce in terms of its demographics and people in the organisation. It identifies the work done to develop the workforce to date, the priorities for moving forward and strengthening the workforce, and sets out an overarching plan as to how the service is going to achieve these priorities.

One Point Service Staff Development Pathways

This document sets out all of the training and development requirements for staff in all roles in the Early Help Service. This includes corporate induction training, service and role specific mandatory, recommended and optional training along with recommended timescales for completion. This document can also be used to aid progression into other roles in the service and includes apprenticeship standards.

Workforce Development Plan

This plan had been developed by the Early Help Workforce Development Group. It addresses the development needs of the workforce, and how they are going to be met, to ensure that children and families can be supported in the most effective way. The plan allows staff to input on their needs to allow innovative ways of working to promote a learning culture within the service.

Career Development Programme

The career development programme is designed to support talented and experienced practitioners and current managers to develop their skills, progress to higher levels of management or diversify across different areas in CYPS to work in the roles which they aspire to. Whether that is progression as a practitioner, in roles that lead and support staff, Team Manager positions or at Operations Managers or Strategic Manager level. The programme will help better understand the role, identify strengths and areas for development, and support to undertake a development programme designed to meet individual needs and make them ready for success.

Chapter 15

Joint Working with Partners

Durham County Council

Working together to support children, young people and families

Collaborative working with key partners is an integral part of the One Point Service in ensuring children, young people and families receive effective seamless early help services. Whether it through coordinating a multi-agency response through Team Around the Family arrangements or through supporting partners to deliver services in and through our Family Hubs. We are committed to ensuring we work closely and effectively with partners to reduce duplication and maximise the impact we can have to help families achieve sustainable positive changes.

The Role of the Early Help Advisor

The Early Help Advisor will work alongside and assist a broad range of key partner community-based organisations to develop and deliver effective early support and help to families using a whole family approach.

The Early Help Advisor offers to support multi-agency partners to identify additional needs which can be supported in and though the 0-19 Family Hub ensuring that need is responded to appropriately and progress towards desired outcomes is made.

One Point Early Help Advisors will attend Behaviour and Inclusion Panels. Their role is to advise partners on the Early Help Assessment process and how we can work in partnership with the Panel. In particular they will:

- Advise of the Thresholds of Need and help the Panel to identify the most appropriate lead agency.
- Advise on a whole family approach to supporting children and young people.
- Advise on Team Around the Family and how to arrange TAF Meetings.
- Advise on the referral process into First Contact and completion of Children's Services Referral Form.
- Advise on the One Point Early Help Offer and how One Point can work with partners to support children, young people and families.

Harrogate and District Foundation Trust 0-25 year Family Health Service

Durham County Council's One Point Service and Harrogate and District Foundation Trust's Family Health 0 - 25 Service work in partnership to provide integrated early help for children, young people and their families from early pregnancy to the age of 25 years.

If a Health Visitor decides that a family requires a specific intervention e.g. speech and language enrichment or parenting support, they will contact the Family Hub Team Manager with a completed **Request for Family Hub Programme Form.**

If a Health Visitor decides that a child/young person and their family requires support from the Family Hub offer, the Health Visitor will remain the Lead Professional. They can request support from the Family Hub Offer i.e. group- based activity which would be suitable to meet the child and parent's needs. In addition, and if appropriate, Health Visitors can request an Early Help Practitioner conducts a specific piece of work outlined in the menu of the Early Help Family Offer. Requests for support will be received by the Family Hub Team Manager who will allocate an Early Help Practitioner.

Once an Early Help Practitioner is allocated the family, they will contact the lead professional and determine the actions required which will involve either a group-based activity or one to one work for a maximum of six weeks.

The Early Help Practitioner will become a member of the Team Around the Family if one is in place.

In both of the above, it will be recorded in 'General Notes' as Non-Lead work on EHM on LiquidLogic.

Enhanced Parent Support Pathway (formerly known as the Vulnerable Parent Pathway)

The **Enhanced Parent Support Pathway** recognises that some families require additional support, whilst others can safely be supported through the universal Healthy Child Programme (HCP). In line with providing holistic, coordinated packages of support to families in greatest need, the Enhanced Parent Support Pathway will involve the delivery of integrated support by Health Visitors and the One Point Service (OPS) and other partner organisations where appropriate. For the OPS this will involve a **minimum of six additional contacts** with the family.

Young Parent Programme

The Young Parent Programme, which is currently being reviewed aims to support young parents aged 16-24 years develop parenting skills, prepare for further education, employment or training and build support networks. The programme is delivered one day per week for 20 weeks and provides clear pathway opportunities on completion into education, employment, training or volunteering.

The Family Hub Team Manager within each area will develop and deliver one programme per year. They will work closely with other professionals including Midwifery, Health Visitors, DurhamWorks, Housing, VCS etc. to identify young parents (mothers and fathers), for the programme. Where possible this will be in the antenatal period or early post-natal period. Transport will be provided and crèche will be provided if required.

Young Parents will be supported and encouraged to also take up offers of support from the broader 'Early Help Offer' in and through the Family Hub.

All YPP will have an assessment and all YPP interventions will be recorded on LiquidLogic Group Work. Where the case is open to a social worker the YPP case recording will be on a LiquidLogic LCS case note and in the Group Work module.

Summary of Roles & Responsibilities

Operations Manager
Strategic Lead Budget Holder
Family Hub Team Manager
Programme Recruitment Lead/Area Programme Lead
Early Help Practitioners
Case Holder, Engagement Activities & Delivery Lead

Young Parent Programme Working Group

The YPP work stream meets on a bi-monthly basis to manage the programme across the service.

The purpose of the group is to:

- Agree programme delivery across the service & timescales.
- Agree programme content.
- Agree engagement activities.
- Set the budget, monitor spend and ensure economies of scale.
- Monitor and review programme delivery.
- Trouble shoot & share good practice.
- Set Key Performance Indicators (KPIs).
- Monitor performance against KPI's.
- Plan celebration event.

- Agree user feedback process & undertake programme evaluation.

The Operations Manager will plan and chair the YPP meetings and all leads will be expected to attend.

Social Inclusion Team

The Social Inclusion team support Children Services and key partner organisations to know and utilise the wide variety of VCS provision available across County Durham. The aim of which is to ensure our children and families are supported to access a broad range of projects, activities and interventions from within their own communities.

The role of the Social Inclusion Development Worker provides support and information in a number of ways including attending locality early help conversations and step up/step down meetings, information requests via an online portal request form and information is also shared in a weekly online bulletin. Any practitioner can submit a request for VCS support and information at the online portal **https://doitonline.durham.gov.uk/service/VCS_Alliance**

Education Development Service (EDS)

Follow up of those children who are not taking up two year free child place.

Eligible two year olds are offered a free childcare place. The Education Development Service is responsible for working with childcare providers to make this offer available for families. Where families do not take up this offer Health and One Point professionals will work with the service to find out the reasons why and offer advice and support as necessary.

Education Development Service (EDS) sends list of parent's names to Business Support

↓

Business Support to add children's name and contact details and send lists to Harrogate District Foundation Trust (HDFT)

↓

HFT to add the provision when known or any other details that will assist in the FC, supporting child into a placement
Health Visitor may contact families directly

↓

HFT return list to EDS

↓

EDS sends list to Family Hub Team Manager

↓

FCTM follows up with families in the following ways, prioritising Term 1

↓

- Ringing Nurseries
- Checking LiquidLogic Early Help Module
- Ringing the Family contact number
- Distribute the list between staff so that they can call, whilst in the locality

↓

FCTM sends back list to EDS by due date

↓

EDS will remove any children on waiting lists from subsequent lists

N.B.

- Parents do not have to take up the whole 15 hours.
- Education Development Advisors (EDA) can be approached for advice re provision.
- Utilise the local Nurseries for intelligence.

Children Missing from Education (CME)

For more information see **CME Flowchart General and CME Flowchart for OPS.**

Behaviour and Inclusion Panels (BIP)

Schools and the Local Authority have agreed to jointly take ownership of young people who come to the attention of the panel and to work in a transparent and fair manner to achieve the best outcomes for the young person.

The BIP will consider referrals from schools for young people, where despite best endeavours of the school, continue to display challenging levels of behaviour and are at risk of exclusion.

The panel will also consider placements for pupils who have moved into the area from other LAs where they have been placed on an alternative provision to mainstream school and pupils attending The Woodlands Pupil Referral Unit (PRU) where a reintegration back into mainstream school has been identified.

The Panel will determine an appropriate way forward which could include:

- Collaborative approaches between local schools to provide full-time education programme.
- Referral to other agencies - One Point, Educational Psychology Service (EPS), Behaviour Intervention Team (BIT).
- Managed Move to another identified school.
- Woodlands Bridge placement.
- Longer term co-ordinated Alternative Provision Placement between the school and alternative providers in the Directory.

All Durham schools (regardless of designation) and the Local Authority are committed to working collaboratively to ensure:

- Pupils receive appropriate full-time education suitable to their age and ability. This will be delivered through high quality learning and teaching experiences, so all pupils are able to achieve and fulfil their potential.
- The holistic needs of pupils and their families can be identified and supported by relevant agencies. The Early Help Advisor attends the panel to advise on this.
- Early interventions counteract the need for exclusion in all but extreme cases.

The role of the Early Help Advisor in the Behaviour and Inclusion Panel

One Point Early Help Advisors will attend Behaviour and Inclusion Panels. Their role is to advise partners on the Early Help Assessment process and how we will work in partnership with the Panel. In particular they will:

- Advise of the Thresholds of Need and help the Panel to identify the most appropriate lead agency;
- Advise on a whole family approach to supporting CYP;
- Advise on Team Around the Family and how to arrange TAF Meetings;
- Advise on the referral process into First Contact for Safeguarding completion of Children's Services Referral Form, advise on 'partner led' Early Help Assessments and Requests for (additional) Early Help
- Advise on the One Point Early Help Offer and how One Point can work with partners to support children, young people and families.

SEND and Inclusion

Working with children and young people with Special Educational Needs AND Disability (SEND)

Full guidance on the early help contribution to children with special educational needs can be found in the in the **Children Services Guidance on EHCP for children with Special Education Needs and Disability (SEND).**

Children with SEND may be supported through the Family Hub or Intensive Family Support Team depending on the nature of the request for help.

The majority of children and young people with SEND or disabilities will have their needs met within local mainstream early year's settings, schools and colleges through a SEND Support Plan.

However, some children and young people may require an Education, Health and Care Needs Assessment in order for the Local Authority to decide whether it is necessary for it to make provision in accordance with an Education Health and Care Plan. The EHC Needs Assessment should be a holistic assessment of the child or young person's education, health and social care needs.

The One Point Service will provide advice on the social care needs of the child for the assessment, if the family is not open to Social Work Teams. Full guidance on the process regarding the request for Social Care Advice and the early help contribution to Education Health and Care Plans for Children with Special Education Needs and Disability can be found in in the **SEND EHC advice flowchart for Social Care Staff.**

The SEND Business Services will check LiquidLogic to ascertain if the child or family are currently in receipt of Children Services. If there is a Lead Professional from the One Point Service they will be e mailed by SEND Business Services and asked to submit their social care advice within 20 working days.

If there is a no OPS Lead Professional involved, the SEND Caseworker will request that the social care needs of the child are assessed by the OPS. They will do this by submitting an Early Help Support Request using CRM, clearly stating that this 'is a request for social care advice to be provided. This request will be put into the LL tray

of the IFS Manager who will allocate it as they would other requests. The OPS Lead Professional will have 20 working days to complete this and send back to the SEND Business Services e mail address.

Team Managers should reference in their allocation that this is a request for SCA with the deadline for submission.

The OPS Lead Professional should inform the SEND Caseworker who has put in the request for social care advice that they have been allocated to the child and family and copy in their Team Manager and Business Support Team Leader.

An OPS practitioner is expected to contribute to the EHC Assessment by using the current Child and Family Assessment to populate the Social Care Advice form. This form can be found in LiquidLogic and there is guidance on completing the advice in the LiquidLogic form and the **Children Services Guidance on EHCP for children with Special Education Needs and Disability (SEND).**

This form enables the information required to contribute to the 'care' element of the EHCP, if it is decided to issue a plan (this is under section D and section H1 of the EHC Plan).
The Team Manager will quality assure and authorise the social care advice in LiquidLogic. Managers are expected to make a comment on the social care advice, indicating that the social care needs are identified and that the associated provision and expected outcomes are detailed or the reasons why not.

The Lead Professional will send the authorised SCA to the SEN Business Services e mail address **senbusinesservcies@durham.gov.uk**

A Multi Agency Meeting (MAM) may be arranged by the SEND Caseworker and the Lead Professional from One Point will be invited. The Lead Professional should make every effort to attend this meeting.

The Lead Professional, family and the SEND caseworker will discuss the alignment of a pre-existing TAF meeting to the EHC Assessment MAM to ensure the family and professionals are not exposed to multiple meetings. If there are no identified social care needs or these have been addressed the family can close to the One Point Service. It is not necessary to wait until the MAM to close unless this is to take place in a few days. If the family have been closed, the OPS Lead Professional will write a case note in LL in general notes to reflect their attendance at the MAM and any actions.

A decision will be made at the MAM whether to issue an EHCP or SEND Support Plan. If an EHCP is agreed a draft plan will be agreed in the MAM. The plan will be sent to the Lead Professional who will have 15 days to make comment on the plan. It is really important that the plan is checked to ensure the social care advice is accurately reflected in the plan. If further social care outcomes are identified these should be sent to the SEND Team, by completing a new Social Care Advice Form.

If there is ongoing One Point involvement the Lead Professional will be invited to the EHCP Annual review.

If there is no TAF where school would be informed of the closure to One Point the **Letter Template SENCO** should be sent to the school SENCO by OPS Worker.

If a family has been closed for up to three months and a request for Social Care Advice is received, advice can be given without opening the family to the service. The former worker, if possible, will write the advice in conjunction with the family and submit this as above. If further worries are identified and it is felt that a further assessment is needed, then it can be opened to the service.

Durham SEND Information Advice and Support Service (SENDIASS)

Durham SEND Information Advice and Support Service (now part of the One Point Service) is a statutory service supporting parents/carers of children with special educational needs and disabilities (SEND).

Durham SEND Information Advice and Support Service operates at 'arm's length' from the Local Authority and the services provided are confidential and impartial.

Durham SEND Information Advice and Support Service provides confidential information advice and support through a range of services. This includes a telephone helpline and 1:1 telephone appointments, email correspondence, virtual 1:1 meeting with the family, support a family to prepare for meetings, attendance at meetings, organisation of school visits, 1:1 support with SEND paperwork, liaison with educational settings on behalf of the family, information about graduated approach to SEND, clarify mis-information, information and support with SEND Mediation, Appeals and Tribunal, support to navigate the Local Offer and Specialised Signposting and a programme of Parent/Carer SEND Training Workshops.

Durham SEND Information Advice and Support Service (SENDIASS)

- is a free, impartial local service.
- provides confidential information advice and support.
- works directly with parents and carers of children and young people with SEND.
- works directly with young people with SEND.
- works in partnership with parents/carers, young people, educational settings the local authority and other agencies.
- supports parents and young people to inform and influence local policy and practice.
- enables parents/carers and young people to make informed choices and decisions with confidence
- has a role in making sure that parents' and young people's views are heard and understood and that these views inform local policy and practice.
- is able to put parents and young people in touch with other local and national organisations.

Durham SEND Information Advice and Support Service provide information on:

- how special educational needs are identified and assessed by educational settings and the Local Authority.
- who parents and young people can talk to in a school or Durham County Council or Local Authority about their worries.
- the SEND Code of Practice 0 – 25, the statutory assessment process and Education Health and Care Plan (EHC Plan).
- parents/carers and young person's rights and responsibilities.
- meetings and reviews about a child's or young person's needs.
- how progress is monitored and reviewed.
- what parents can do if they are not happy with a decision made about their child's SEND.
- what young people can do if they are not happy with a decision made about their SEND.

Access to Short Breaks for Families with a child with SEND

Being a parent carer of a child or young person with special educational needs and or disabilities (SEND) we know can be difficult, and parent carers may need some time to help them cope with family life. Short breaks are designed to help parent carers have a break from their caring responsibilities.

Short breaks are different for every family. They will depend on the family's needs, but may include:

- Getting support from the parent carers networks (e.g friends, family and people who are involved with the family).
- An activity their child/ young person attends gives them some time to themselves.
- An activity that the parent carer can do without their child.

Something to do as a whole family

Short breaks:

- Allow time for the parent carer to look after their physical and mental health wellbeing and spend time with their friends and family.
- Allow the child to develop new interests, keep fit, be more independent, spend time with their friends and take part in hobbies.
- Where possible, short breaks will be provided through the child/ young person accessing activities and groups in the community. These are not just groups that are just for young people with SEND. If there is something that is stopping you being able to take part in a short break, SENDEIC will work with the parent carer to help them access the break they need.

This may include your child:

- taking part in a virtual activity
- going to a leisure facility
- taking part in a physical activity
- going to a local youth activity for a few hours per week
- receiving additional support and sometimes very specialist support to help them access the community.

A small number of children/young people, who have had their needs assessed, may sleep overnight at a children's residential setting to give you a break.

The following flow chart shows the range of short breaks available to a family. Full guidance on how to access these short breaks can be found in the Short Breaks Statement, Short Breaks Statement March 2023 (durham.gov.uk)

There is also the facility for practitioners to request advice and guidance through SEND-Empowering Inclusive Communities-(SENDEIC) by emailing **SENDEIC@durham.gov.uk** or by telephoning **03000 260 270** and more information can be found at the **Short breaks (respite care) - Durham County Council**

The Short Breaks offer available to families in County Durham

If the family is open to the Family Hub Team and it becomes evident that a family may require an **assessed** short break having tried all other options, the Family Hub Team Manager will discuss the family in the weekly case management meeting and Step-Up if appropriate. OPS Step-Up/Step-Down procedures should then be followed, and the family allocated to a Key Worker.

The Key Worker/EHP will follow the guidance for an assessed short break as outlined in the **Short Breaks Practitioner Guidance** (due for review)

Pre-Birth Intervention Service

The latest guidance is on Tri.X in the **Safeguarding Practice Guidance**. The Pre-Birth Intervention Service works with those families where a previous child has been permanently removed from their care and either placed for adoption or with extended family members.

Our work with the family is to provide intervention, assessment and support during the second stage of pregnancy with the aim to support parents to provide safe appropriate parenting of their baby.

One Point Service Involvement

The One Point Service will allocate a dedicated Early Help Practitioner from our Family Hub Team to work with the PBIS Social Worker to provide the family with the support element of the intervention plan. The EHP will become a member of the Team Around the Family and work closely with the PBIS Team, delivering support in accordance with the Intervention Plan. The Social Worker will be responsible for arranging Family Time, making referrals to other services for additional support and arranging transport for families to appointments as appropriate.

Intervention Plan

The Pre-birth Intervention Plan has been developed utilising theoretical models and evidence-based practice, consistent with Healthy Child Pathway (DH).

The plan should provide a framework for intervention to ensure families receive consistent support and be adapted to their needs.

Intervention will be focussed on delivering persistent, proactive, practical and emotional support to parents that will build upon existing strengths and address gaps in their knowledge and skills which affect ability to care for a baby.

The plan will also need to be adapted to comply with ongoing safeguarding decision which impact on child's placement and parental contact.

Although the plan is presented in four-week segments, the level and frequency of support will vary from family to family and will also require a co-ordinated approach by the Team Around the Family to ensure the parent(s) are not over-welcomed by professional support.

Allocation of Work

Due to the nature and intensity of the intervention, each Early Help Practitioner will be allocated a maximum of 2 pre-birth interventions at any given time. In exceptional circumstances, Family Workers within the IFS Team, may be asked to support the Intervention Plan.

Working together arrangements

Allocation of Work

1. The PBIS Social Worker will be responsible for directly contacting the appropriate Family Hub Team Manager to request support via email within 5 working days of the family been allocated to them.
2. The Family Hub Team Manager will allocate the family to an Early Help Practitioner within 5 working days and enter the following note on LiquidLogic in general notes:

"PBI support allocated to (named practitioner). Contact to be made with the Social Worker within 5 working days"

Workflow

The workflow process chart below clearly lays out the agreed joint working arrangements between PBIS and One Point Service for the Pre-Birth Intervention Plan.

Planning the intervention

Prior to interventions being delivered, the Early Help Practitioner must meet with the PBIS Social Worker to discuss the danger posed to the unborn baby. At this meeting, the following will be discussed:

- Danger to the Unborn child (as an unborn and after birth);
- Key information from the bundle concerning the sibling;
- Any staff health and safety issues;
- Communications plan between the EHP and SW during the course of the intervention;
- Dates of interventions and review points.

The EHP should create a clear plan of work which can be provided to the family and evidence how (including tools/models such as practical activities) the family and EHP will work together on the dangers.

Each individual intervention should be specifically linked to the Intervention plan and the identified dangers posed to the child.

Recording your work

Where interventions need to be recorded?

The interventions for the child and family should be recorded in LCS in LiquidLogic.

What needs to be recorded?

- In all cases, the record of the intervention should include the following:
- Date of session
- Who was present (including those invited but did not attend)?
- Location of session
- Aim and purpose of session (Social Worker/EHP aim and purpose of the session)
- Parents/Family points or issues raised for discussion:
- Review of last session (agreed tasks completed, outstanding tasks?)
- Feedback from parents from the last session, including work and activity which was shared/tools and resources such as homework tasks
- Outcome of the session (What were your observations, how effectively were you able to deliver the aims of the session) Include how much time was spent on the agreed aims and how much time on parents' points or issues for discussion.

- How well did the parent/family engage?
- What feedback did you provide to parents/family (either in written or verbal format)?
- Agreed tasks, actions and timescales (including any decisions made):

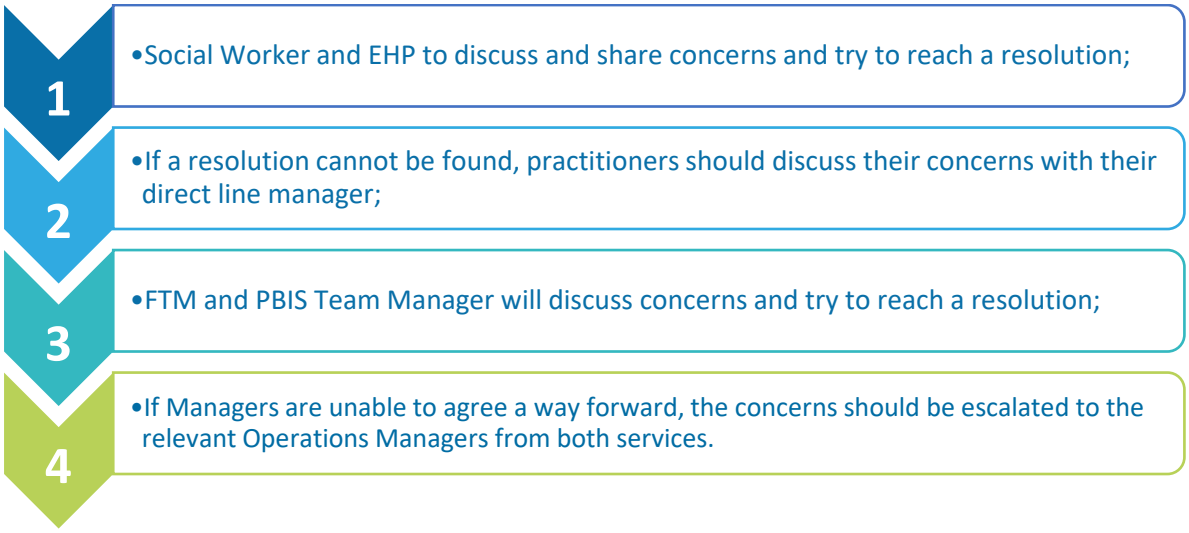
Uploading documents and resources used

Direct work such as work plans, quizzes, photographs, resources should be uploaded to the case file on LiquidLogic.

Review of EHP intervention

At the relevant stages of the EHP work, review points are scheduled to meet with the Social Worker and consider the work completed so far, what's working well and what is causing worries. Any additional work and opportunity to offer additional services or support should be clearly outlined.

If there are any conflicts or disagreements, these should be appropriately recorded, and practitioners should use the following process:



Case Supervision provided by PBIS

Supervision between EHP, Social Worker and PBIST Team Manager should be held on a monthly basis. The supervision should consider EHP work completed and provide an overview of what is working well and what professionals/family are worried about. The supervision should provide the EHP/SW to discuss ways of working, communications and any staff safety issues.

The supervision session will be recorded on the child's electronic file within LCS (as per PBIS supervision recording procedures).

Case Oversight provided by One Point Service

Family Hub Team Managers (or in exceptional circumstances Senior Key Workers) are not expected to provide case supervision to One Point practitioners working on pre- birth intervention plans.

Managers are expected to have oversight of all their practitioner PBIS families on a monthly basis as part of the One Point case discussion cycle. This will provide both the manager and the practitioner with the opportunity to discuss progress and share any concerns within the context of their day to day practitioner role. Any relevant developments/observations should be recorded by the manager on LiquidLogic using general notes in the case file.

Team Around the Community (TAC) Programme

Team Around the Community (TAC) is a team of experienced youth workers who will work within communities where there are concerns about young people engaging in either anti-social and/or risk-taking behaviour, with a view to supporting those young people to choose healthier and safer lifestyles.

Team Around the Community recognises that some young people meet and socialise on the streets, in parks and other outdoor areas in communities across County Durham and in most cases do so with no risks to themselves or others – it is a normal part of growing up.

In some cases, however, the activities of young people may be a cause of concern to residents and communities, and in these instances a Team Around the Community response may be required. TAC will be delivered using either detached youth work, or a targeted group work programme.

Where TAC is delivered using a model of detached youth work, youth workers will contact and engage young people “on the streets” in the places they are gathering within communities. They build relationships and deliver programmes that will enhance the young peoples’ social and emotional capabilities, supporting young people to make positive life choices and achieve good outcomes.

Alternatively, TAC will deliver a targeted group work programme to young people who are identified by the Anti-Social Behaviour Team as being involved in ASB. This programme will be delivered by TAC in partnership with the Council's ASB team, the Fire Service, Police, and may include other agencies such as the Drug and Alcohol Service. The programme aims to educate young people about the risks they are putting themselves in, whilst also developing their Social and Emotional Capabilities, helping them to make more positive choices.

The criteria for TAC are young people who are gathering in groups within communities, or are known as an individual, who may be engaged in or vulnerable to the following:

- Anti-Social Behaviours and/or criminal activity;
- Negative risk-taking behaviour (i.e. alcohol and/or substance misuse);
- At risk of **Child Exploitation.**

A range of intelligence gathering will inform the locations of work and prioritisation of referrals to TAC:

- Community engagement mechanisms within the locality, such as Community Wardens or Police Community Safety Officers;
- Areas where Anti-Social Behaviour is prevalent and the ASB Escalation Process has been implemented;
- Anti-Social Behaviour "Hot Spots";
- Areas of concern, e.g. **Child Exploitation,** identified by the Durham Safeguarding Children's Partnership (DSCP) ; Missing and Exploited Group (MEG), Police; Erase Team;
- Areas of concern brought by partners.

Once a location for work has been identified, a referral form should be completed by the designated Family Hub Team Manager who will agree with partners the programme of intervention.

The TAC intervention will usually last for **no more** than 12 weeks and all work will be reviewed every six weeks to ensure progress and monitor outcomes.

Durham Constabulary - Police Community Support Officers and Local Inspectors

The aim of our partnership arrangements with Durham Constabulary PCSO is to provide specialist support to the One Point Service teams in order to improve outcomes for children, young people and their families with a specific focus on Anti-Social Behaviour (ASB) and crime.

The PCSOs bring a specific skillset and expertise to the One Point Service, particularly in relation to crime, anti-social behaviour (ASB), missing from home (MFH) and **child exploitation (CE)**. There is an expectation that advice and guidance in these areas will also be provided in the Team Around the Family (TAF) and Local Authority ASB teams.

Where possible the PCSO will attend all relevant TAF meetings, if attendance is not possible written feedback will be provided at the request of the Lead Professional.

The flowchart below details how to request support from PCSO.

Are you working with a Young Person or family who you think would benefit from contact from a Police Community Support Officer?

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Email the Safeguarding Coordinator Ralph.Thompson@durham.police.uk

Include the name of the young person, date of birth, address, parent's details and a short summary of why you are involved and what you would like to achieve from PCSO Intervention.

↓

Your request will be assessed, and an email will be sent to advise you regarding the next step.

↓

Sgt. Ralph Thompson will task local officers to contact you to identify a plan to support a positive outcome for the family or young person.

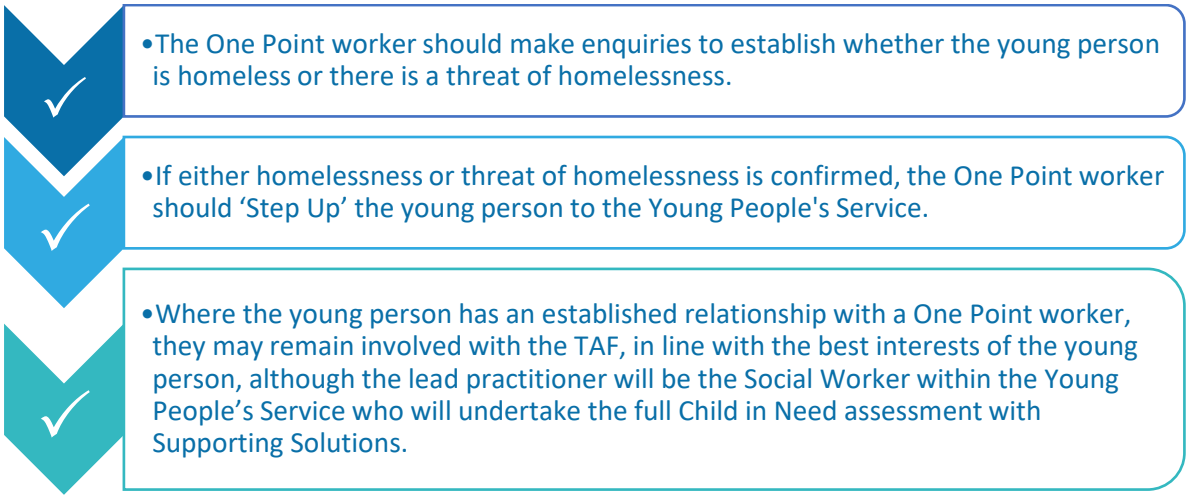
County Durham Joint Protocol for Homeless 16- & 17-year olds

16 and 17 year olds who are homeless or threatened with homelessness are likely to be vulnerable and will often be at risk of harm in the absence of intervention. The County Durham Joint Protocol for Homeless 16 and17 year olds is an agreement that establishes the roles and responsibilities of different agencies towards homeless 16- and 17-year olds. It outlines the respective statutory responsibilities of the Durham County Council Children and Young People's Services (CYPS) and Housing Solutions (the Housing Authority). In addition, it details the practical joint working arrangements between the housing authority, CYPS and other agencies that can assist with the housing and support of homeless 16- and 17-year olds in the county.

The latest Homeless Reduction Act 2017 came into force in April 2018. The main change is that any child or young person at risk of homelessness will be regarded as a Child in Need.

Durham's Joint Homeless Protocol February 2021 (JHP) sets out what One Point's role will be.

If a young person open to One Point presents as homeless or is at risk of being homeless:



Children Social Care Full Circle Service

Full Circle provides a post-trauma service for children and young people up to 18 years of age and/or their families and carers, or up to 25 for care leavers and those eligible for Adoption Support Fund (ASF). **Refer to Full Circle Criteria.**

The service is for children and young people who have experienced trauma as a result of abuse or neglect, where the impact of this trauma continues to affect day to day functioning and emotional wellbeing. The need for therapeutic support should be identified by professionals as part of a current plan.

The Full Circle team also works into all stages of an adoption journey and provides post adoption support for the Local Authority. Staff at Full Circle have experience of working with the impact of trauma and disrupted attachment which are issues that challenge adoptive families.

Adoptive families need to be supported to reach Full Circle without delay. They should not be offered universal services even if they appear straightforward.

Regardless of any additional early help needs a child on an SGO/RO need to be open to OPS for Full Circle Consultation. Adopted children need to be accessing support of an Adoption Social Worker.

The One Point Service will work closely with Full Circle through either the Intensive Family Support Team or Family Hub Teams, and each family will be assigned a Key Worker or Early Help Practitioner as per usual process at point of allocation. All referrals, which do not meet the threshold for Families First or Supporting Solutions, will come to One Point through First Contact Early Help Triage. **Refer to Full Circle Early Help Process**.

One Point will support and work with families who require the following Full Circle services in addition to Early Help needs that can be supported through One Point:

- Attachment Training for Connected People for SGO families
- Therapeutic Services for Adopted Children and their families (At present this is when therapeutic need only identified - if there are other factors impacting on family life progress to OPS - Adoption Team clear won't manage "crisis" situations)
- 'Letting the future in' programme for children and young people who have suffered historical sexual abuse (for Children Looked After - see below for full explanation. For children currently not CLA/historical sexual abuse recommendation is the Meadows).

Some families on an SGO are eligible for Full Circle support. They will be offered three days of 'Connected People Attachment' Training and often need considerable encouragement and support from their One Point practitioner to successfully attend this training and to put into practice what they have learned.

SGO families are also likely to need far greater input and support from One Point regarding non-therapeutic needs, often to stabilise situations.

One Point practitioners will initially support families to access Full Circle and then offer continued support to attend and complete the Connected People Training. They will also support the families with any non-therapeutic issues that are identified. For SGO families who would like to access direct therapeutic support for child/family AND child previously CLA, OPS assessment required and application to the Post Adoption Support Fund (via Full Circle Admin). OPS have a list of private providers for carers to select.

Post Adoption Support Process Flowchart clearly sets out the process for One Point practitioners working with Post Adoption/SGO families.

If a family is not identified as being 'Post Adoption / SGO' on allocation to One Point but this becomes evident during working with the family, One Point practitioners will support families to access Full Circle and then offer continued support with any non-therapeutic issues that are identified.

Full Circle Working with Non-Adoptive/SGO Families

Full Circle will support Children and young people in the care of Durham County Council who have experienced sexual abuse (either historical or there has been multi-agency agreement for the work to progress alongside an ongoing investigation in line with NICE guidelines).

Full Circle will support children and young people who have suffered historical sexual abuse, where they are now safe, but where their experience of abuse is still impacting on normal day to day life.

'Letting the future in' is an NSPCC programme to support children and families where sexual abuse has occurred in the past.

One Point practitioners will initially support families to access Full Circle and then offer continued support with any non-therapeutic issues that are identified. Once OPS have concluded work with the family the case will close to OPS and remain open to Full Circle.

Where a child has experienced historic sexual abuse but not eligible, we can support by signposting.

Requests for Full Circle support for Non-Adoptive/SGO Families Flow Chart (overleaf) clearly sets out procedures for working with these children and families.

Workflow 3

Requests for Full Circle support which are not SGO/Adoptive Families

Manager
- Allocate case to a Key Worker.
- Ensure timescales relating to this workflow are used in the allocation summary.

One point Worker
- Open Episode on EHM.
- Contact Family to arrange initial home visit.
- Gain Consent from the family.

One point Worker
- Undertake Initial Home Visit.
- Complete referral on Liquid Logic (form will automatically go to The Full Circle duty tray).
- Open C&F on EHM and begin proportionate assessment.

Full Circle Admin
- Contact One Point Practitioner to invite family and practitioner to a Screening Assessment Meeting.

One point Worker
- One Point practitioner supports family to attend Screening Assessment Meeting (for example, arrange transport).
- Key Worker attends Screening Assessment Meeting with the family.

Full Circle
- The Full Circle Social Worker will determine what intervention is required and how progress will be reviewed at the Screening Assessment Meeting.

One Point Worker
- Arrange an initial TAF at 6 weeks to review progress if required or,
- Review progress with the family and The Full Circle Social Worker every 6 weeks.

Full Circle
- Complete Full Circle Assessment in LL withing 10 working days following Screening Assessment Meeting.
- Complete Family Plan.
- Attend TAF's meeting (if appropriate).
- Record interventions in child's file, case notes on LL.

One Point Worker
- Access Full Circle Assessment via Basic Demographics page, Episode History and copy and paste relevant information onto C&F assessment.
- Send to manager for approval within 10 working days.
- Meet with the family to complete/share C&F Assessment.
- Keep in contact with the family at least once every 4 weeks virtually or by telephone to complete welfare check if there is no ongoing OPS support.

TAF
- Agree closure if outcomes inlcuding Stronger Family Outcomes have been met (with the TAF if this is in place).
- Discuss possibility of stepping up the case if significant concerns remain.

Children Missing from Home

Anyone whose whereabouts cannot be established will be considered missing until located or their well-being otherwise confirmed.

The terms child, children or young person refers to any person under the age of 18 years old.

If there are concerns that the child is a victim of crime or in immediate danger, then the police should be contacted immediately.

If it comes to the notice of any agency that a child falls into the category of a missing person, they must advise the parent/carer to report this to the police and, if necessary, follow this up by contacting the police to verify that the child has been reported missing.

Missing episode's will be recorded on LCS by the Missing Co-ordinator.

See the full document **Missing From Home Procedures 2021.**

Cases Open to One Point when a Child is Missing from Home

Return to **Home Interview Process** (Early Help)

1. Supporting solutions business support to email allocated worker, senior key worker and operations manager re. missing episode
2. Allocated worker to complete RTHI with young person within 72 hours – If you are aware that the young person has returned home, you can still complete the RTHI prior to receiving the Police information. However, you will not be able to complete the form on Liquid Logic until you the missing and found information has been added to the system. All information is added prior to 12pm everyday so this should not create a delay.
3. RTHI form to be completed on Liquid Logic

    a) Select "MISP"

    b) Select missing episode

    c) Go to Documents and open up Police missing and found reports

    d) Go to Forms – Select Return to home interview from drop down menu

    e) Click start

    f) Page one – Enter DHM number, dates and times of missing episode found on Police reports

g) Click Questions for RTHI on the left hand side and enter information from RTHI

h) Once completed click 'send for authorisation.'

4. Allocated manager to review RTHI – This will also need printing and saving as a PDF prior to finalisation (To create a copy to send, click Print on the top left side of the RTHI screen, "Print Assessment" then click on the PDF icon at the top right of the RTHI screen, save).
5. Finalise RTHI form
6. Forward saved RTHI form onto: ERASE@durham.pnn.police.uk and Ashleigh Ditchburn Ashleigh.Ditchburn@durham.gov.uk
7. Supporting Solutions to close down Missing person episode
8. Allocated worker to follow up on any actions from RTHI.

Notes:

- If the manager is not happy with the quality of the RTHI, they can select "requires further information" which will send the RTHI back to the workers tray.
- Any case notes in relation to missing episode should be recorded within EHM case notes selecting "Return to home interview" from the drop down menu.
- When typing our RTHI's up we add a section at the end of our RTHI's, using signs of safety to review: What's working well? What are we worried about? Next Steps.
- Missing concerns and safety plans should be included as part of the child's plan.
- The missing episode will remain in the supporting solutions tray throughout the process.
- The RTHI should be completed and sent to ERASE as soon as possible.
- Any crimes should be reported directly through 101.

S7 Procedures

Section 7 Report under Section 8 of the Children Act 1989.

A Section 7 report is ordered by the Court when they want information about a child's welfare, what is best for the child and sometimes where there are certain risk factors or concerns raised in relation to a child, parent or other relative.

Occasionally the court will request a Section 7 report on families where there are Private Law Proceedings and with whom One Point may be working.

When a request for a Section 7 report is made by the court it will be completed by a Social Worker in Families First.

If One Point are working with the family the case will remain open to One Point. The plan of work will continue. There will be discussion with the Social Worker regarding One Point interventions.

The Process when a Section 7 request is made is as follows:

- Request for Section 7 is made by the court
- Request is processed via First Contact who will progress the request to the relevant Families First team through the Section 7 pathway on LiquidLogic.
- Families First Team Manager will allocate the case to a Social Worker.
- Families First Team Manager will email One Point/Family Hub Team Manager to inform them of the Section 7 report request and name of allocated Social Worker
- The report will be completed by the Social Worker
- One Point will continue their intervention and case will remain open EHM.
- One Point will continue to record on EHM
- If the case requires stepping up, the step up process will apply and Lead professional in One Point will follow the Step-up process.

Partnership Meetings

The County Durham Prevention and Early Help Forums are designed to strengthen joint working and consistency across partners to ensure that we work together to identify needs and provide support to children, young people and their families at the earliest possible stage, improving outcomes and reducing costs. They are designed to facilitate arranging support locally around families and communities which is called a ‘place-based approach’.

There are 3 Prevention and Early Help Forums across the County; North, South and East which meet termly. Smaller Task and Finish Groups maybe agreed to progress 'place-based' work between the Forums. For more information contact **fiona.smith@durham.gov.uk.**

It is an expectation that One Point Managers / VCS Alliance and Early Help Advisors attend for their area.

Families First

Locality Meetings

The purpose of the Locality Meeting is to ensure teams across Children Services work together in the best interest of children, young people and families to provide a

seamless service regardless of their level of need.

The group members will be responsible for ensuring effective service delivery through the development and implementation of service delivery plans across all teams.

The membership will consist of the following:

- Families First Operations Manager;
- One Point Service Operations Managers
- Families First Team Managers, Families First Social Work Consultants;
- One Point Service Intensive Family Support Team Manager; Senior Key Workers
- Family Hubs Team Managers
- Health Manager
- Social Inclusion Development Worker

The Locality Meeting are monthly, with dates agreed and set annually. They will be held for approx. 2 hours. The meetings will be held in each locality.

Health

One Point Service and 0-19 Family Health Service

Durham County Council's One Point Service and Harrogate and District Foundation Trust's Family Health Service meet regularly with Health Managers attending weekly Step-Up/Step-Down Meetings, monthly Locality Meetings and HDFT Manager attends bi-monthly One Point Senior Management Team Meetings. The purpose of these partnership meetings is to provide integrated early help for children, young people and their families from early pregnancy to the age of 19 years and for some children and young people who have a disability, up to the age of 25 years.

Chapter 16

Health and Safety

Durham County Council

Lone Working Arrangements

The One Point Service operates a Lone Working system called 'Care Connect'. All practitioners working face to face with children and families must complete the Lone Working Training prior to using the system. All practitioners are required to use the system at all times when undertaking home visits or when 'lone working' with a family in a non DCC building. It is essential for staff to consistently log in and out of the system for each home visit/when 'lone working', as alerts will be triggered to management and staff's emergency contacts maybe alerted where this does not take place.

Following recruitment, a new Lone Worker form must be completed.

- When workers move within One Point Teams where there is a change of manager, it is the workers responsibility to complete/submit a new Lone worker form with updated information.
- Team manager requests Lone Worker form is completed by staff member.
- Completed Lone Worker form is passed to Admin Locality Manager by Team Manager.
- Admin Locality Manager to upload the Lone Worker form onto SharePoint.
- Admin Locality Manager to forward the completed Lone Worker to the Admin Locality Manager who is dedicated Lone Worker Lead.
- Team Managers and OPS Operations Managers, to check monthly spreadsheet sent by Lone Worker Team for usage and accuracy.
- Where there are inaccuracies a new Lone Worker form to be completed and the above to be followed.
- Where workers are not using the Lone Worker system this is to be addressed in supervision.
- Continuous failure to use the Lone Worker system, Team Manager to escalate to Operations Manager and seek HR advice.
- Lone worker to be used when OPS staff member is 'lone working' with a family in a non-DCC building.

Transporting Children & Young People

Risk Assessment

This risk assessment is to be used for;

- Taking a child or young person to an appointment.
- Collecting a child or young person and transporting them to a group at the Family Hub.
- Taking a child or young person out as part of direct work.

These events do not need to be entered into EVOLVE but the following guidance should be followed by staff. Staff will continue to risk assess during the time they have the young person with them and put in control measures as appropriate.

Hazard	Risk	Persons at risk	Control measures/controlling risk	Comments/ actions
On foot	Injury, death	Children, Young people, Parents, staff	Work on foot planned to avoid fast roads wherever possible Supervision on pavements, roads and especially crossing of any fast roads is pre-planned Young people are briefed re hazards and behaviour required	Planning, leader and young person briefing
Use of private vehicles	Injury, death, allegations	Children, Young people, Parents, staff	Driver confirms car is insured to carry clients and is roadworthy i.e. business class insurance Seatbelts worn at all times and child car seats to be used when required Car seats to be inspected prior to use Staff to use the Lone Worker system Good practice is that 2 workers will be in the car with a child or young person Written consent obtained from parents Child / young person to sit in the rear of the vehicle, ideally behind the passenger seat. Child locks on rear car doors to be turned on. Additional consideration be given to any risk the child / young person presents; i.e. violence, aggression, mental health psychosis, history of allegations made to staff, to assess if transport can be provided safely Staff to have mobile phone with them and this to be charged Child/young person not to be transported if behaviour appears challenging etc	Check and follow Driving at Work policy Written consent gained from parents to transport child or young person Staff to use lone worker and record on voice recording names of people in the car and starting point, any planned stops and end point. Office to know planned route and estimated arrival time

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Hazard	Risk	Persons at risk	Control measures/controlling risk	Comments/ actions
Adverse weather conditions / road closures	Injury, death	Children, Young people, Parents, staff	Staff to ensure that vehicle is ready for changes in weather. To risk assess journey based on roads, route and weather conditions. To take extra care when driving in bright sun light, rain, sleet or snow. To only do journeys in snow that are absolutely essential. To ensure that all are dressed for conditions (all have coats in the winter) If caught out by unexpected weather to drive with extra care and attention. Driver to avoid minor roads. Staff to inform office of planned route home. Staff to contact emergency services in extreme cases	Worker to check weather forecast Office to be updated if planned route changes due to weather

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Offsite Activities

An offsite activity is an outing where children and young people are attending an activity, where One Point are involved in transport (this could be in vehicles or walking) and is not at their local One Point building. This could be either with or without their parents.

e.g. Family day trip to Hardwick Park, young people's holiday activity at Beamish, Young Parents end of programme activity, taking a child or young person to an activity at Moorhouse / trampoline centre, Family Hub activity at the beach where the staff are presenting and running the activity.

As a Service it has been decided that all trips of this nature are to be recorded on EVOLVE even if parents / carers are attending and are responsible for their own children. This allows for the tracking of all trips and shows evidence of risk assessment and approval should there be an accident or incident that needs to be investigated.

What is not an offsite activity?

- Taking a child or young person to an appointment
- Collecting a child, young person or family and transporting them to a meeting or activity at the Family Hub.
- Taking a child or young person out as part of direct work
- A session that One Point have funded at a local provider, but we are not transporting, attending or running ourselves (i.e. we pay for a family to attend a Family Activity at TCR's Hub but do not provide transport, we provide a swimming pass to a family for the local Leisure Centre)

Staff should refer to **Durham County Council's Policy and Guidance for Educations Visits, Off Site Activities and One Site 'Adventures' 2019** for procedures around this and use of the EVOLVE system.