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**EARLY HELP ASSESSMENT FRAMEWORK**

**IN KNOWSLEY**



**Feb 2016: NB. This document is under revision as part of the development of the Early Help Offer in Knowsley. For information on CAF processes and thresholds, contact the Early Help Assessment Manager on 0151 443 4092**

**FOREWORD**

This is a key document which will help us implement the Early Help Assessment Framework across all partner agencies in Knowsley. The ability to undertake one assessment and use this across agencies will ensure compliance with Government guidance and legislation around joined up services and a focus on prevention and early intervention for children, young people and their families. Importantly, it will help us to protect children and young people and give clarity on thresholds and roles and responsibilities for all agencies. This is an important Government driver for improving services and we all have responsibility for making this work.

We see the implementation of the Early Help Assessment Framework as a key priority in Knowsley and welcome the opportunity to strengthen our partnership working and our joint responsibility for planning and delivering services for children, young people and families across the Borough.

The document sets out the Early Help Assessment Framework procedures, gives helpful case studies and sets out useful information on the role of the Lead Professional. I hope you find the document useful and thank you for supporting our vision to improve outcomes for children and young people in Knowsley.

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**NB**

**This is a working document and therefore will be reviewed on a regular basis**

**EHAF MODEL IN KNOWSLEY**

**Summary/Introduction**

Following the death of Victoria Climbie and the subsequent inquiry by Lord Laming, the government revised its legislation regarding the safeguarding of children (Children Act 2004) and introduced the Every Child Matters – Change for Children agenda. This legislation states that no single agency has the responsibility to ensure a child/young person’s needs are met and that a co-ordinated, multi-agency approach from every Practitioner working with that child/ young person is essential to ensure needs are met.

As such, Knowsley is developing its services to provide more effective, earlier interventions for its children and young people to ensure that they can achieve the 5 outcomes:

* Be Healthy
* Stay Safe
* Enjoy and Achieve
* Achieve Economic Well-being
* Make a Positive Contribution

The model’s objective is to provide Practitioners with a framework for delivering services to children, young people and their families by:

* Providing a framework for co-ordinated multi agency working to support children in achieving their full potential across the 5 outcomes
* Focusing on the early identification of children with additional support needs and provide appropriate, timely and co-ordinated interventions
* Minimising duplication in service delivery whilst maximising the efficiency of local resources
* Promoting a shared responsibility between all services working with children/young people and their families to ensure needs are met
* Creating a common language and clear procedures for integrated working across all services
* Recognise that children and their families have differing levels of need. Service delivery should be developed to meet these needs, including preventative services.

**Early Help Assessment Framework in Knowsley**

The Early Help Assessment Framework (EHAF) is a key part of delivering frontline services that are integrated and focused around the needs of children and young people, supporting them to achieve their full potential across the 5 outcomes. The EHAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. The process will promote more effective, earlier identification of additional needs, particularly in universal services. It is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking into account the role of parents, carers and environmental factors on their development. Practitioners will then be better placed to agree, with the child and family, about what support is appropriate. The EHAF will also help to improve integrated working by promoting co-ordinated service provision.

Within Knowsley, four levels of need have been identified and defined:

Knowsley Model of Children in Need

**Universal Need**

**1**

**2**

**3**

**Need For Support**

**4. Protection**

**Child Welfare Concern**

Examples of each level are shown below

Examples of each level are shown below:

Children, young people and their families can require support at any of the above levels and may move up and down levels dependent on their needs.

**Level 1 - Universal**

|  |  |  |  |
| --- | --- | --- | --- |
| No additional support required – Services for all children and families  | Possible indicators to be determined by assessment  | Possible agency involvement | AvailableAssessment Tools |
| Children where there is no concern regarding health or development | Children attending school regularlyChildren meeting developmental milestonesChildren appear happy, good level of emotional literacyStable, home environment, good attachmentsEffective support networks Children with carers who take advantage of universal services  | Universal ServicesHealth EducationLeisureCommunity Resources ConnexionsPolicePrivate day care, etcHousing | Routine assessments as required  |

Children at Level 1 should be able to reach their full potential across the 5 outcomes. If a Practitioner identifies a need at this level it is likely that a referral/appointment would be made internally or to another single agency that would address this need, but practitioners may find it useful in helping identify specific needs at this level to use an EHAF.

Examples of low level support would include offering advice and support, sign posting and referral on to other universal agencies.

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| **Case Study of Level 1**a) A Health Visitor makes a routine visit to a new mother. The mother is having difficulties breast feeding her baby and is worried the baby is not getting enough milk. The Health Visitor provides advice on breastfeeding techniques.b) A mother and her 2 year son regularly visit the local Children’s Centre for the ‘Mum’s and Tot’s session. She tells the Family Support Worker that she would really like to go back to work but she is not sure of her entitlement to benefits. The Family Support Worker makes an appointment for her to see the Children’s Centre’s Financial Advisor for further advice and information.c) Mary, a 15 year old girl is caught smoking by a teacher during lunch break. She tells the teacher that she has been smoking for several years. She says she wants to stop because she is finding it harder to do the sport she enjoys. She says she has tried and is finding it hard. The teacher makes a referral to the School Health Advisor to ask for smoking cessation help. |

**Level 2 – Need for Support**

|  |  |  |  |
| --- | --- | --- | --- |
| Need for support – Services for children and families with identified needs  | Possible indicators to be determined by assessment | Possible agency involvement | Available Assessment Tools |
| Children from households where the carer(s) is/are under stress which may affect their child’s health and development.Children whose health and development may be adversely affected  | Children who have regularly missed important health or education appointmentsChildren with isolated, unsupported carer(s).Families with a high number of children or more than two under five.Concerns re: possible parenting difficulties (unborn babies) Children or parents with mental or physical health difficulties.Young CarersChildren with additional needs Children who present management problems to their parents.Children in families where there is poor hygiene. Children identified by schools as requiring additional educational support.Children who have started involvement in criminal activities.Children involved in contact/residence dispute.Children of parents involved in substance misuse.Children of parents where there are concerns regarding domestic abuse.Children starting to have absences from school. Children experimenting with drugs/substances. Children unnecessarily accessing health services e.g. walk in clinics, A & E, GP  | Level 1 Services plus:Health – Specialist/Additional servicesEducation – Specialist/Additional servicesLeisure –Specialist/Additional servicesYoung Carers ServicesHome StartChildren’s Centres YWCA Domestic Violence Support ServiceYouth Offending Service Legal ServicesDrug and Alcohol Action TeamChild Development CentreNeighbourhood Nurseries Parent PartnershipMentoring SchemesSmoking Cessation TeamFamily Support Service | EHAFSEN Code of PracticeAPIRChild View (YOS)  |

At this level issues can be resolved by accessing appropriate support from available services (see Case Study 2a below). If the full needs of the child are not clear an Early Help Assessment could be completed at this level to assist in accurately identifying support required (see Case Study 2b below).

At this level, Practitioners should be able to provide assistance, advice and information. It should also be possible to offer specialist support and involve other agencies as appropriate. However if the support provided does not meet the needs of the child/young person and further intervention from other agencies is required, then the family support /EHAF model should be followed.

If the Practitioner decides that a EHAF is required then he/she should take the following steps:

**Step 1** – In order to find out who else may be working with a child, young person or family, the Practitioner should do a background information search on the Early Help Module (expected Summer 2016). As an interim measure, the Practitioner may contact the Early Help Team who will conduct a search on EHM. (Tel no 0151 443 4092/4707)*.*

This search will highlight:

1. whether an EHAF already exists and/or whether issues and concerns have been raised previously.
2. which services are currently or have been involved with the family

**Step 2** – Depending on the outcome of the search, the Practitioner has three options:

1. If the background information search identifies that the child has a Lead Practitioner or an EHA a in place, the Practitioner should contact the relevant Practitioner leading on the case to share his/her own concerns (see Case Study 2c below); or
2. If the background information search identifies that the child or young person is already well known to services and is receiving uncoordinated support, the Practitioner should call a multi-agency Team Around the Family (TAF) meeting with all those involved, including the family. The Practitioner is responsible for organising and chairing the meeting and also inviting the appropriate service providers. The meeting will serve to co-ordinate the response from all services and enable the relevant Practitioners to work closely with the family to share information and plan interventions, creating a Multi-agency Support Plan (See Case Study 2d and 2e below). Practitioners with limited experience of TAF processes can call on the assistance of the Early Help Team (0151 443 4092) who will advise on the process and offer hands-on support where practical
3. If the background information search identifies that the child or young person is NOT well known to services, apart from universal services, and there is no existing or recent assessment information available, the Practitioner should intitiate an Early Help Assessment (in document form pending access to EHM). (See Case Study 2b below). If the Practitioner is confident with the assessment and knows which services could offer support to the family, the Practitioner can move straight to completing the EHAF and call a TAF meeting to create a Multi-agency Support Plan. This meeting should decide on the level of support required in relation to the Threshold Document and identify a different Lead Professional if this is appropriate.
4. If reviews of service interventions at TAF meetings show that progress is being made and the child’s/young person’s needs are being met, he/she may move down to less intensive support from Universal Services for example. If more time is needed to meet the family’s needs then Early Help should continue to be provided by the Lead Professional and partners until it is agreed that needs have been met as far as possible, support is no longer required due to progress, or an escalation of support is required (including to Children’s Social Care).

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| Case Study of Level 22a. Wendy is a 13-year-old girl whose self-esteem is low. She has started to take time off school with sickness notes covering her absence and her schoolwork is suffering as a result. Informal enquiries reveal that she is being bullied by a classmate. The Head of Year addresses the bullying. Wendy spends time with the School Mentor on a programme of support for victims of bullying. The programme addresses her self-esteem, how to stand up to bullying and how to report any further incidents. The bullying stops immediately and within a few weeks Wendy’s self esteem has improved and she is no longer missing school.2b. Michael is a 14-year-old boy. He has always been a confident young person who has participated fully in school life and in extracurricular activities. Recently however his self-esteem has dropped, he is withdrawn in class and does not participate in any activities. His latest exam results are disappointing. His friends do not know why he has changed. Rumours amongst other parents are that his mother has just left home and you believe his father has a disability. The Learning Mentor searches on EHM and finds that Michael is not receiving any support. The Learning Mentor approaches Michael’s father, expresses her concerns about Michael and offers support to the family. An EHAF assessment is completed to fully understand the family circumstances at this time and to gain an evidence-based assessment of the situation within the family. 2c. A Connexions PA (Personal Adviser) is working with Peter (15 years old) on his options for further education. During conversations Peter says that he needs a job to get a flat of his own. He says he does not get on with his parents and he has run away from home and is staying with friends. The Connexions PA uses EHM to see if any other services are involved. The search reveals an EHAF was completed on Peter 6 months ago and that he has a Lead Practitioner and a Multi-agency Support Plan in place. The Connexions PA contacts the Lead Practitioner and shares this new information. As Peter will continue to need support into further education, the Connexions PA is invited to join the TAF Meeting and contribute to Peter’s Plan. 2d. A Health Visitor makes a routine visit to a family with a new-born baby. Whilst at the house, mum says she is fearful she will lose her home as she has not paid the rent and the local Housing Authority are moving towards eviction. She is a single parent with two other children to care for and the eldest, Josh (5 yrs), has suspected ADHD and mum finds it difficult to cope with his behaviour. All the children look well cared for, but it is clear Mum is struggling and the Health Visitor fears that things could get worse for the newborn unless mum receives some support for finance, housing and Josh’s behaviour. 2e. A background check on EHM shows that Josh is known to the School Health Advisor and the Educational Psychology Service. The local Children’s Centre and the Vulnerable Tenancy Support Service have also been involved with the family. Many of these services were involved with the family before the local implementation of an EHA and therefore there is no EHA, TAF or Multi-agency Support Plan in existence. The Health Visitor recognises that this family is receiving a lot of support but that the services involved need to become co-ordinated. As such, she calls a TAF meeting to bring all of the services together, with the family, to share information and to agree support. A Multi-agency Support Plan is completed which outlines the existing work and new areas of work. The group agrees who will be the Lead Practitioner and the Health Visitor formally hands responsibility for the case to the new Lead Practitioner. |

**Level 3 – Child Welfare Concern**

N.B. BEST practice dictates that consent should be sought for the sharing of information. Practitioners can share information without parental consent if they feel this is in the best interest of the child.

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| --- | --- | --- | --- |
| **3.** Child Welfare Concerns - families with complex problems | Possible indicators to be determined by assessment | Possible agency involvement | Assessment |
| Child Welfare Concerns - children & young people who may be at risk due to concerns regarding parental involvement/compromised parenting | Children with emotional/behavioural disorderChildren regularly absent from school/outside school altogetherChildren beyond parental controlChild being considered for an anti-social behaviour orderHomeless children/young peopleChildren with chronic ill health or terminal illnessChildren whose parents’ life-styles mean they are unable to meet their basic needsChildren previously on the Child Protection Register/ List of Children Subject of a Child Protection Plan or siblings of a child who is the Subject of a Child Protection PlanSiblings of Looked After Children Children with mental health/well being issuesChildren in families where there has been one serious incident of domestic violence or several lesser incidentsUnaccompanied children/asylum seekersChildren with severe disability Children in families where parents/carers have substance dependencyChildren/young people with substance dependencyChildren and Young People with / without disabilities, including unbornchildren, who are likely to have a high level of needs, where parenting may becompromised, and may be identified as follows:• Children and Young People with disabilities with complex needs where impact onparenting could lead to breakdown in care arrangements• Children / Young People from families experiencing a crisis likely to result in abreakdown of care arrangements• Children and Young People may be deemed to be at increased levels of risk becauseof the parenting they receive, which is likely to be compromised by some of thefollowing factors:• living in household where there has been one serious or several significant incidents ofdomestic conflict/abuse• who have previously been subject of a Child Protection Plan• with high level of needs whose parents do not accept the concerns of Practitioners• with high level of needs where there is little confidence that parents will accept servicesor remain involved with them• needs arising from emotional and mental instability and / or including self harmingbehaviours which involves multiple serious incidents and admissions to hospital | Level 1 & 2 Services Plus:Child & Adolescent Mental Health ServicesWillis House Learning Disability TeamSpecialist health or nursing provisionFamily First 0-18Children’s Social CareCRI-drug and alcohol servicesPortage | EHAFFramework for Assessment for Children and Families in need.Initial AssessmentCore AssessmentEducation Health Care PlanChildren with Disabilities Team (CSC) |

At this level, Section 17(1) of the Children Act (1989) states that it is the general duty of each local authority:

* To safeguard and promote the welfare of the children within their area who are in need; and
* So far as is consistent with that duty, to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children’s needs.

A child is taken to be in need if

1. He is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a Local Authority
2. His health and development is likely to be significantly impaired or further impaired without the provision for him of such services, or
3. He is disabled

Therefore, at this level it is likely that the child/young person will already be known to services due to the complexity of their presenting needs. This should be identified through an Early Help Assessment.

Many concerns about children/young people can be reduced at this stage by appropriately matching need to services. Practitioners working with a child or young person with presenting needs at Level 3 should therefore follow their internal procedures. For example; contacting the Lead Safeguarding Person in their organisation with a view to seeking further advice and guidance.

If an Early Help Assessment identifies the potential needs for services from the Children & Families’ Division, the completed EHA must be shared with the Children & Families’ Division at the point of contact, and consent sought from the child’s parent/person with parental responsibilities.

At this point the Children & Families’ Division/Local Children & Families’ Social Work Team would consider the child’s identified needs and whether or not it is appropriate to undertake an Initial or Core Assessment.

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| Case Study of Level 3a) A detached Youth Worker talks to 14 year old Kayleigh on the streets one evening. The Youth Worker knows Kayleigh as she used to attend the local Youth Club. The Youth Worker notices that Kayleigh is very drunk, suspects she has been using cannabis and feels she is very vulnerable in her drunken state. The Youth Worker is concerned about Kayleigh so conducts a search on EHM to see if other services are involved. The search reveals that she has a Family First 0-18 Worker as her Lead Practitioner and that there is a Family Support Plan in place. The Youth Worker contacts the Lead Practitioner to update him on the recent events.b) A Learning Mentor is working with Aron, aged 11 years. He is often misbehaving at school and has had a number of short term exclusions for hitting other children and threatening staff. The mentor also knows that Aron is being aggressive to his mother, (who is disabled) and younger siblings and is hanging around with older youths in the community. Other pupils have reported that he brags about knowing how to take drugs. He is under-achieving at school and will not achieve his potential. School check EHM and find that Aron has been known to Social Care but currently has no involvement from CSC or other family support service. The combination of Aaron’s issues seems beyond the scope of the mentor to address from school alone. The Learning Mentor, with the agreement of Aron’s parent, initiates an EHA and calls a TAF to which an Early Help Co-ordinator is invited. From information shared at the meeting it becomes clear that Araon’s needs are multiple and complex and that mother is struggling to manage her home and all of her children. The threshold document indicates that these needs fall within the bounds of Level 3 need and the EH Co-ordinator recommends escalating the case to Family First 0-18 for whole family, mutli-agency co-ordination. The mentor transfers the case to FF but stays involved and responsible for their elements of the developing Family Support Plan to co-ordinate his care and review his needs.  |

**Level 4 – Need for protection**

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| --- | --- | --- | --- |
| Need for Protection – High risk of family breakdown | Possible indicators to be determined by assessment | Possible agency involvement | AvailableAssessment Tools |
| Children experiencing significant harm or where there is a likelihood of significant harm. | Children Subject to a Child Protection PlanChildren from families experiencing a crisis likely to result in a breakdown of care arrangements. Children whose parents are unable to provide care whether for physical, intellectual, emotional or social reasons.Children whose behaviour is sufficiently extreme to place them at risk of significant harm e.g. control issues, risk taking, dangerous behaviour, sexual exploitation.Children who disappear, or are missing from home on a regular basis.Children in the households where parents/carers have all of the following problems: mental health, substance dependency and domestic violence. | Services at Levels 1, 2 + 3 plus:Specialist multi-agency funded placementsKnowsley Adoption and Fostering Service Residential Services Probation Services  | Child Protection enquiriesFramework for AssessmentCore Assessment |

A child in need of protection will be assessed under section 47 of the Children Act 1989 which states:

Where a Local Authority

a) Is informed that a child who lives, or is found, in their area

 i) is the subject of an emergency protection order; or

 ii) is in police protection; or

b) has reasonable cause to suspect that a child who lives or is found in their area, is suffering or is likely to suffer, significant harm, the authority shall make, or cause to be made such inquiries as they consider necessary to enable them to decide whether they should take an action to safeguard or promote the child’s welfare.

Therefore, many children and young people at this level will have their needs met through existing Safeguarding procedures for multi-disciplinary working. [www.knowsleysafeguardingchildren.co.uk](http://www.knowsleysafeguardingchildren.co.uk) . If safeguarding procedures are in place, but some of the child’s needs are not being met, Practitioners should identify the statutory Lead Practitioner and the concerns should be re-directed appropriately (See Case Study 4a and 4b below). It is not appropriate for children and young people at this level to be discussed at a Service Allocation Meeting.

In the unlikely event that a child is assessed to be at Level 4 but is not currently receiving a service (e.g. those with acute illness, mental health needs, complex disability), the procedures outlined at Level 2 / 3 should be followed to identify needs and take appropriate action. However, if a child/young person is identified as being at risk of significant/immediate harm, Practitioners should not follow the procedures set out for Levels 2 & 3. They should immediately make a direct referral to the local area Children & Families Social Work Team and follow up with an EHA within 48 hours if appropriate.

Once the child/young person is making progress and is moving towards achieving their full potential across the 5 Outcomes, he/she may move down to an appropriate level. At lower levels, the child’s/young person’s needs will be monitored closely through both specialist support and Multi-agency Meetings.

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| **Case Study 4 - Level 4 CIN**Joel is 22 months old. His mum has brought him in to the nearest A&E department with a scald. Mum said that this happened when Joel spilled a cup of tea over himself. Hospital records show that Joel came to A&E two months ago after swallowing medication at home. Following this incident a Health Visitor visited the family at home on an unplanned visit. In the Health Visitor’s records it had been noted that Joel had missed his 8-9 month development check. During this visit the Health Visitor discussed home safety with Joel’s mum. At this visit the Health Visitor picked up that Joel’s mum had some mild learning disability. The Health Visitor referred the family, with mum’s consent, to the local Children’s Centre which both Joel and mum have been attending since. An EHA is in place with a Support Worker from the Children’s Centre as the Lead Practitioner.Whilst treating Joel’s scald to his neck and chest bruising to his abdomen is noted. Upon further examination it is discovered that Joel has a cracked rib. The hospital contacts the local Children & Families Social Work Team and an Initial Assessment is undertaken taking into account information in the EHAF and the latest information from Health Colleagues. The Children’s Centre support worker continues to provide support until the outcome of the Initial Assessment is known and a decision is made as to whether the case should ‘step-up’ to Level 4 or remain open to services at level 3. |

**EHAF Procedure within Knowsley**

The EHAF exists to support children, young people and their families. It will help to ensure that children and young people receive the right support at an early stage, as a preventative measure. As the EHA is a shared assessment, overseen by single practitioner but including the contributions of others, it will also prevent families having to repeat the same story to different practitioners.

Having identified that a child has additional need(s), Practitioners must decide whether this need can be met via a referral to a single external agency or whether the needs are more complex, requiring referral to two or more teams. If the presenting needs can be met by a single agency then existing referral procedures can be used and there is no need for an EHA. However if the presenting needs require support from two or more teams then the EHA must be completed and the following process followed:

* Use the EHM when available, to check if an EHA already exists and support is in place.
* If an EHAF already exists, the practitioner should contact the Lead Practitioner to discuss the issues. If the practitioner has access to EHM and they could request permission to contribute the EHM episode and become part of the TAF process making contributions to ongoing review and assessments.
* If an EHAF does not exist then an EHA should be completed with the child and/or family. At this time informed consent must be obtained to share the information with other teams/agencies.
* If not created on EHM, the completed EHA must be logged centrally with the Early Help Assessment Manager who will record on EHM that an EHA and support are in place.
* The Lead Practitioners must co-ordinate the actions of the multi-agency teams plan and ensure that it is reviewed in a timely manner (suggested maximum of 6-8 weeks);
* At this review, it may be decided that the child’s needs have been met and the EHA and can be closed. At this point the EHA must be closed on the EHM system.
* Consent should be regularly reviewed as the family also has the right to withdraw consent at any stage. If this was to happen the Practitioner should follow their own internal procedures but recorded on EHM

* If during discussion with the child/young person/family it has been identified that an EHAcannot go ahead due to lack of engagement with the family and the Practitioner is of the view that the child/young person may be at risk of significant harm. The Practitioner should speak with his/her local named Safeguarding Person.

**Consent**

Consent is the key to successful information sharing and central to the EHAF process as without the family’s consent the EHA process cannot proceed. As such, it is essential that children, young people and their family understand the EHAF process and how their information will be shared between agencies.

Throughout the process, Practitioners should discuss the issue of consent with the family and explain why it may be necessary for agencies to share information. The Practitioner should be clear about what information is likely to be collected, how it will be used, who it will be shared with and why. Children, young people and their families may agree only to partial consent, specifying what information may be shared and with whom. The individual’s wishes should be respected, unless a child is at risk of harm.

There are some circumstances in which it would be appropriate to share information without consent, such as:

* the disclosure prevents the child/young person from committing a criminal offence or places the Practitioner at risk of collusion;
* the child/young person is at risk of significant harm or harming someone else;
* the information is required as part of a legal proceeding;
* information is requested by the police as part of a criminal investigation;
* in any other circumstance where public interest overrides the need to keep information confidential.

When decisions are made to share information without consent, the reasons for doing so should be recorded and the family should be made aware (if this does not place the child at increased risk of harm).

**Working with young people and consent**

Although the EHAF process focuses on the need to share information and the importance of including the whole family in assessment, Knowsley recognises that young people may not always want to involve their families in decision making. As such, procedures have been established to allow young people to consent to the EHAF process alone if they are of sufficient maturity and development (see below).

When working with a young person it is important to encourage them to discuss issues with their parents/carers, however this may not always be appropriate. At this point, depending on the young persons needs, it should be explained that only limited support may be offered to meet their needs as many services work with the whole family. However, the young person should be reassured that the appropriate services will work with him/her and respect their wishes if they are deemed to be ‘Fraser Competent’

A young person (12 years and over), who has the capacity to understand and make their own decisions, may give (or refuse) consent to sharing information. In these circumstances the young person is deemed to be ‘Fraser Competent’

A child has sufficient understanding if they can:

* understand the question being asked of them;
* have a reasonable understanding of: what information might be shared; reasons for sharing the information;
* implications of sharing/not sharing the information;
* appreciate and consider alternative courses of action;
* weigh up one aspect of the situation against another;
* express a clear personal view on the matter;
* keep a reasonable consistency in their views.

Any child below the age of 16 can give consent when they reach the necessary maturity and intelligence to understand fully the intervention proposed and the consequences of their decision. However the Practitioner must consider the fact that intelligence and the ability to understand will vary greatly for every child, so the decision of ‘Fraser Competency’ must be carefully considered. If a child is deemed ‘Fraser Competent’ after receiving all appropriate information regarding the intervention, then the consent (or refusal to consent) is valid.

Young people should also have a say in who will act as their Lead Practitioner. Provided they have the skills and knowledge, any Practitioner may be requested to act as a Lead Practitioner, meaning that those who specifically work with young people, such as a Youth Worker or a Connexions Personal Adviser, could take on this role. The young person should feel comfortable with the Practitioner and able to express their opinions, knowing that the Practitioner will work in partnership with them to ensure their needs are met.

**The Team Around the Family Meeting (TAF)**

\*The Practitioner who completes the EHAF with a family should call a Multi-agency meeting. These meetings are a way in which to co-ordinate the delivery of services to a family. Attended by the family and representatives from each service working with that family, these meetings will ensure that children/young people are receiving the support they need and that the family is involved in the decision making process.

The Practitioner who has completed the EHA is responsible for:

* Convening the meeting;
* Inviting the child/young person/family and Practitioners working with the family to attend ;
* Ensuring that the family have consented, fully understand the process and are able to contribute to the proceedings;
* Sharing information;
* Agreeing actions for the Multi-agency Support Plan.

It should be a requirement of this meeting that a Lead Practitioner is appointed and agreed upon in consultation with the multi-agency team and the family. This does not need to be the person who has completed the EHA but the Lead Professional will assume responsibility for the EHA and subsequent planning and review (see below).

To ensure that services are delivered in a timely, co-ordinated manner, the Practitioners involved in EHA support should complete meetings and reviews within the following recommended time frames:

* TAF meetings should be held within 15 working days of completing an EHA. It may be appropriate to convene a TAF to inform the completion of the EHA however.
* Multi-agency support plans need to be reviewed approximately every 6-8 weeks (maximum suggested time lapse of 3 months)

**Lead Practitioner**

The Practitioner who completes the EHA is responsible for convening the intial TAF Meeting. It is at this meeting that a Lead Practitioner will be appointed. This decision is made in agreement with the multi-agency team and the child/young person/family, based on the ability of the Practitioner to coordinate services that meet the needs of the family.

The responsibilities of the Lead Practitioner include:

* acting as a single point of contact for the child/young person/family;
* acting as an advocate for the family, ensuring that their needs are being met and that they are kept informed of progress, so that they may contribute to proceedings;
* ensuring that children, young people and families get appropriate interventions and that these are well planned, reviewed and effective.

When a Lead Practitioner has been assigned they are responsible for:

* keeping an overview of what is to happen;
* monitoring progress on behalf of the group;
* keeping track of plans and timescales, ensuring regular reviews, calling and chairing further meetings;
* making sure all Practitioners involved know what they need to do.
* making sure the family are aware of information sharing;
* being the first contact for any new Practitioner;
* being the first contact for the family or young person;

Although the Lead Practitioner will be the main point of contact for the family, each service represented on the Multi-agency Support Plan will have shared responsibility for the outcomes and service delivery within their own agency. The Lead Practitioner is NOT responsible or accountable for the quality of services delivered by other agencies.

**Conclusion**

The EHA model provides a framework to develop effective multi-agency working. All Practitioners, regardless of their role, should be working to the same procedure.

By providing a common language around levels of need and clear guidance on the EHA process, Practitioners should be able to clearly identify a child’s/young person’s needs and be able to offer the relevant services to support them. Monitoring this service provision will provide Knowsley with an up to date needs analysis, allowing gaps in service provision to be identified. As such, these processes can be utilised to inform future commissioning decisions.

Following this model will help to ensure that services within Knowsley not only meet the requirements of the Children Act 2004 but also co-operate to improve the outcomes for children and young people within the borough.

**GLOSSARY OF TERMS**

ECM Every Child Matters

EHAF Early Help Assessment Framework

SEN Special Educational Needs

Connexions PA Connexions Personal Advisor

SENCo Special Educational Needs Co-ordinator

EHM Early Help Module

ISA Information Sharing Assessment

CYP Children and Young People

TAF Team Around the Family (meeting)

DCSF Department of Children, Schools and Families (National)

DCFS Directorate of Children and Family Services (Knowsley)