Council of the Isles of Scilly Early Help Assessment

Information for children, young people and families

* When the form refers to “you” it means the child or young person being assessed.
* This form belongs to you. It is to help you record information and make a plan. The information you share with us will not be shared with anyone else without your consent unless you are at risk of harm.
* You should keep the original copy of this form. Keep in a safe place with other important documents.
* You can use this form at meetings and appointments so that you can share important information easily and other can know about your plan.
* You can also ask for the form to be updated if your plan changes.

**Your details**

**Child or young person’s details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | | | |
| Telephone/Contact details | | | | |
| Male | | Female | DoB or EDD |  |
| Address | | | | |
| Post code |  | | | |

**Child or young person’s details continued**

|  |  |  |
| --- | --- | --- |
| Religion |  | |
| First language |  | |
| Do you understand written English? Please tick | | Yes  No |
| Are you disabled? Please tick as appropriate | | Yes  No |
| If yes, give details | | |

|  |  |  |
| --- | --- | --- |
| Do you need an interpreter or signer? Please tick as appropriate | | Yes  No |
| If yes, has this been arranged? Please tick as appropriate | | Yes  No |
| Details of any special requirements | | |
| **Who lives with you (the child)?** | | |
| Name | Date of birth | Relationship to you |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Other significant family members** (e.g. friends, family, parents without parental responsibility) | | |
| Name | Date of birth | Relationship to you |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Details of person/s with parental responsibility**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name |  |
| Address | | Address | |
| Contact details |  | Contact details |  |
| Relationship to you | | Relationship to you | |
| First language |  | First language |  |
| Are any additional communication methods needed. Yes  No | | Are any additional communication methods needed  Yes  No | |

**People / Agencies involved with your family**

|  |  |  |  |
| --- | --- | --- | --- |
| Agency | Practitioner’s Name | Contact Details | Contributed towards assessment? |
| GP |  |  |  |
| School / Nursery |  |  |  |
| Health Visitor / School Nurse |  |  |  |
| Add other agency/ies involved with the child/family below: | | |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

CENOGRAM

**Our details (the professional undertaking this assessment)**

|  |  |
| --- | --- |
| Date of assessment (THIS NEEDS TO BE COMPLETED) | |
| Name of person undertaking assessment | |
| Role |  |
| Organisation |  |
| Address and Postcode | |
| Contact details (Phone & Email) | |

**Family Summary**

Consider both the strengths and worries for the child. Be clear about what the current worries are and how the strengths support improvements for the child. Be clear about what you consider what could happen if the worries are not sorted out. Include Health, Development, Education, Parenting Capacity, Family and Environment factors.

**What are we worried about?**

*What has happened or what have you seen that has made you worried about this child/YP*

**What is going well?**

*Thing that are going well, resource in place, and things which can be built on to reduce the worries.*

What are you worried will happen if nothing changes for the child (worry/danger statement and professional analysis)

**What needs to happen?**

*What does the parent, child, practitioner need to see happen to be satisfied that the worries were sorted out (wellbeing outcome).*

Child or Young Person’s views on the assessment.

Parents’ or Carers’ views on the assessment.

**Wellbeing scale (must be completed)**

Given what you have talked about, how well do you think things are, zero being not well at all and we need help and 10, not worried at all and you can end the assessment.

Child/Young Person

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MCj04238440000[1] |  |  |  |  |  |  |  |  |  | MCj04238420000[1] |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |

Parent

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MCj04238440000[1] |  |  |  |  |  |  |  |  |  | MCj04238420000[1] |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |

Professional

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MCj04238440000[1] |  |  |  |  |  |  |  |  |  | MCj04238420000[1] |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |

**What needs to happen here and now today?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Actions following assessment | | | | |
| Consent withdrawn before or after EHA completed | |  | TAC/F to be convened |  |
| Escalated to CSC | |  | Interim wellbeing goals to be completed |  |
| If other, please give details |  | | | |
| **If closure following assessment, the family’s needs had:** | | | | |
| Decreased | |  | Stayed the same |  |
| Increased (referral to other agency) | |  | Increased (CSC Referral made) |  |

**Interim Action Plan**

What needs to happen pending the TAC/F meeting.

|  |  |  |  |
| --- | --- | --- | --- |
| What are our Goals and Aims | What actions or support are required? | Who will be doing this? | On what date will this be reviewed? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Date assessment sent to CSC Coordinator | |  | |

**Ethnicities**

|  |  |
| --- | --- |
| Mixed – Other Mixed Background  Mixed – White and Asian  Mixed – White and Black African  White Other European  Mixed – White and Black Caribbean | White British  White Irish  White Other Cultural Background  Any Other Ethnic Group  Client declined |

**Your consent for information sharing and storage**

(Please send a copy of this page, signed, to the Early Help Assessment Coordinator)

|  |  |  |  |
| --- | --- | --- | --- |
| Do you agree to the information recorded on this form being shared with other practitioners and /or services in order to support you? Please tick as appropriate | | | |
| Yes | No | Some | |
| If no or some, what information can/cannot be shared and with whom? | | | |
| **I agree that the information on this form can be securely stored centrally by the Early Help Assessment Team** | | | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Carers’ Name: |  | | |
| Signature: |  | Date: |  |
| Child’s Name: |  | DOB |  |

**Give a copy to the child, young person or family,** retain a copy for the practitioner and, if consent given, sent a copy to:Children’s Social Care, Carn Thomas, St Mary’s, Isles of Scilly, TR21 0PT01720 424354

[ChildrensSocialCareGC@gcsx.gov.uk](mailto:ChildrensSocialCareGC@gcsx.gov.uk)

This is for secure storage and to avoid duplication only. The Children’s Social Care Team will not use this Early Help Assessment for any other purpose or share information without your consent. If you do not consent to information being shared, this may impact on our ability to provide services to you and your children.

|  |
| --- |
| **Data Protection Notice** |
| The personal information that you give us will be processed by Council of the Isles of Scilly in accordance with the Data Protection Act 1998 and will only be used for the purpose(s) of providing services to you and your children. This information will only be shared within the Council and with other organisations to ensure the best possible outcomes for your family but may also be disclosed if required by over-riding legal statute or, to protect you or others from harm. |

**APPENDIX 1**

|  |
| --- |
| **TAC/F Meeting Minutes** |
| Name of Children:  DOB:  Address: |
| Attendees:  Invited but did not attend: |
| Overall aim of the previous plan: |
| What is working well: |
| Child’s voice: |

|  |  |
| --- | --- |
| **Danger/Well-being Statement:** | |
| **Well-being/ Safety Goal:** | **People who will help to achieve this goal:** |
| **Actions to achieve the Wellbeing/Safety Goal:** | **Timescales and by Who:** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Lead Professional Name: | | |  |  | |  |
| Lead Professional Role: | | |  |  | |  |
| Lead Professional Organisation: | | |  |  | |  |
| Lead Professional Telephone | |  | | Lead Professional email: |  | |
| Next meeting date: | | | Click here to enter a date. | | | |
| *Please note, invitations will not be sent out so please put this date in your diaries* | | | | | | |
| Location: | | |  |  | |  |
| Copies to: |  | | | | | |
| Signed:  Name:  Position:  Date: | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Presenting Needs (from Early Help Assessment):** *Please tick* ***all*** *that are appropriate* | | | | | | | |
| Adults or children with potential crime problems |  | Child Sexual Exploitation (CSE) concerns |  | Missed multiple immunisations | | |  |
| Adults/children referred with unhealthy behaviours eg obesity, malnutrition or diabetes |  | Child Sexualised behaviour |  | Not in Education, Training Employment (NEET) | | |  |
| Adult Disability / Special Educational Need |  | Child Substance / Alcohol Misuse |  | Not taking up Early Years Entitlement | | |  |
| Adult frequently in/out of work |  | Child Victim of Bullying |  | Parenting | | |  |
| Adult Mental / Emotional health |  | Community Isolation |  | Parent Substance / Alcohol Misuse | | |  |
| Adult Physical Health |  | Debt / Money Management |  | Parent serving community service in last 12 months | | |  |
| Adults with a proven offence in the last 12 months |  | Domestic Abuse |  | Parents with less than 12 months on sentence | | |  |
| Child Bully |  | Direct Payments |  | Pupil is not on a school roll | | |  |
| Child Challenging Behaviour |  | Economic Disadvantage |  | School Attendance Issues | | |  |
| Child Disability / Special Educational Need |  | Family Function |  | Self-Harm | | |  |
| Child in Pupil Referral Unit or alternative provision |  | Gang member |  | Teenage Pregnancy (under 18) | | |  |
| Child Mental / Emotional health |  | Homelessness issues |  | Young Carer | | |  |
| Child Neglect |  | Housing / Rent Issues |  | YP leaving school with few/no qualifications - NEET | | |  |
| Child Physical health / Development |  | Missed appointments with the health visitor |  |  | | |  |
| **Please tick as appropriate below: (This must be completed)** | | | | | | | |
| If Child Sexual Exploitation (CSE) is a concern, has the CSE Screening Tool been completed? | | | | Yes: |  | No: |  |
| Is this Early Help Assessment Episode as a result of a step-down process from Children’s Social Care? | | | | Yes: |  | No: |  |
| Was a referral to Children’s Social Care made as a result of this assessment? | | | | Yes: |  | No: |  |
| **If a referral to any other service was made, please identify which service/services**: | | | | | | | |
|  | | | | | | | |
| **Did the assessment result in the Early Help Assessment being closed?** | | | | Yes: |  | No: |  |
| Date Early Help Assessment Closed: |  | | | | | | |
| **Reason for Closure:** | | | | | | | |
| Needs Met |  | Consent withdrawn before actions delivered | | | | |  |
| Family moved out of Somerset |  | Escalated to CSC | | | | |  |
| If moved out of Somerset, has cross border handover been made? | | | | | | |  |
| Other: |  | | | | | | |
| **At Early Help Assessment Closure the family’s needs had:** | | | | | | | |
| Decreased |  | Stayed the Same | | | | |  |
| Increased (Referral to other agency) |  | Increased (CSC Referral made) | | | | |  |