



**MANCHESTER
CITY COUNCIL**

**What Does 'Good'
Look Like in Child
and Family
Assessments?**

**Aide Memoire for
Manchester City
(MCC) Children's
Services Social
Workers and
Managers**

**Aligned to MCC
Practice
Standards and
Procedures and
statutory
guidance**

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WHAT DOES 'GOOD' LOOK LIKE IN CHILD AND FAMILY ASSESSMENTS (CAFA)

This is an aide memoire for use when planning, doing, writing, reviewing, and ending CAFAs. It should be read alongside MCC Children's Services' Tri-X procedures, Practice Standards and the CSS Quality Assurance Framework. It is assumed that workers will adhere to these, including meeting timescales. This aide memoire assumes that the Signs of Safety practice model is used. Indicators of 'good' assessment practice are cited below. These are based on local procedures, plus Ofsted Inspections' Key Judgement Criteria, Ofsted's Thematic Report "The Quality of Assessments for Children in Need of Help" (2015) and 'Working Together to Safeguard Children (2015)'.

SIGNS OF SAFETY PRACTICE MODEL (SOS)

Ofsted (2015) found the best assessments are done when the LA adopts a robust practice model which workers then use. Signs of Safety (SOS) is the model used in MCC. This is important because (some) procedures focus more on *what* to do. SOS focuses on *how* to do. SOS will suffice in almost all cases. Where another model is used in CAFA, e.g. PAMS, this can only be with the permission of a manager.

THE IMPORTANCE OF THE MANCHESTER MULTI-AGENCY NEEDS AND RESPONSE FRAMEWORK

The Manchester Multi-Agency Needs and Response Framework is sanctioned by MSCB for use by *all* agencies. It *must* be used to inform decisions to allocate for assessment and do, review and end all CAFAs.

WHAT GOOD LOOKS LIKE - INDICATORS

In the rest of this document, headings and sentences in (blue) bold equate to key indicators of 'good'. Followed by criteria that evidence these were met. It is assumed all work takes account of the diverse and individual backgrounds of the families MCC CSS works with.

1. ASSESSMENTS ARE CHILD FOCUSED

Child observed/engaged early and often enough, including about decisions to signpost/transfer/NFA. Seen alone unless recorded good reason why not.

Clear 'pen picture' of child, strengths, needs, vulnerabilities and progress child comes 'alive' by succinct description of their situation, and **Physical**, **I**ntellectual, **E**motional and **S**ocial (PIES) presentation as judged against relevant developmental milestones.

Child's voice evident record *makes clear when child's voice is being noted*. Voice evidenced by eg directly quoting child's own words/vocalisations (verbatim quotes), silences, facial expressions, physical appearance, behaviour, writings and drawings. Also voice noted indirectly as expressed by child-focused adults. This includes family and professionals advocating for the child or *putting themselves' in the child's shoes'*. Records show consideration was given throughout to the potential or actual impact on the child of views, actions/behaviours or decisions by adults, *both family and professionals*. Record differentiates between children's wishes, feelings and best interests.

Child is involved in assessment age-appropriate means used eg observations of non-verbal babies, toddlers in family and other settings, or direct work with older children at home or elsewhere. Managers challenge 'too young to express a view' statements for all but toddlers and babies. Toddlers and babies' interactions with carers and environment are noted. *Always note/scan completed tools used with/by child into ICS eg 3 houses.*

Siblings/connected children considered evidence that the welfare of siblings/connected children is addressed in light of information about the subject children

2. THE PURPOSE OF THE ASSESSMENT IS CLEAR

Type of assessment (eg s17, s47), and what is being assessed are both clear best expressed by clear referrals and using SOS,

mapping/columns, harm/danger statements, scales etc, even in s47 cases which necessarily exclude family from strategy discussions.

3. PLANNING THE ASSESSMENT IS INCLUSIVE AND SMART

Plans should be co-produced, early, using SOS except where unsafe to do so (start of s47), CAFA plan is co-produced with families, children and relevant colleagues. SOS forms and methods used eg Assessment and Planning Form, mapping needs, harm/danger, followed by 'what needs to happen' and 'safety planning' exercises.

Outcome focused using SOS, plans *specify* which aspects of the child's physical, intellectual, emotional or social (PIES) needs will be assessed, alongside the parents' capacity to meet these. Simple language makes clear what families are being assessed against and what outcomes are desired eg what 'good enough' physical care would look (smell?) like? What an emotionally secure child this age would say and do? *What a good enough parent would say and do with, for, and around this child i.e. safe behaviour over time?*

Plans include timescales and clear roles, whilst fostering partnership and team-work CAFA plans are clear that the SW is lead professional, but also promote joint-working from the off. *Plans say who will do what, when, where and how during the assessment. This includes family (including extended/kin) and professionals. Unless there is good reason not to, joint-working by professionals on some tasks is the norm.* This includes some joint-visits/sessions: more efficient, less duplication for family, shared experience of the work and ownership of outcome.

Plans involve the right people, in the right way, at the right time in allocating joint and individual roles, a 'key group' is identified i.e. those most closely, or frequently, involved in the assessment. Big enough to do tasks effectively, small enough to avoid overwhelming families eg parents and between 3-5 professionals. A second 'wider assessment group' is identified to include those with time-limited or specialist assessment tasks. These can be useful for addressing 'complicating factors' eg grandparent living abroad, psychiatric assessment, housing or debt. Membership of both groups can change as assessments unfold.

Plans include input from adult services for parents as needed where parents have un-assessed/un-met needs or known problems with eg 'toxic trio' (common), assessment plans include input from services that assess or support adults, either as part of the key group or the wider assessment group. Managers check for this to prevent silo working. Joint visits, joint appointments, and joint sessions are promoted where possible.

Plans include review dates and contingency plans agreed at the outset, SOS safety planning can be used

4. CONDUCTING THE ASSESSMENT

It is assumed that SOS is used during visits and assessment sessions, and that partnership and joint work are used. Resulting in the following

Consent is addressed consent to seek information from agencies and others was secured or dispensed with, *and appropriate reasons recorded.*

The assessment draws skilfully on the Assessment Framework ('Working Together 2015') the assessment covers the 3 domains: child's developmental needs, parenting capacity, and family and environmental factors. This is done in a way that carefully reflects the *specifics* of the case, not in a mechanical or formulaic way.

The assessment focuses on the right issues assessment addresses needs and risks as agreed in the plan. 'Dynamic' assessments responding wisely to events/information is different from assessments wandering off key issues for no reason. Assessment focus did not change unless agreed by those involved. Significant changes in focus or deadlines made only with agreement of management to avoid drift and stop-start.

Proportionate and timely amount, type, and length of assessment activity, and recording, is right for the level and complexity of presenting concerns. Starts and ends in a timely way.

SOS 'EARS' approach used record shows questions and conversations elicit and amplify the most relevant information from family and professionals. Result is deeper understanding, meaningful dialogue.

Evidence of professional 'respectful curiosity' as appropriate, worker asks about anything that might impact on the child but not raised voluntarily by parents/family eg adults' own childhoods, past CSS involvement, past addresses, visitors to home, adult relationships, family's support networks, leisure activities: including social media, finances.

Information from family/kin is sought and used appropriately depending on case, includes from child, siblings, parents (including connected males, estranged or not), extended family/kin. *Where information is not sought from a relevant family member/kin, reasons are recorded.* Results in wider understanding of:- family history, the extent of agreement within the family about needs and risks, and extent of agreement between the family and professionals about these: avoided over-reliance on parental self-reporting only.

Information from agencies is sought and used appropriately depending on case type, sources include CSS history, Cafcass, *other* LAs, Police, Probation, Health eg GP, midwives, health visitors, school nurses, CAMHS, hospitals, Education e.g. pre-school, nursery, primary/secondary/college, Youth Justice, Housing etc. Don't forget checks with UK Armed Forces and foreign authorities if needed. Avoided over-reliance on parental self-reporting and meant more holistic assessment, highlighting behavioural patterns and similarities and differences in views between all parties about family functioning.

Effective observation and engagement of the child seen alone: child-friendly venues, techniques and tools, used to capture the child's presentation, functioning and voice, *resulted in clearer information about the child's experience of being parented, both negative and positive.*

Parents (and extended family/kin if needed) meaningfully involved records show an inclusive approach, using plain language and SOS tools and techniques. Enabled parents/family to show their understanding of 'good enough' parenting and their actual, or potential, attitude and behaviour towards or around the child, negative and positive: addressed risk whilst promoting positive change where possible. And avoided men being inappropriately excluded from the process.

Home environment checked extent depends on case detail. Bedrooms, food cupboards, living and eating spaces, dustbins etc all checked. Including for 'damage' (DV), hazards and evidence of inappropriate lifestyle i.e. drugs/alcohol. Ditto checks for 'child-friendly' regimes, activities, equipment, toys etc.

Past, present and future considered current needs/risks are assessed in the context of family history, past behaviours, past harm and these used to inform judgements about current and (potentially) future needs, dangers, safety planning.

Risks and protective factors are balanced done in a structured way. Appropriate risk assessment tools used, eg SOS scales, EARS, appreciative enquiry approach used, but worker alert to risk of disguised compliance and family closure versus willingness and ability of family to engage in assessment.

A bias for action is evident if needed, worker responded appropriately and quickly enough if emerging information required this; ranging from early case closure to emergency protective action, subject to management sanction as needed.

Worker balanced partnership approach with appropriate use of authority where needed, worker took authoritative stance and actions in child's interests, both with family and other professionals; done in a professional way.

5. SOCIAL WORK ANALYSIS, CONCLUSION AND RECOMMENDATIONS

The assessment report includes a social work analysis, not just a repeat of events or information worker does not simply recount the assessment process and/or repeat information and label that analysis.

The analysis is sound analysis includes clear statement about what was being assessed. Analysis flows logically from information gathered during the assessment. It summarise the child's current and, potential future, strengths, difficulties, and needs, the parents' capacity to meet needs, and any family or environmental factors relevant to the child's progress. A

structured approach (actuarial/clinical/stepwise) is used to identify high and low risk indicators - and protective factors. The analysis cites examples of actual behaviour observed, statements made and information gleaned during assessment. This backed by reference to practice wisdom, relevant guidance and formal knowledge eg re child development or the impact of substance misuse on behaviour. Research cited as needed. Evident that worker has considered arguments for *and against* her final conclusion i.e. weighed up *evidence* for agreed and contested explanations and opinions about the child's progress and quality of parenting.

Capacity for change is addressed where the assessment decides parenting needs positive change in the child's interests, the parents' capacity to change is described; including any changes already occurring during assessment. Done using recognised tools eg SOS or 'Cycle of Change' (Prochasta & Di Clemente) etc.

Conclusions and recommendations are clear and appropriate reader not left to draw own conclusions. Worker makes clear her conclusion. Recommendations flow logically from the conclusion be they NFA, step-down, continue under CiN Plan, escalate etc.

Impact on the child clearly considered in analysis, conclusions and recommendations, it is clear the impact on the child is the deciding factor.

6. RECORDING

However good practice is in life, poor recording will pull down grades, hence the following

Clarity about who's who family's' personal details, including alternative surnames and relationships, are clear and accurate. Ditto details of relevant extended family/kin and professionals in the case (with job titles and contact details of latter when first mentioned). ICS fields and e.g. genograms and eco-maps used to good effect as needed. Diversity information eg language, ethnicity, disability, sexuality is clear.

Assessments are well written (translated if needed). Plain English, is used, minimal jargon, up to date. Good balance of background information

and analysis. Child's voice is evident. Succinct, coherent, well laid out, free of mis-spellings, typos and errors. Not repetitious and proportionate in length. Everyday language used to describe *this* family's *specific* strengths and difficulties, not clichés or euphemisms. The purpose, process and outcome of assessment and who was involved are all clear. No poor/unedited cut and paste, good *concise* chronology: not wholesale pasted case notes. Opinion/fact separated, evidence-informed analysis feeds appropriate conclusions and recommendations.

The assessment report is fair and transparent report reflects the views of family, children and other professionals accurately. It weighs up positive family attributes against vulnerabilities, including how agency and kinship support can mitigate risks. It differentiates between children's wishes, feelings and best interests. The rationale for any conclusion is made plain. *Uploading scans or anonymised photos of completed direct work tools is helpful.*

Relevant parties have seen and signed and dated the report (subject to data protection) includes assessing worker, family and manager overseeing the assessment

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