Recording Guidance for Family Services Staff

November 2007

Introduction

Record keeping is a cornerstone of good social work practice. Records serve a variety of important purposes. Bearing these in mind when recording helps practitioners ensure records are useful and that appropriate information is recorded.

Key Functions of Recording

- Full and detailed information is available about families' needs and the success of past interventions. This can be used to guide future work.
- When social workers record objective information about a case (separately from their analysis and views) managers can use this to inform their own views about what intervention is indicated. Social workers vary in their aversion to risk and managers can help restore balance.
- In the case of an allocated worker being unavailable colleagues are able to obtain information about a case including information regarding any risks to children and can then use this information to effectively work on the case.
- Records provide evidence of work undertaken, decisions made and the rationale for those decisions. Records can help demonstrate that expected standards of social work have been met.
- Children may choose to view their records when they are older and this may help them make sense of events that have taken place in their lives and understand the rationale for Social Services intervention.
- Records provide information and data that the Borough can use to evaluate its performance.

Certain records, for example assessments and reviews, should generally be shared with clients. Clients are entitled to view their file and may request this. Records may be scrutinised by management in case audits and records may be shared with the Courts. The practitioner should be constantly aware when recording that what they write may be viewed by others. Clarity and writing about service users in a respectful way is critical.

This guidance begins with some general pointers regarding good recording. Advice regarding recording is then set out with reference to the Integrated Children's System (ICS) and LACmon System, looking specifically at recording on Events, Meeting Records and Assessments. The section on Assessments contains guidance regarding difference and diversity issues.

Guidance is given regarding what information should be recorded in supervised contact reports and regarding how to record legal advice. Guidance available on the intranet regarding compiling chronologies has been incorporated in this guidance. Lastly, standards for recording data are given, including what data should be recorded, timescales for this recording, and details of which documents require management authorisation. Examples of good and poor recording practice are included as appendices where names have been anonymised. The final appendix is a summary of recording do's and don'ts.

This guidance should be read in conjunction with data protection legislation available on the intranet.

References:

Department of Health (1999) *Working Together to Safeguard Children*. Department of Health, London.

Department of Health (2000) *Framework for the Assessment of Children in Need and their Families.* Department of Health, London.

Laming H (2003) *The Victoria Climbié Inquiry.* www.victoria-climbie-inquiry.org.uk

Walker S, Shemmings D and Cleaver H *Write Enough; Effective Recording in Children's Services* www.writeenough.org.uk

General Recording Guidance

Keep records up to date

It is important to record quickly after the event both to ensure that all relevant information is on the case file if the social worker is absent, and because the sooner recording is undertaken after the event the more likely the worker is to remember key information.

To facilitate this it is important to allocate time to record when there will be minimal interruptions and to record as you go along to avoid accumulating lots of outstanding write-ups. It can be useful when planning a significant contact with a family or individual to include recording as part of your time allocation.

Ensure the child is present in the record

Crucial in terms of safeguard children's welfare is that information is recorded regarding children's behaviour and emotional well-being and information about their views wishes and feelings and that consideration is given to this information.

It is necessary for the practitioner to spend time alone with children when undertaking assessments and monitoring plans. Sessions to elicit information about the child's world should be planned to meet the needs and abilities of the individual child. It is necessary to raise difficult issues with the child that may have an impact upon them so that the practitioner has a better sense of the child's experiences in relation to these things.

Children are not necessarily able to articulate in words their wishes and feelings or information about what they are experiencing. It is necessary for the social worker to record what the child says, but also for the social worker to state what the child's behaviour, what they say, and their interaction with their parent(s)/carer(s) indicates about their emotional well-being and the care they are receiving.

When assessment and casework is undertaken parents' needs can dominate at the expense of the child. It is critical that time is spent with the child and information about the impact of the parent's problems on the child is recorded.

Distinguish between facts and professional judgement

The first stage of the social work assessment is gathering information and this information should be set out in the assessment. Opinions of professionals and the family should be recorded as opinions and not as fact.

Following the information gathering stage the social worker should record their professional judgements, views and analysis that will be based on the information collected and also research and their own experience. It is crucial

this analysis is present as otherwise all that is recorded is facts / description. It is necessary to record why things may be happening and the rationale underpinning decision making. The social worker should make clear these views are not fact but their opinions and they should be substantiated with supporting information so managers can follow or test the conclusions arrived at.

The record should be clear and concise

The record should allow someone who is not familiar with the case to easily locate key information and patterns in the child's life. (Chronologies are very important in relation to this and should be started on ICS when a decision is made upon referral to undertake an Initial Assessment. Recording of Assessments, Reviews and Meetings should be focused and concise. Cutting and pasting from other documents should be avoided.

Records of contact with families should not be narrative and should only be descriptive if this necessary to illustrate something important. Otherwise these should be clear and concise and outline the relevant information obtained. Bullet points can be helpful.

It is necessary for records to contain information about contact with families and professionals and information about a family's needs and action undertaken by the agency. However, information should be focused and excessive and defensive recording is unhelpful and inefficient. It is necessary for the social worker to use their professional judgement when deciding what to record and what to leave out. Supervision discussions and research can be helpful in assisting identifying significant information, as can ensuring there is a clear plan for each case and using this to structure intervention and recording.

Ensure an Initial or Core Assessment is on ICS where appropriate

Crucial to ensuring children's welfare is promoted is that up to date assessments are undertaken and held on ICS. These must consist of thorough information that has been systematically collected, evaluation / analysis of this information and a plan of intervention to guide future work. The 'Framework for the Assessment of Children in Need and their Families' (2000) should be adhered to. Reviews and closing and transfer summaries should include evaluation of progress made and the social worker's and family's view regarding effectiveness of interventions being tried. This may indicate another plan.

Analysis should be recorded

Analysis and reflection is a key social work task and evidence of this should be found in the record. Obvious points for this to be undertaken are when

Assessments and Reviews are completed. Analysis should be set out separately from information about the family. The worker will evaluate information about a child's needs using research, monitor progress, evaluate effectiveness of interventions and justify why a certain course of action is being taken. In addition to assessments and reviews analysis can be set out at various points on the record when the social worker wishes to record their thoughts regarding any case developments.

The record should be fit for sharing with the service user

Service users have the right to access their family services records and many reports are now routinely shared with service users. Sharing drafts of reports with users is good practice. Perceptions can be checked out with families and areas of disagreement can be noted in the final draft.

Care should always be taken that spelling of names and other basic information is correct. These details should be checked out with the family at an early stage, Mistakes can undermine confidence and give the impression a lack of care is being taken.

The sharing of records can facilitate partnership working. It is crucial that recording is undertaken in a way that conveys respect for the service user. Fact should be distinguished from professional opinion and unsubstantiated opinions or oppressive and discriminatory statements should be avoided. The practitioner should have at the back of their mind when recording that the service user may read what is being written.

Records should be clear and written in a way that the service user is likely to be able to understand. Plain language should be used and jargon avoided or explained. For many service users, particularly those Looked After, the case record may be the main source of information about events, decisions and people in their lives. It is therefore crucial they would gain a sense of their story from reading their file.

Checking over work

Prior to completing a piece of recording it should be read through and mistakes corrected. The spell check should be used. Generally the third person should be used consistently. It is important to be clear about identity, for example, record people's full names and when relevant their job title and the agency they work for, or their position in the family.

Referrals

A referral document must be completed for each family referred to Family Services. A new referral has to be completed for each new episode. There is an expectation that within one working day from the referral being received, there will be a decision about what response is required. A referral does not need to be lengthy but should rather give a ‘snapshot’ of the information provided at the time of referral.

The identity of the person making the referral and their relationship to the family should be clear. It should be possible to tell at a glance the reason for the referral.

The section ‘Reason for Referral’ should also include brief information about any previous social work involvement. For previous episodes the reasons for Family Services becoming involved and any significant concerns should be made clear. The reason for the most recent closing should be noted. Any existing chronology should be referred to.

The section ‘Action’ should contain a brief but clear action plan and the rationale for the proposed plan should be clear.

If a referral is received regarding an open case (for example a police notification or someone who does not know the case is open makes a referral), this information should be recorded on an Event. The Event type ‘information exchanged or received’ should be selected and the Event title should contain reference to the source of the information and whether it is an additional referral. The information should be entered on the chronology.

Events

An event should be used to record information, incidents or day to day recording relating to a particular case. Events can be brief, or as detailed as required, and can be recorded at case or at child level on ICS. It is not necessary though, to provide a blow by blow or very detailed account of every single thing that happens. Practitioners should use their judgement about what should be included in the record.

It is important to select the appropriate Event type when recording, so that when wanting to read through a case it is possible to filter by Event. For example, you may wish to look at all previous Supervision Decisions or CP Home Visits or FSCPA Consultations.

Events should be recorded with the date of the event and not the date that they were written

Entries relating to a single day can be recorded within one event if they are linked to the same incident and are of a similar type. For example, when contacting several agencies as part of a Section 47 enquiry, these calls could be recorded within a single Event of the type 'Telephone Call' and of the title – to GP, Health Visitor, Police re S47.

Some Events will be critical incidents and should be marked as such on ICS. Some Event types will automatically be marked as critical incidents – Police 78's and Sexual Abuse Allegations.

Records of home visits should explicitly state which children were seen and whether they were seen alone.

Any legal recording should be recorded under the Event title 'Legal' or 'Court Report' as this information requires a higher level of security.

Letters

Letters sent by Family Services should be attached to an Event and a brief note made stating whom the letter is to and the nature of its content.

It should be noted when formal written correspondence is received in relation to a case. The note should state the nature of the correspondence and whom it is from. If an electronic copy is provided this should be attached to an Event. If a paper copy only is received it should be recorded that the copy is in the paper file.

Emails

Lengthy or informal emails should not be copied and pasted onto Events. They often contain irrelevant information and can make the record hard to follow. If the content of the email is important the key points should be

summarised. If the email is formal and important it should be attached to an Event with a note advising of its content and whom it is from. All emails from Emergency Duty Team (EDT) should be pasted onto contact sheets and linked to the diary.

Meeting Records

Meeting minutes should be recorded on a Meeting Record. Examples of types of meetings that should be recorded here are Network, Professionals, Legal Planning and Planning. (N.B. Child Protection Conference Secretaries will usually minute Child Protection Conferences and Review Conferences).

The practitioner must select from the drop down box the type of meeting.

It is necessary to concisely record the following:

- Who was present at the meeting and their role and what agency they are from
- Brief record of discussion (it may be useful to use subheadings). Information regarding each child and their needs should be recorded. Progress in relation to any plans made should be made clear.
- Decisions made and who is responsible for carrying out each decision out and timescale set for this when relevant. The rationale for each decision should be clear.

Assessments

This section should be read alongside existing guidance on completing Initial and Core Assessments (Richard Holden) and risk (Peter Robinson). This information is available on the R.B.K.C Intranet in the Family and Children's ServicesSection.

Assessments are undertaken to determine the needs of children and families and plans for those needs to be met. When an assessment is undertaken the reason for the referral is explored and information is systematically gathered. This is then analysed by the worker and an understanding emerges of the needs of the child, the parenting capacity within their family, and the impact on the child of any difficulties. This information is used to determine what plans need to be made to ensure the child's optimal development.

Following receipt of a referral a decision must be made regarding whether an initial assessment should be undertaken.

Initial Assessments

The Framework for the Assessment of Children in Need and their Families advises that the decision to gather more information constitutes an Initial Assessment. An Initial Assessment is defined as a brief assessment of each child in the household that should be completed within a maximum of seven working days following referral. Information should be gathered about the family according to the dimensions of the Assessment Framework. Initial Assessments determine whether a child is in need and involve formulating a plan to meet any identified needs.

In order to complete an Initial Assessment you should:

- Compile a chronology and consider its implications
- Conduct at least one meeting with the family
- Meet with each child and obtain their views
- It may be appropriate to liase with professionals or agencies involved with the family to gather information to inform the assessment.
- Propose a plan including the nature of any services required and whether a further more detailed core assessment should be undertaken

If the referral is in relation to a young person aged 16 or 17 presenting as homeless, and there are other children in the family, the Initial Assessment should address whether further assessment needs to be undertaken in relation to the other children in the family.

Core Assessments

Core Assessments are in-depth assessments that address in detail the child's needs and the capacity of their parents or caregivers to respond appropriately to these needs within the wider family and community context. Core

Assessments must be completed within 35 working days of a decision being made to undertake a Core Assessment. The assessment will involve other professionals and agencies; information about the family should be obtained from those involved in the family's care and specialist advice, or assessment regarding specific areas, may be obtained to inform the assessment.

To complete a Core Assessment you will need to:

- Add to the chronology and consider its implications
- Meet with the family on several occasions and at least once in their home.
- Meet with each child and obtain their views
- Gather information from involved agencies and professionals
- Request that other assessments are conducted by professionals of other disciplines to address identified needs where this is indicated
- Analyse the information gathered which will provide an understanding of each child's circumstances and inform planning, case objectives and the nature of service provision.

Core Assessments should be undertaken if section 47 child protection enquires are initiated and where there are suspicions or allegations about child maltreatment and concerns the child may be suffering, or likely to suffer, sign harm. Core Assessments may also be undertaken if the family's needs are complex, if there has been a long history of concerns and Family Services involvement, or if a more sophisticated understanding of a family's needs is desirable.

An Initial Assessment must be completed before a Core Assessment can be undertaken.

If while an Initial or Core Assessment is being undertaken it becomes apparent immediate action is necessary to safeguard children from danger this should be carried out straight away rather than waiting for the full assessment to be completed.

Completing an assessment

Before you start writing an assessment it is necessary to read over the information you have gathered to inform your assessment.

Pertinent information you have gathered should be set out on the assessment form under the headings provided in the structured fields. You should use the subheadings for each of these headings that are set out as prompts.

An assessment can be broken down into three distinct stages and the following factors should be considered regarding your recording at each stage:

Stage One: Information Provision

- Information provided should be comprehensive.

- Information provided should be collected from a variety of sources and include the social worker's observations of the family
- Department of Health guidance *Assessment Framework for Children in Need and their Families* should be used.
- Information about each child in the family should be included. If a decision has been made not to seek further information about one or more children in the family, this will need to be clearly recorded in the child's individual section.
- Information provided should be child centred.
- Factual information should be set out separately from the workers opinions / analysis.
- The views of the child(ren), their parent(s) / carer(s) and involved professionals should be represented.
- Information provided should be set out under the appropriate headings and subheadings.
- Sufficient information must be provided to enable the assessment to make sense to someone unfamiliar with the case
- Care should be taken to avoid overly descriptive information

Stage Two: Analysis

- Information about strengths and needs should be set out. If risks are identified the worker should be explicit regarding what these are
- The implications of the chronology should be considered
- Relevant research should be considered
- Views and hypothesis of the social worker regarding the sense they make of the family's situation should be set out. For example, regarding whether they feel the child's emotions and behaviour are cause for concern and their view regarding the cause of any difficulties.
- Observations and judgements should be backed up with appropriate examples
- Balanced judgements should be made about the children's needs and their parents' capacity to meet those needs. (Primacy should be given to the children's needs if these conflict with those of their parents).
- An assessment of the likelihood of parental change should be included (i.e. whether parents are willing and able to achieve identified goals necessary to promote their children's well-being).

Stage Three: Plan to Meet Identified Needs

- A plan to meet the family's needs should be set out. It must be appropriate and proportionate to the risk and complexity of the case
- Plans need to identify different interventions and services that may meet identified needs and evaluate different options.
- Interventions must be appropriate to the urgency of the child's needs at each stage of their development. Consideration should be given to whether the changes needed can be achieved within timescale consistent with those of the child
- Plans need to identify persons and agencies responsible for planned interventions and services
- Plans should take into account the wishes and feelings expressed by the family (whilst not necessarily meeting current expressed wishes)

- Plans should identify desired SMART outcomes for child and family: specific, measurable, agreed, realistic, time-limited
- Plans should clearly identify non-negotiable goals; goals required for child safety
- Plans should identify goals that must be achieved before the case can be closed.
- Plan should include a proposed deadline for subsequent case review
- The frequency for home visits to be undertaken must be stated.

Difference and Diversity

Key to ensuring equality of opportunity and inclusive practice in assessment work is responding appropriately to difference and diversity. Department of Health guidance in the *Assessment Framework for Children in Need and their Families* and *Working Together to Safeguard Children* covers this area. The key points are summarised here.

The focus in all assessments should be on the child as an individual who has the right to grow up to achieve their potential and be safeguarded from harm. When undertaking assessments important areas that influence child development will be explored including genetic factors, the quality of attachment to their primary caregivers and the quality of their every day life experience.

It is also crucial to consider the impact of any disability, as well as the influence of race, culture and ethnicity on the child and their family, ensuring this is done in a non-discriminatory way.

Disability

It should be borne in mind that although all children have the same developmental needs the pattern of progress for individual children may vary because of factors associated with health, impairment and disability. When considering development or behaviour that is outside the range of what may be expected of the child given their age, it is necessary to consider to what extent this is attributable to any disability, and also to any other factors that influence child development

Consideration must be given to how the extra care needs of a child with a disability may impact on their caregivers and how they can be best supported.

Race, Culture and Ethnicity

As soon as possible when a referral is made information about race, culture and ethnicity should be ascertained. This is crucial in terms of helping to understand the family and ensure that the service is tailored to their needs. Information about the family's ethnic origin, ethnic category, language and

religion should be recorded on the Case Overview Sheet and Child Information Sheet on ICS. The family should be asked to define each of these things, choosing from the list available in the drop down boxes for ethnic category (based on the census categories), language and religion.

It is crucial that judgments regarding race, culture and ethnicity are sensitive and informed. The worker must be sensitive to different family, lifestyle, and child rearing patterns that may vary across and within ethnic and cultural groups. Consideration must be given to the religious beliefs and traditions of different racial, ethic and cultural groups and how these influence attitudes and behaviour, and the way family and community life is structured and organised. How these things may impact on the child's well being and development must be considered. Judgements should be based on evidence relating to both the strengths and needs of a family.

Workers must be aware of the effects of discrimination that black and ethnic minority people may be subject to and how this may affect them adversely. Particular care should be taken to ensure services that are offered meet client need, which may involve for example using interpreters or resources that cater for specific groups.

A non judgemental approach involves not making assumptions and guarding against myths and stereotypes, both positive and negative, of black and ethnic minority families.

Department of Health Guidance is clear that cultural factors neither explain nor condone acts of omission or commission that place a child at risk of significant harm. Anxiety of being accused of racist practice should not prevent the necessary action being taken to safeguard a child.

Recording Supervised Contact Sessions

Supervised contact tends to be of children and parents who live apart. This may be following children being removed from their parents care within the context of Care Proceedings. Supervision of contact may be necessary to ensure the children's safety but another important purpose of supervised contact is so that observations can be made of parent-child interaction.

For contact taking place in the context of Care Proceedings, information from the contacts will inform assessments of parent-child attachment. The behaviour of children and their parents during contact reveals important clues regarding who is important to the child, their expectations of their parents and how their parents respond to them. Information from supervised contact will help social workers address questions such as whether parents are able to meet their child's needs, whether contact is a good experience for the child, and whether continued contact with a parent will help or undermine the stability of a child's permanent placement away from their parent.
Reports of contact sessions will be read by social workers, and sometimes by the Courts, and detailed and descriptive reports are very useful in helping determine whether contact is the children's best interests.
For contact sessions with children in permanent placements, where the purpose of contact is for them to maintain a relationship with their parents, there may not need to be as much detail, but information around whether contact appears to be beneficial for the child, and whether the parent responds appropriately to the child and is supportive of the permanent placement should be noted, as well as a summary of what happened during the contact.

Reports of supervised contacts should always be recorded on contact sheets on LACMON or on Events on ICS. The date recorded should be the date of contact and not the date upon which the report was written.

The following areas should be addressed when cases are in court proceedings and may be relevant for other types of contact as well.

- Names and roles of those present

- Date of contact and time contact was scheduled to begin and end. If the actual times of contact varied from these the reason for this and times the contact occurred during should be noted.

- Regarding the parent(s):
    - Their interaction with the child at the beginning and end of contact (how they greet the child and how they end the session)
    - Whether during the session the parent concentrates their attention on the child and actively attempts to involve the children in age–appropriate conversation, play or physical affection.
    - Whether they demonstrate emotional warmth and concern about the child

- Whether they are attentive and responsive to the child
- Whether they manage the child's behaviour appropriately
- Whether the parent did anything that upset the child, or anything that had a positive impact
- Whether the parent appears to be supportive of the child's placement (for example telling them to be good in the placement) or if they appear to be undermining the child's ability to form a good relationship with their current carers (e.g. by making derogatory comments about their carers)
- Whether the parents give the children any information that is confusing, unhelpful or untrue (for example telling their child to inform their social worker that they want to return home, or telling the child they will be returning home soon when this is not yet known)
- Whether the parent spends time not engaged with the child (e.g. outside smoking, speaking at length with the contact supervisor, or the parent is withdrawn)
- Any concerns regarding the parent's behaviour (for example if they are aggressive), or concerns they may have been under the influence of drugs or alcohol, should be set out.

- Regarding the child(ren):
  - Frame of mind of the child prior to contact and following contact if this is observed.
  - Whether the child came to and left contact willingly and without distress or whether there was any reluctance
  - Behaviour of the child on first seeing and later on leaving their parents
  - What the child spends their time doing during the session
  - Whether the child approaches the parent for play, affection, help or comfort (whether they attempt to have these needs met by others present)
  - Whether they spend time in conversation or play with their parent
  - How they respond to the parent
  - How the child responds if the parent leaves the room
  - Whether the child does anything to indicate they wish to avoid the parent or are anxious at the parent's presence (e.g. the child may withdraw through play or may often try to leave the room
  - Describe any behaviour outside the normal range of what may be expected of a child of their age
  - Describe if the child demonstrates any distress

- If more than one child is present at contact details should be given of how the children interact with each other

- Judgements or views of the supervisor should be noted. It should be made clear what evidence these are based on

Chronologies

Background

The Honourable Mrs Justice Bracewell in 2000 highlighted the importance of chronologies in a case she presided over where the children in the family had suffered chronic severe maltreatment. There had been no protective Social Services action despite a very long history of involvement. It was not until a chronology was compiled in 2000 that comprehensive information was available about a pattern of child protection concerns and failure of the parents to change that triggered emergency court proceedings and the removal of the children from the home. Bracewell stated that if a chronology had been undertaken sooner effective intervention was much more likely to of occurred years ago and the children would have been protected from years of dysfunctional parenting which left them very damaged. Laming re-emphasised the importance of chronologies in his report into the death of Victoria Climbie and recommended all case files carry a properly maintained chronology. Chronologies should ensure social workers are aware of any serious or deep-rooted problems that need to be addressed.

When is a chronology required?

A chronology should be compiled from the time a decision is made to undertake an Initial Assessment. The chronology should be updated when the case is reviewed and prior to important meetings. Up to date chronologies must be available for review by managers, child protection advisors and solicitors prior to child protection conferences, network, professional, and legal planning meetings, and when consideration is given to voluntary care under section 20 of the Children Act 1989. Regular audits of chronologies are undertaken of numbers and quality.

Case level chronologies should be started on ICS via the Actions Menu. Where a child has complex needs or is Looked After/Accommodated, a child level chronology will need to be created in the same way on ICs, via the Actions Menu.

Specialist cases/teams

- For Looked After Children who are unaccompanied minors, producing a historical chronology may be difficult since it may be difficult to corroborate

information. However a chronology giving an overview of their experiences prior to coming to this country and key events in their life whilst being Looked After must be attempted.

- For out of borough cases (e.g. ones held by the Healthlink Team) where the home authority holds case responsibility a chronology should still be completed but the focus of this may differ and for example focus on the history of health interventions. An exception to this is if a Core Assessment is conducted by R.B.K.C. in which case a full case level chronology should be compiled. One may be available from the Authority in which the family resides.

What to include in a chronology

As stated above the purpose of a chronology is to provide workers, managers and in some cases the Courts with a chronological list of significant events in a child's or their family's life. This enables the reader to quickly gain a picture of formative events and patterns of behaviour helping to improve decision making.

A chronology is not expected to be a repetition of the detailed records contained in case recordings, but brief bullet points indicating incidents, events or issues within a family that significantly affect a child's life. Family strengths and protective factors should be included to ensure a full and balanced impression is obtained. It therefore requires familiarity with the case information, and analysis to identify the critical moments in a child/family's life experience.

When completing a chronology all case records should be read. This includes records held on ICS and LACMON (the archive should be checked) and also paper files relating to the family. You should ask the team Business Support Officer to check on the Person Index database whether any paper files exist and to locate these if they exist. If important data is missing from the file it may be possible to obtain this from the family or professionals who are/have been involved. If it is not possible to read the entire case file in the timescale required then meetings records, assessments and reviews should be read.

Chronology entries should be factual and not include opinion or hypothesis. The prompts below indicate the types of information that should feature in a chronology:

- Family History - including marriages, births, deaths, changes in the make-up of the household, and emigration details as appropriate
- Child's changes of address/school
- Child Protection Case Conferences, Child Protection Registration(s)
- Key Network/Planning/Professionals Meetings and Assessments (For important meetings a bullet point list of plans made should be included and it should be clear whether the plans were implemented)
- Relevant Medical Examinations
- Critical Incidents, including Police Notifications (Form 78s) and section 47 Child Protection investigations, giving rise to concern about the well-being of a child

- Take up/non take up of services
- Case open/closed and whether allocated, held on duty or referred to other agencies - including summarised reason(s) for decision(s)
- Accommodations (including requests for and consideration of accommodation)
- Any behavior of the child(ren) that is of concern
- Concerning information from agencies/individuals e.g. allegations (substantiated or otherwise)
- Recorded positive events or strengths
- History of Court Applications, Hearings and Orders

Chronologies for different purposes

Chronologies may be compiled to gain a sense of a family's history and past social services involvement but may also be undertaken for very specific purposes. If a child has more complex needs or is Looked After, a child level chronology will need to be completed that may be used in child protection or legal proceedings or to assist in specific planning for the child. It is necessary for practitioners to use their professional judgment about how detailed a chronology should be and what events/information to include.

Format

The chronology in ICS is in a set format. It is possible to make an entry from within another document in ICS by clicking on the 'add chronology' button and making a free text entry which is saved to the chronology. It is also possible to add to the chronology from within the chronology document, by clicking on 'add entry'. The date field is free text as you may wish to indicate a period of time rather than a specific date for particular chronology entries. It is possible to move entries up and down the chronology into date order.

It is also possible to save entries made in the case level chronology to the child level chronology and vice versa – the option will be presented to you when you click on 'save'.

Updating

- Existing chronologies on allocated cases should be regularly updated, and updated at a minimum prior to any review, planning, child protection or network meetings.
- Existing chronologies on cases that have been re-referred must be updated at either the point of referral or as part of the subsequent Initial Assessment.
- Chronologies on Looked After Children should be updated, as a minimum, prior to each LAC Review, ensuring that an easily accessible overview of the case is available, covering key events in the child's life, including the period of accommodation.

Recording Legal Advice

Legal advice must remain privileged and exempt from disclosure to Guardians and clients. ICS has a section for legal records that can only be accessed by social workers. Legal information, which includes advice given by solicitors and legal planning meetings is confidential and should not be shown to Guardians who come to view the child's Family Services file.. The solicitor for the child will have provided the Guardian with all the legal documents relating to a case.

Legal planning meetings should be recorded on ICS but no note of legal advice given should be made. Rather, here should be recorded the reason the meeting was held and the decisions and rationale for them. The solicitor will provide a summary of the meeting and decisions which should be attached to the Legal Planning Meeting record.

Previous social workers may have recorded legal advice on the system used before ICS - Lotus Notes. Therefore the Lotus Notes case notes once printed from the system must be checked for this, and legal advice removed, before Guardians can view them.

Data Standards

The social worker is responsible for ensuring that for each of their allocated cases the data within these standards is recorded on the ICS/ LACMON file.

That this data is easily retrievable is crucial in enabling the Business Information Team to fulfil the statutory duty of providing central government with information about the Borough's performance. This information being easily accessible helps facilitate effective working of cases when the allocated worker is absent. It also enables the department to obtain an overview regarding work being undertaken with children and families and information regarding the progress of Looked After Children.

Case Overview Sheet and Child Information Sheet on ICS

- For each member of the family / household the following must be recorded:
- First and surname
- Date of birth
- Sex
- Person number

- The household address must be recorded in full (including postcode) (For Looked After Children this is the address the child was living at prior to them becoming Looked After).

- The ethnic origin, ethnic category, language and religion of the household members should be specified. The family should be asked to define this.

- The person who has parental responsibility for the child should be clearly recorded.

Basic Information Sheets on LACMON

The following must be recorded for each Looked After Child

- Current placement address and postcode
- The name and address of the school they are on roll at. If they are not on roll this should be noted.
- Levels achieved for SATs and GCSEs where relevant
- Whether immunisations are up to date
- Date of initial medical on becoming Looked After

Recording on LACMON

Upon a child becoming Looked After all recording should be done on LACMON. You must request that your Business Support Officer creates a LACMON file and 903 form for the child. To do this the social worker must provide the following information:

- Date child became Looked After
- Legal status of child
- Child in need code (Business Support Officer has a copy of these)
- Type of placement

If a child ceases to be Looked After the Business Support Officer must be informed. Recording once a child is no longer Looked After should be on the Assessment System. Once the Assessment System is used again the LACMON record will freeze and cannot be edited. The worker must therefore ensure all records on LACMON are complete prior to resuming recording on The Assessment System.

Review Sheets for Looked After Children (LAC)

- *Timescales for Reviews*

In response to the question 'was the review completed within the statutory timescales?' the worker should indicate whether the actual review meeting took place within timescales.

- *Education*

  Indicate:
  - Whether the child has been permanently excluded
  - Whether the child has a Statement of Educational Need (SEN)
  - Whether or not the child has missed more than 25 days education in the last year
  - If the child is 16+ what they are doing now

- *Health*

  Indicate:
  - If child under five whether their developmental assessment is up to date
  - Whether immunisations are up to date
  - Date of most recent health assessment / medical examination. (If the chid refused this indicate that was the case)
  - Date of most recent dental check

- *Parenting*

  Indicate whether the child has become pregnant, given birth or fathered a child

- *Offending*

  Indicate if the child has received any cautions, convictions or reprimands in the last year.

- *Participation in Review*

  Indicate by choosing from options within the drop down box how the Looked After Child participated in the review. Take care to select the correct box.

903 Forms on LACMON

- The latest 903 form should indicate the LAC's current placement. It is necessary to inform the Business Support Officer if there is a placement change. If a child is missing from their placement for more than twenty four hours a new 903 form is needed stating this. The team Business Support Officer needs to be notified if the placement status changes, for example from a foster care to an adoptive placement.

- The business support office needs to be informed if a Looked After Child's legal status has changed to ensure this is accurately recorded.

LAC Visit Forms

- All visits to LAC in their placements should be recorded on visit forms on LACMON. This enables the Business Information Team to easily obtain information regarding how recently each LAC has been visited.

Attachments

- All Basic Information Sheets on the Assessment System should have a chronology attached.

- All LACMON Basic Information Sheets should have an up to date copy of the following documents attached:
  - Care plan
  - Placement Plan Part One
  - Placement Plan Part Two
  - Essential information Part One
  - Essential Information Part Two
  - Personal Education Plan

Dates

- Utmost care should be taken to enter dates that are accurate and correctly formatted (i.e. dd/mm/yy - so 1 June 2005 would be 01/06/05). Dates of birth, person numbers and case numbers should be used consistently.

Recording on ICS and LACmon – Timescales and Management Authorisation

This section relates to expectations in relation to how soon social workers should record information on ICS and LACmon. It also highlights which documents need management authorisation.

Information about child protection concerns should be recorded on ICS as soon as possible and within 24 hours. If full recording of child protection concerns has not been possible by the end of the working day it should be briefly noted that Family Services has information in relation to child protection concerns and the nature of the concerns stated. In cases where there is child protection information relating to children who have just become known to Family Services and the case has yet been entered on ICS by the end of the day then this information should be emailed to the Emergency Duty Team along with details of the family composition and home address.

Document type	Timescale for recording	Management authorisation required?
Referral	Within 24 hours	Yes – manager signs off
Initial assessment	7 working days	Yes – manager signs off
Core assessment	35 working days	Yes – manager signs off
Reviews	First review to be completed within three months of the assessment being completed and further reviews to be completed within six months of the last review being completed.	Yes – manager signs off
Telephone contact with professional or family	Within 24 hours if related to child protection concerns. All other information to be recorded within 3 working days.	No
Office / home visit	Child protection visits (for section 47 enquiries and to children subject of	No

	Child Protection Plans) to be recorded within 24 hours. For all other visits, a note should be made within 24 hours if the children have been seen, and any concerns noted, and the full write-up should be completed within 3 working days. If children are not seen on any planned home visits then this should be clearly noted in the Event. If a child subject of a Child Protection Plan is not seen by the social worker within the timescales set in the child protection plan the line manger should be informed and a record made of the contingency plan. If a child is not seen by the social worker within two weeks of the missed appointment the conference chair should be contacted and a record made of the contingency plan.	
Meetings	All meetings bar Child Protection Conferences: Details of those present and decisions made should be recorded within 24 hours. Record of discussion should be recorded within 3 working days. Child Protection Conferences: Decisions to be recorded within 48 hours. Full record to be	Meeting chairs should sign off meeting records. For core group meetings the chair should sign off the first meeting record and the line manager should sign off future meeting records.

	completed within 15 working days.	
LAC visits	If the child has been seen this should be noted within 24 hours. The full visit record should be completed within 3 working days.	These must be recorded on statutory visit form on LACmon – manager signs off.
Closing of cases	Once a decision has been made to close a case and all outstanding work has been completed the case should be closed within three working days.	Manager signs off
Opening cases on LACmon	The social worker should advise the Business Support Officer in order that the case is opened on LACmon within 24 hours.	Manager signs off
LACmon - 903 changes	The social worker should advise the Business Support Officer to enable the 903 form to be updated within 24 hours.	No
LACmon – change of placement address	By end of working day	No
LACmon – SATs and GCSE results	This information should be put on within one month of the results being given	No
Closing cases on LACmon	Within three weeks of child ceasing to be LAC	No
Review sheets to be completed on LACmon	Within three weeks of the review being held.	Yes – line manager to sign off.
LAC documents	Essential Information Part One and Placement Plan Part One should be attached within 24 hours of child being placed Placement Plan Part Two should be attached within three working days of the placement planning meeting taking place	No

	(which should be held within 7 days of the placement starting). The Care Plan and other documents to be completed and attached by the first review.	
Personal Education Plans (PEPs)	These should be attached to the system within three days of the PEP meeting taking place. (PEP meetings must take place within 28 days of a child becoming looked after, and then after three months and then on a six monthly basis).	No

Appendix One

Recording Do's and Don'ts

Do

- Do think before you record – Why? Who for? Who else might read?
- Do be concise and clear
- Do record decisions made clearly and obviously
- Do use plain English
- Do record in a timely fashion
- Do remember that the case record is a public document, and users have rights of access; write in a way that conveys respect
- Do include accurate factual information and analysis/opinion separately, and evidence both
- Do in general use the 3rd person (Mrs A, s/he, they) consistently; be clear about identity
- Do remember assessments and reviews may need editing –use spelling and grammar checks
- Do think about where you are going to record a particular piece of information on ICS

Don't

- Don't repeat – cross refer
- Don't cut and paste without editing
- Don't forget to sign and date reports for meetings
- Don't copy every e-mail into the record- summarise
- Don't assume others know about the case (especially for initial assessments)
- Don't use jargon
- Don't be obsessed by the running record
- Don't write as you speak
- Don't do process recording