Peter

aged four – early years
to nursery transition

From Joint Working to
Integrated Working in a
nursery setting

Before he was due to attend nursery, Peter’s mum
approached the nursery school to share her concerns
that Peter seemed to be experiencing some difficulties
with communication. Mum discussed her early
concerns with the depute head, questioning whether
he was ready for nursery. She reported that she had
previously discussed Peter’s difficulties with the public
health nurse who had advised activities to encourage
speech and social development. The depute head
listened and advised that Peter should start nursery
as planned and assured her that he would be carefully
observed in his settling-in period at the nursery. The
depute head asked for Informed Consent
from mum to talk to Peter’s Named Person, the public health
nurse, to alert her to mum’s continuing concerns. This
early connection allowed nursery staff to:

- Develop a relationship with Peter’s primary carer
- Have an early focus on Peter’s social and emotional
  communication skills for his age and stage of
development
- Identify a protective factor of mum drawing attention
to a potential problem and attempting to find a
  solution
- Check the Named Person’s professional opinion
  about Peter’s well-being
- Establish the need for Joint Working with public
  health and ensure a positive transition for Peter
  through early communication and liaison with the
  Named Person.

Nursery staff received information from the Named
Person and understood some of the early efforts to
encourage Peter’s social development. The nursery
staff identified some difficulties in communicating as
they observed Peter in the initial settling-in period.
Using the Getting it right for every child practice
model, the education Single Agency Assessment
Part I (well-being) was completed which, although
brief, allowed a picture of Peter to emerge capturing
his strengths and difficulties. There was clear evidence
that Peter had consistent, caring adults regularly
responding to his needs (safe/ nurtured). He was
physically healthy and confidently enjoyed most
aspects of large, physical play within the nursery
(healthy/active). There was some evidence of
sensory triggers in his intense dislike of toothpaste and
very restricted choice of snacks. He appeared more
reluctant to engage in play involving other children or
a lot of noise and required encouragement to interact with his peers. He also demonstrated potential to achieve with abilities in numbers, letters and IT while struggling with oral communication and appropriate verbal responses (achieving). The nursery was able to see that he was isolated and focused on the activities he was able to cope with, avoiding those he couldn’t (included). Peter was more co-operative when he had his comfort toys. The nursery staff also involved Peter in what was happening and using some verbal communication, non-verbal and observations of his behaviour, they completed a What I Think tool to record Peter’s own views.

The collective experience among nursery staff indicated that Peter’s areas of difficulty may be related to autistic spectrum disorder and that he may need a Single Agency Assessment Part II (My World Triangle) to record a more detailed picture of Peter. The nursery contacted the Named Person to explain that they would Request Assistance from speech and language therapy and ask for advice from educational psychology. The public health nurse agreed to act as the Lead Professional to bring everyone together to share information between services. The Lead Professional also Requested Assistance from the community paediatrician. The intervention resulted in some improvements, but in reviewing his progress, all professionals agreed that Peter would benefit from a full psychological assessment. The Lead Professional Requested Assistance from the early years multi-agency team (remit for support and co-ordination of information for children with disabilities) attaching the Integrated Assessment completed by the health and education staff involved. The multi-agency core team (South Lanarkshire specific) reviewed all available information and facilitated an assessment by the Lanarkshire Autism Diagnostic Service who confirmed a positive diagnosis of autism.

Using this approach, education and health were able to work together jointly building a picture of Peter’s needs and moving to Integrated Working after establishing he needed more support to develop his well-being. Practitioners were able to access the right help as early as possible for Peter by clearly articulating their observations and the strategies they were using. They were also able to build on the positive indicators of well-being, involving his parents in supporting his needs. Once they had clarified Peter’s needs, health and education agreed that it made sense for the nursery to take over the role of Lead Professional as they had most daily contact with Peter and were able to monitor his progress first hand and ask for any further help if needed. Public health retained the role of the Named Person and Peter’s progress was tracked using an Integrated Chronology of significant events. Mum was satisfied that Peter’s difficulties had been carefully assessed and that everyone had a clearer idea of how to support the development of his well-being. The diagnosis of autism helped education and health to clarify Peter’s support needs and together they are revising the Integrated Assessment and Child’s Plan for Peter with short, medium and long term outcomes which will require ongoing specialist support.
Lily

-aged 13 – mid secondary school transition

From Integrated Working to Compulsory Intervention with a change in Lead Professional

Lily is 13 years old and was diagnosed with pseudo seizures three years previously. Lily’s Named Person (principle teacher learning support) had growing concerns about Lily’s social, emotional and academic development and began by monitoring Lily’s situation using the Single Agency Assessment Part 1 for education (well-being). There were significant concerns about Lily under each indicator of well-being ranging from poor attendance (safe), issues of physical hygiene (healthy), lack of self care skills and resilience (nurture), social isolation and inability to make friends (included), and the ongoing management of Lily’s medical diagnosis (healthy).

By considering Lily’s progress against well-being, it became clear that a more detailed assessment was needed and that education and health should work more closely together. Lily’s Named Person explained to her that she thought it might help Lily if they both worked together with health. Lily agreed and gave her Informed Consent and also agreed that the Named Person would invite her parents in to discuss working more closely with health. Lily’s Named Person contacted the public health nurse to share her concerns and suggest that they work together on an Integrated Assessment and Child’s Plan.

Lily’s public health nurse had a long-standing relationship with Lily and had previously alerted the school to some of her support needs. Because of the impact of Lily’s seizures on her well-being and the concerns about her social and emotional development (would mean gathering considerable medical information together), the public health nurse agreed to act as the Lead Professional for a period and both health and education began to record their information on the Integrated Assessment format. The Lead Professional’s relationship with Lily since her early years was used to support her to complete the What I Think tool.

Before health and education were able to meet together with Lily and complete the Integrated Assessment, the process was interrupted by a self-disclosure to Lily’s learning support assistant in school. Lily disclosed sexually inappropriate activities between herself and her two male siblings aged 17 and 12. This
Disclosure required a child protection investigation coordinated by children and families social work. Because there was a compulsory role for children and families social work, the social worker took on the role of **Lead Professional** at this point and began co-ordinating an investigation.

Although health and education were in the process of completing an **Integrated Assessment** with Lily, the information was not complete but they were able to share the previously completed **Single Agency Assessments**, and the **What I Think tool**. This provided much more in-depth information than can normally be collected in this time frame and allowed the social worker to bring together the information within the **Integrated Assessment** format in preparation for the child protection conference (there wasn’t time to analyse information together with health and education). By using the **Resilience Matrix** to map all the information available about Lily, including Lily’s own view, the social worker was able to identify that Lily had very little resilience and her main protective factor of her grandparent had broken down after the disclosure. The other protective factor, the school, was affected by non-attendance. The adversities included evidence of a chaotic home environment involving alcohol misuse with groups of adults, lack of appropriate sexual boundaries, lack of nurture and lack of respect for Lily as an individual by her parents and grandparent. The matrix enabled the social worker to conclude that the best way to protect Lily was registration and a child protection plan was developed to highlight and manage the immediate risks.

Lily was angry that mum and dad did not appear to believe her account of what had happened. Her long-standing relationships with learning support and the public health nurse were used to support Lily through her emotional difficulties.

Immediately following the development of a child protection plan, the **Lead Professional** and Lily’s core group became her **Network of Support** and together they analysed all available information to develop an **Integrated Assessment** and **Child’s Plan**. The **Child’s Plan** outlined the desired long-term, sustainable improvements to Lily’s **well-being**. An **Integrated Chronology** of positive and negative significant events was put in place to track Lily’s progress and inform reviews of her plan.
Chrissie

aged four – early years
to nursery transition

Chrissie attended nursery school. After a period of settling, nursery staff became aware that although Chrissie was thriving at nursery, her recent attendance had become more sporadic and attempts to communicate with mum were unsuccessful. Nursery staff felt it was important to engage the family in a discussion about Chrissie’s well-being. The nursery head phoned dad at his work and he agreed to come in to speak to nursery staff.

Discussions with dad explained some of the concerns about Chrissie. It turned out that mum was suffering from multiple sclerosis and she and Chrissie’s dad had recently separated. The loss of support to Chrissie’s mum was significant because getting Chrissie to nursery now depended on how she was feeling on any particular day. The head of establishment asked for dad’s permission to share information with the public health nurse who was the Named Person for Chrissie until she reached the age of five. The public health nurse visited Chrissie’s home to support mum. She explained that she would change the health plan indicator from core to additional which meant completing a Single Agency Assessment Part II (My World Assessment Triangle). The public health nurse recognised the need for health and education to work jointly with the family and agreed with the school that they were best placed to take on the role of Lead Professional. Each used the Single Agency Assessment Part II to record and analyse their own information and were quickly able to bring the information together in the Integrated Assessment and Plan format.

- Health and education recognised the priority to make sure that Chrissie was still able to benefit from daily nursery attendance. The head of establishment arranged with dad to admit Chrissie earlier than the normal opening hour which allowed him to pick Chrissie up from home and drop her at nursery before work (safe/achieving)

- Daily contact with dad also helped Chrissie to cope with the issue of separation and loss and had a positive impact on her emotional well-being (healthy/nurture)

- The public health nurse agreed to explore some of the home supports that Chrissie’s mum may benefit from to relieve any practical pressures (responsible)

- The public health nurse supported mum and Chrissie to understand multiple sclerosis and to know what to expect, which recognised Chrissie’s need to be respected, to understand what was happening in her life and to express her own views and opinions about the situation (respected)

- Nursery staff were made aware of this work and agreed to be open to Chrissie raising any of the issues discussed with her mum and the public health nurse

- Early identification of mum’s degenerative illness highlighted the need for health and education to monitor Chrissie’s progress carefully. An Integrated Chronology of positive and negative significant events was created to track her progress. This would also help to inform Chrissie’s Plan to reduce the possibility of her taking on inappropriate caring responsibilities for her age and stage of development (respected)

- Chrissie’s daily access to education was recognised as even more important to make sure her own health and development needs were being met as well as her need to be a child and engage in play and fun (active/included)
Daniel

aged 15 – residential school to world of work

Daniel was 16 and living in a residential school in Glasgow. Daniel was working with his key worker in school and a social worker in Lanarkshire who were preparing him for the transition from school to the world of work with a new Lead Professional.

Daniel’s own background had been chaotic and included sexual abuse, substance misuse, antisocial behaviour, frequent changes of address and the recent bereavement of his mother (safety, respect, responsible, nurture). He was socially immature and found it difficult to connect with young people his own age (included). He was not ready for the responsibility of earning his own living as well as being on his own for the first time (responsible).

Daniel’s social worker, the Lead Professional, was responsible for developing an appropriate package of care to support him through a difficult transition. The Lead Professional talked to Daniel and asked his permission to invite a number of supportive agencies to help including housing services, community alternatives, community learning and development, the residential school key worker, and a children’s house worker from his home town. They met with Daniel as his Network of Support. Over a period of months they jointly considered all of the information available about Daniel, including his own capabilities and strengths, his need for continued protection, and a supportive place to live, which was analysed and recorded using the Integrated Assessment and Plan. Daniel’s Plan included:

Desired outcomes:

Short term (ST)  Medium Term (MT)  Long Term (LT)

- **Safe** – safe accommodation which is within Daniel’s means to manage and maintain financially (S-MT). Daniel reports feeling physically and emotionally safe in his new situation (MT). Evidence that Daniel feels able to protect himself emotionally (LT)

- **Healthy** – improved physical health (MT), confidence and emotional well-being (M-LT). Evidence of increased capacity to make healthy choices in relation to nutrition and substance (M-LT)

- **Achieving** – goals devised by Daniel (ST) improved awareness and development of personal strengths (MT). Progress with agreed goals in preparation for the world of work (LT)

- **Nurture** – a strong Network of Support in place with relationships which Daniel uses to deal with any anxieties and the daily challenges of living independently (S,M,LT)

Social work as the Lead Professional in Compulsory Intervention
Active – engagement in activities which reinforce strengths and stimulate positive interests (M-LT)

Respected – evidence of Daniel’s own views being listened to and recorded (ST). Evidence of growing capacity to exercise his rights, expressing his views and concerns constructively before they reach crisis point (M-LT). Evidence of positive relations with immediate neighbours (MT)

Responsible – maintained tenancy (MT). Increased capacity to pursue positive activities and withstand negative influences (MT-LT). Able to protect himself and new home from exploitation (LT)

Included – evidence of using the resources available within the community (ST) evidence of developing positive relationships independently of professional support (MT). Daniel reports a sense of belonging within his new community (LT)

Daniel’s plan included the following actions:

Intensive support from the housing officer to find suitable accommodation in his own familiar community. Help to prepare Daniel for the responsibility of living on his own and maintaining a tenancy which would provide the basic need of somewhere to live (respect and responsible)

Support from a key worker in community learning and development More Choices, More Chances hub to create an activity agreement in the form of a sixteen-week programme of personal, social and academic development to progress his learning (achieving)

The development of a relationship with the children’s house in his home town which could act as an emergency support at any hour if Daniel needed it as well as daily support and encouragement (safe, nurture)

Ongoing support to Daniel from social work on consequential thinking, risk awareness and management to ensure his safety. This included discussions on unhelpful connections in the community and developing resilience to the negative influences on Daniel’s behaviour (responsible)

Support from community learning and development to access alternative ways of occupying Daniel’s time, improving confidence and fitness (active, included)

A transition from residential school to his flat for a period of time which allowed him to sleep overnight at school and spend his days on his own to get used to the new situation (nurture, healthy, achieving)

Support to access health care by registering with a GP in his own community (healthy)

Support with benefits, budgeting and other life skills (respected, responsible, healthy)
Rory aged 14-16 – transition to full time education

Rory was a happy, healthy, well-adjusted young man until a skiing accident at 14 changed his life. Rory suffered severe spinal injuries which resulted in paralysis and significant medical needs, primarily respiratory. He spent a year in the spinal accident unit under the care of a paediatric consultant. With support from education and health, Rory completed his standard grade courses in hospital achieving eight grade 1 passes. His ambition was to return to school in fifth year and his occupational therapist took on the role of Lead Professional, arranging for the necessary adaptations to provide classroom and toilet facilities as well as training and support for Rory’s teachers, support assistants and peer group. Rory required support at home for his daily care needs, support with medical needs as they arose, and support before and during school to ensure he could access his subject choices. His Plan ensured that he was challenged to regain as much of his physical and emotional independence as possible, supported by his peer group and school assistants. Once he was settled in school, Rory’s guidance teacher assumed the role of Lead Professional, continuing to work closely with health staff to make sure that Rory’s well-being was developing as it should. Rory was sitting four Highers and applying for university courses.

As the Lead Professional, the guidance teacher recognised that Rory’s conditional offer would be confirmed on receipt of his results and that he would need significant support to make a successful transition to university. He acknowledged that considerable forward planning would be needed to ensure all of Rory’s needs were catered for. He Requested Assistance from all professionals working with Rory, which included staff from the spinal unit, the occupational therapist, physiotherapist, paediatric nurse, district nursing, the public health nurse (schools), social work disability services and a number of school support staff, to update Rory’s Integrated Assessment and Plan. Rory’s strengths and pressures were recorded using the Integrated Assessment which brought all information together in one place. Together Rory, his parents, his university of choice, adult disability services and Rory’s existing Network of Support analysed the information available and reached conclusions on what needed to happen. The information recorded against the My World Triangle is summarised below (the full Integrated Assessment is also available).

How I Grow and Develop – summary analysis of needs and risks

There are risks to Rory’s health, primarily the continuing respiratory difficulties which must be planned for. However, he has shown significant physical and mental resilience thus far and demonstrates awareness of his own health needs. He has proved his intelligence, cognitive skills and ability to respond to radical changes in circumstances, all of which will help to make the transition from receiving care to managing those who provide his care. However, his upper body strength could be significantly improved and this in turn could improve his independence. He is well able to express his opinions although requires support to listen and accept advice from those with greater experience. Early planning to ensure a smooth transition is essential. Discussions with Rory about course choices will help to address accessibility issues. To ensure his continued growth and development Rory’s complex and detailed care package, which includes daily social care and health care needs, will have to be continued
in his university town. Detailing his timetable and mapping out daily journeys would also be helpful prior to starting. His **Network of Support** has been crucial to his success, particularly his peer group and care team. Therefore, a key element of the transition would have to be proactively building a new **Network of Support** for Rory within his new community. Although there are acknowledged risks to Rory’s health and well-being his right to attempt independence has to be supported and, with the right care package secured, there is every possibility that Rory could maintain independent living and study away from home.

**What I need from the people who look after me – summary analysis of needs and risks**

Rory continues to need twenty-four-hour social and health care to meet his basic needs and ensure his continued well-being. Securing the right mix of skills and experience to provide support around him is critical to his successful transition. Rory must be involved in the process of finding the right carers as he will be more dependent on them in the absence of his family and he will also be responsible for managing his own care. Updating his passport (tool detailing care needs) with Rory would be a helpful step. Accessible and reliable transport will also be essential. Rory is aware of the risks to his safety and takes responsibility for this. He is intelligent and well able to seek support if he feels his safety is being threatened. Disability awareness work might help to prepare him to cope with prejudice. His care must be highly organised and structured but also discrete enough to allow Rory to take part in university life and form relationships on his own.

**My Wider World – summary analysis of needs and risks**

The crucial issue for Rory is securing the right accommodation that will facilitate a successful transition away from home and every effort must be made to achieve this. Student accommodation adapted for disability may be the best option as long as it can also accommodate his carer. Rory’s statutory entitlement to financial support must be confirmed and any additional funding support available from independent sources should be explored to ensure his income will provide what he needs. Connecting Rory to community supports such as the student disability council, groups of interest and the student advisory services is very important. It would be helpful to begin this work now to ensure supports are in place from the outset. Arranging a mentor or buddy for Rory might also help to connect him to his new community and encourage a sense of belonging.

The overall objective in Rory’s **Plan** was to ensure a successful transition from home and school to university.
Charlotte
pre-birth to eight weeks

The midwife as Named Person in Compulsory Intervention

The GP attached midwife received a phone call from the duty social worker informing her of a young woman who thought she may be pregnant. She would be accompanied by a support worker to the booking in clinic to confirm whether this was the case. Jean’s midwife confirmed she was ten weeks pregnant and registered her pregnancy. The midwife gave Jean her pregnancy well-being wheel and explained that she would be the Named Person for her child until the baby reached 10-14 days. In her role as the new Named Person, the midwife began to gather information to support Jean and the unborn child. The registration process alerted the midwife to some of the complexities in Jean’s current situation and she began to realise that Jean’s baby would require Integrated Working co-ordinated by a Lead Professional. The midwife explained to Jean that she would begin a very detailed assessment known as the Integrated Assessment to make sure that Jean and her unborn baby’s situation could be clearly understood. She explained that she would Request Assistance from children and families social work and that other people would be involved in agreeing the help Jean needed.

Jean’s situation included previous compulsory intervention, specifically child protection. Her two older children were placed with an uncle and aunt under kinship care arrangements. Jean herself had a family history of domestic abuse, and a previous mental health diagnosis, including self-harming. Jean was currently misusing drugs and alcohol and her husband was a Schedule 1 offender. Jean was living in the homeless unit having left her husband, but this accommodation was at risk because she was returning to her husband each night and not using the facility.

Attempts by the midwife to engage Jean in assessment and planning proved challenging as she defaulted on appointments each time. The Named Person sought support from children and families social work and the specialist midwife through a multi-agency meeting (familiar as the pre-birth screening group). The midwife shared her early concerns around engagement and the risks to the unborn child. Social work had already recognised their compulsory role to protect the unborn child and had made the decision to convene a case conference immediately after the baby’s birth prior to the baby being discharged from hospital. It was recognised that if risks remained the baby may need to be placed in short term foster care to make sure the child’s health and well-being needs were clearly understood and to allow assessment of Jean’s capacity to parent. In the role of Lead Professional, the social worker agreed to co-ordinate all contributions together...
from maternity and public health into the Integrated Assessment and Resilience Matrix. The midwife shared the information she already had against the Integrated Assessment and agreed to continue to gather information.

At 20 weeks pregnant, Jean was subjected to an assault by her husband and was admitted to the Emergency Receiving Unit. This became a turning point for Jean who began to engage with the substance misuse nurse and agreed to attend maternity appointments with support. With Jean’s knowledge, an early case discussion took place with housing services, addictions services, maternity services, public health, children and families social work and criminal justice social work services who worked together to analyse all available information to understand Jean’s support needs. With a statutory duty to protect the unborn child, there was a compulsory role for children and families social work who continued in the role of Lead Professional.

Jean’s pre-birth action plan:

- Jean was prescribed a methadone programme to help control her drug addiction and improve the health of her unborn baby (healthy)
- Jean developed a good relationship with her addictions counsellor. She reduced her alcohol consumption and her own physical health began to improve, which in turn helped the health prospects for her unborn baby (healthy)
- Social work supported Jean to understand and manage the risks to herself and her unborn child from violence. Contact with her husband ceased and this had a positive impact on the safety of her unborn child (safe)
- The homeless officer worked with Jean to find suitable alternative accommodation which could be sustained. Together they achieved this goal which was the beginning of creating a nurturing environment for the baby (nurtured)
- As the Named Person, the midwife continued to monitor Jean’s health and well-being. Using the Integrated Assessment, she gathered as much information as she could about Jean’s capacity to provide for the well-being of her child. She helped Jean to understand that a baby delivered on methadone would have to stay in hospital for four days to monitor withdrawal. She also accepted that her baby would be placed in foster care for a period to ensure her baby’s well-being while she concentrated on creating a safe home environment, and worked with services to strengthen her own parenting capacity (responsible)
- Jean’s midwife and social worker made joint visits to prepare Jean for the birth, for parenting and to plan her involvement in the baby’s care (nurtured)
- The midwife and public health nurse worked together on the transition to the baby’s new Named Person which would support Jean to take a key role in developing her baby’s well-being.

Post birth:

- Immediately following the birth a case conference was convened and a child protection plan was drawn up (safe)
- The focus of Charlotte’s assessment in hospital was to monitor methadone withdrawal and general health (healthy)
- Contact with Jean and Charlotte was facilitated and supported by the social worker, the midwife, the public health nurse and the foster carer to ensure Charlotte had a secure attachment to her mother (safe/nurtured)
- Early observations showed evidence of attachment and bonding with the baby. Jean responded to the baby’s needs appropriately; talking, soothing, cuddling, feeding, and changing which provided some positive indicators of capacity to support well-being.

Developing Charlotte’s Plan:

The next step for Charlotte is to develop an Integrated Assessment and Child’s Plan which will be reviewed four weekly to make sure her well-being is developing as it should. The focus will be on Charlotte’s outcomes, although many of the actions will be centred on supporting her mother to ensure the baby’s well-being. Jean is currently maintaining her tenancy, keeping her new home clean and tidy and building up what she needs to provide a nurturing environment for Charlotte at home. Contact has gradually increased between Jean and her baby to daily visits. All observations show positive signs that she is aware of the needs of her baby and shows potential to provide for her. The plan is working towards overnight stays for Charlotte with Jean. To date, Charlotte’s father has had no contact with Charlotte but he receives regular reports of her progress.
Claire aged four

The nursery supporting the roles of Named Person and Lead Professional in Integrated Working

Claire was one of four children involved with social work. There had been a previous child protection investigation and no further action was taken. Social work remained involved on a voluntary basis. Although social work were involved, the public health nurse remained the Named Person until Claire reached the age of five years old.

Claire started nursery which was managed by the head teacher who was keen to make sure that Claire's needs were being addressed and that everyone involved was clear about what they and each other were doing to help develop Claire’s well-being. The head teacher began by mapping what was known about Claire using the Single Agency Assessment Part 1 (well-being) and the What I Think tool. The head teacher understood that if social work were involved voluntarily, Integrated Working may be necessary and she asked mum's permission to invite partners in social work and health to a meeting with mum and the school, to share their experience of Claire’s progress using the school’s Single Agency Assessment Part 1 as the starting point.

Health were able to identify that although Claire’s family home was unkempt and untidy, there was evidence of nurture from mum in terms of oral and physical affection, appropriate toys, up to date immunisations, etc. It was also identified that the children had some structure and boundaries (responsible). Mum was clearly aware of her role as a parent and all children in the family attended school and nursery regularly and were making good progress in relation to their learning and development (healthy and achieving). Claire’s mum engaged well with education services for all four children. Claire's father was not available during the home visit.

A What I Think tool was completed with Claire, based on close observation, some verbal and non-verbal communication which was age and stage appropriate for a nursery child. This exercise provided evidence of a strong self image and a child who felt that she had people she trusted and could approach if she was in difficulty (safe). Claire was also observed to relate well to and mix with her peer group but only during nursery hours (included). Claire rarely volunteered her view or opinion within the nursery environment.

Bringing information together allowed health, education and social work to identify some areas for development. Under included, it was identified that Claire had very little opportunity to relate to her wider world and make relationships outside of her immediate family because her parents...
chose not to mix within the wider community. There was also recognition that Claire needed significant support to express her opinions and did so reluctantly. It was also acknowledged that although the family engaged well with education, health and social work services experienced barriers. Claire’s father refused any medical intervention for cancer and the family resisted offers of support from children and families social work. The information that Claire’s father was suffering from advanced, untreated cancer was not known to education and social work prior to the multi-agency meeting. The father’s illness could be impacting on Claire and there were concerns about her ability to cope with the loss of her father. The partners agreed that forward planning to support Claire in dealing with her father’s death and the impact on her own well-being would be helpful.

In considering all the information available to Claire’s Network of Support, it was agreed that communication between agencies had been helpful and continued co-ordination would be beneficial to Claire. Building on the strong connection with school, it was agreed that the head teacher was best placed to act as the Lead Professional. The information gained about Claire was able to be recorded quickly in an Integrated Assessment and a straightforward Child’s Plan developed recording the desired outcomes. Building on the strengths of her cognitive abilities, resilience and strong self worth, the plan made the most of her positive engagement with her educational setting which was extended to an out-of-school placement. This would allow Claire to extend her social contacts and positive relationships. Claire was actively encouraged to express her views and opinions and steady progress was observed. Public health and education worked together with Claire’s mum and the children to support understanding of the father’s illness and help mum to prepare the children for changed circumstances.

Through the developing relationship with Claire’s mother, the Network of Support became aware of the controlling behaviour of the father and the domestic abuse which impacted on the mother and the family dynamic which led to social isolation. Partners continue to work towards the outcomes of improved inclusion within the community; a wider network of support and consistent, steady progress in respect and achieving. With health and education working closely together on developing Claire’s well-being, it was acknowledged that there should be a diminishing role for social work and that health and education should continue Claire’s Plan. Claire now enjoys attending an out-of-school club where she is making new relationships. She has been supported through the loss of her father and has coped well with the change of circumstances. Claire’s mother accepted the support of health and social work and also coped well with the loss. Claire’s family circumstances and the impact on her well-being are reviewed at agreed intervals and any significant events are tracked using an Integrated Chronology of positive and negative significant events.
Matthew aged 14

Requesting Assistance from the voluntary sector as part of a child protection plan

Matthew is 14 years old, living with dad in a rural village, having moved from Glasgow four years ago. Matthew has no contact with mum – hasn’t since he was a baby. He has an older brother who visits very occasionally (last visit over a year ago). Matthew had heart surgery as a small baby and has regular medication and treatment which dad supports.

Dad has alcohol misuse issues that he has difficulty acknowledging. Dad has had a sporadic relationship over the past four years with a friend whom Matthew refers to as his mum. Matthew maintains contact with dad’s partner even when they are separated. Matthew struggled in late primary school years becoming aggressive towards teachers and absconding.

At high school he is regularly suspended because of his behaviour and non-attendance much of which his dad is aware of. His behaviour (fire-raising/theft) has created issues for him within his local community. Matthew is on the child protection register and his child and family social worker is his Lead Professional.

He also works with a family support worker. As part of his child protection plan, the core group Requested Assistance from a local voluntary sector organisation, COVEY Befriending, to provide a service and become a member of Matthew’s Network of Support.

COVEY began the process of providing a service. With permission from Matthew and his father COVEY visited the family and explained how they intended to proceed.

After successfully matching Matthew with a befriender, Matthew’s Network of Support agreed that the first few months would be spent getting to know Matthew in order to complete a well-being assessment to identify how COVEY could help. With Matthew’s permission, COVEY shared the well-being assessment with Matthew’s Network of Support recording how they believed they are able to contribute to Matthew’s well-being.

A befriender spends three hours per week with Matthew, engaging in a range of activities to help develop his well-being.

Below are excerpts from the well-being assessment:

Analysis – What is getting in the way of this child/young person’s well-being?

Dad’s alcohol issues and attitude to his own well-being is impacting negatively on all aspects of Matthew’s well-being, from his education and achieving to physical and emotional health, his social inclusion and his need to be respected and develop a sense of responsibility. The only nurture Matthew...
receives is dependent on his father’s partner who is not around consistently. Prioritising the purchase of alcohol means Matthew is denied some of his basic needs, such as nutrition, as well as opportunities to develop and access facilities which might benefit his well-being. The lack of acknowledgement of difficulties and pressures for Matthew caused by the alcohol problem makes it difficult to provide help and support to dad and Matthew. Matthew's diet could be significantly improved as could his attendance and progress at school. His offending behaviour has decreased since befriending began but he is some way off making positive choices for himself.

**What can I do NOW to help this child/young person?**

Covey Befriending can continue to offer one-to-one support to Matthew, exposing him to positive activities and experiences and providing a consistent, reliable and stable relationship which will impact to some extent on his sense of self-worth.

Befriending can offer an alternative view of the world through a positive role model which may encourage him to exercise his own choice in how he wishes to behave.

Essential to continue to work closely with the school, his social worker and any other relevant professionals to support their objectives in improving Matthew's well-being.

The positive relationship with befriender means we are able to monitor how he is feeling and advocate on his behalf objectively. Befriending is an important protective factor in Matthew’s life as we are in regular contact and can monitor Matthew's physical and emotional safety.

**What can my agency do to help this child/young person?**

COVEY can fill some of the gaps which result from lack of dedicated resources for Matthew. Providing transport, group activities and outings, as well as individual activities based on his interests, can continue to contribute to reviews of Matthew’s **Integrated Assessment** and **Plan** as part of his **Network of Support**, modifying what we contribute or agreeing a particular focus if necessary.

Matthew’s ambition is to go to college but there are steps to getting there, such as sticking to a programme of learning and being reliable, functioning independently with transport and self management, and eliminating some of the behaviours which may become obstacles to sustaining college. COVEY will support him in his ambition by setting these steps as goals with COVEY and positively reinforcing his achievements towards them.
Joselyn is 18 years old and expecting her first child with her partner, Richard. Joselyn and Richard did not plan for a baby at this point in their lives but they have been together for two years and the relationship is stable. Having considered their options, Joselyn and Richard have taken the decision to go ahead with the pregnancy, supported in their decision by their own parents.

One month before falling pregnant, Joselyn was diagnosed with epilepsy having suffered a number of tonic seizures. Her last recorded seizure took place in January and the baby is due in September.

At the first point of contact with Joselyn and Richard, the community midwife, Jackie, explains that as the Named Person until the new baby reaches 28 days old she will be responsible for the baby's well-being. Jackie gives Joselyn and Richard a well-being pregnancy wheel with an explanation of well-being and her own contact details.

From the point of the first visit to the booking-in clinic, Jackie is made aware that Joselyn is a recently diagnosed epileptic and understands that the family will need additional support from within maternity services. Jackie decides to begin with the Single Agency Assessment Part I understanding that she may move to Part II if necessary. She explains to the couple that she will be gathering information as she goes along which will be recorded in the Single Agency Part I Assessment which is passed to the public health nurse when he/she takes over the role of Named Person.

Jackie recognises the need for a home risk assessment and thinks it will also be helpful if Joselyn and Richard receive advice from the specialist nurse at the Southern General Hospital. With the couple’s permission, she completes a Request for Assistance attaching the information she has gathered in the Part I assessment. Jackie is encouraged by the information she is able to record against the well-being indicators.

The unborn baby’s safety is being taken care of by Joselyn’s choice to give up smoking and drinking during pregnancy and by her determination to learn as much as she can about managing her epilepsy which might present risks. Joselyn and the baby are healthy and all appointments are kept as far as possible. Joselyn speaks positively of her own childhood and is accompanied by her own mother with whom she appears to have a very positive relationship.

After the initial shock of discovering she is pregnant, Joselyn now appears excited and talks affectionately about the baby, indicating some potential to nurture. Although young, Joselyn appears able to express her views readily and seems to be respected by those around her. She is organised about keeping her various appointments, arriving on time and engaging well with services which indicates potential to maintain routines and structures for the new baby.

As the Named Person for Joselyn and Richard’s baby, Jackie recognises the understandable anxieties about the epilepsy but is fairly confident at this point that with a bit of extra help from maternity services, and early involvement of the public health nurse before the baby arrives, the couple will parent successfully and the baby’s well-being will develop. She explains that she will update the well-being assessment over the coming months but seeks permission to pass the information currently available to the team leader in public health to Request Assistance for early involvement.
Jamie (7) & Josh (3)

From Compulsory Intervention to Integrated Working

concerns of domestic violence

A notification was received by social work from the police. There had been an incident the previous evening when the father had assaulted the mother, who had bruising to her face. The children were in bed seemingly unaware of the disturbance. The father had fled the scene and had not been interviewed by police officers. In addition to children and families social work, the Named Persons for Jamie and Josh were also both informed immediately of the incident.

Social work reception service received the notification. The social worker noted from the police report that there had been a previous domestic incident when the family lived in Glasgow four years ago. She contacted Glasgow social work resources. The only information on the family was in relation to the previous domestic incident where there had been no further action as the mother advised it had been a minor incident and she did not require support. No concern for Jamie was noted.

The reception social worker contacted Josh’s Named Person, the public health nurse, to establish how much was known about Josh. Josh has been on the public health nurse’s caseload for two years with a health plan indicator of core. She was able to share the brief information contained in her Single Agency Assessment Part I with social work as well as a Single Agency Chronology which had very few entries. There were no particular concerns noted for Josh by his Named Person.

On noting the second incident of domestic abuse, the public health nurse changed the health plan indicator from core to additional and social work and public health agreed that a Single Agency Assessment
Part II would be completed.

The social worker also contacted Jamie’s Named Person through the school who reported some recent concerns about Jamie’s well-being. He has always been a quiet co-operative child but had recently become distracted, his homework was not completed and absences were becoming frequent. There were also reported incidents of disputes with his classmates. The school was able to share their initial consideration of Jamie’s needs on the Single Agency Assessment Part I (well-being), which was fairly brief as concerns were recent.

Reception services contacted the mother who advised that her husband had started using drugs again from being clean since Josh was born. She reported that they had been arguing a lot about this and that he had assaulted her the previous night. She knew the situation was affecting the children and she did not want him back in the home until he stopped using.

She was willing to accept support.

Reception contacted the police for an update on the children’s father and they reported that he had been charged and was held over to appear in court. He was given bail with a condition not to approach his wife or the family home.

The information available about Josh and Jamie’s well-being is gathered by reception services in social work who collate the information and advise the relevant area team that there are child care concerns and support to the family is needed.

Due to this and the fact that the mother was willing to accept support, the team leader decides that child protection measures were not required at this point but concerns for the children’s well-being should be addressed. He arranges for the mother to grant permission to share information between health, education and social work and allocates the case to a team member requesting an Integrated Assessment and Plan for Jamie and Josh.

A member of the children and families team takes on the role of Lead Professional and working closely with mum and the boys, she Requests Assistance from the Named Person for Jamie and the Named Person for Josh to participate in an Integrated Assessment and Child’s Pan for both boys. A multi-agency meeting is arranged chaired by the children and families team leader and the mother supported to participate.
Greg

aged 14 – transition to adult services

The Network of Support in a long-term role

Greg is 14 and he has been known to children and families social work and educational psychology since he was four years old. He has also been involved with child and adolescent mental health services (CAMHS). All have been concerned about Greg living with a mother who has an alcohol dependency issue and Greg’s behavioural difficulties in school which present as anger and aggression. At various stages in his primary school, specialist behavioural support has been involved as a result of exclusions from school. He has benefited from an aunt and uncle who live nearby and have been able to care for him at various points in his life. Greg has regularly been under a supervision order with an understanding that his aunt and uncle would provide for his basic care needs. High levels of supervision from children and families social work have enabled him to remain within his family and community throughout his childhood. However, various episodes of offending behaviour have meant that residential care has been considered on a number of occasions. Because of his persistent behavioural difficulties, a decision was made to place him within a specialist school for children with emotional and behavioural difficulties outwith Lanarkshire for his secondary education.

Greg achieved a lot of success within school, rising to challenges and developing his resilience which resulted in some academic success. Greg has in the past evidenced the capacity to modify his behaviour when it is in his own interests to do so. Greg’s enthusiasm for learning has often been apparent. Greg’s engagement and co-operation with school and social work is inconsistent but frequently he has been willing to co-operate with school staff at times when he is being uncooperative with other adults in his life.

Over many years Greg has shown a determination to do what he wants. He is closely attached to his mum although their relationship has changed as she has begun to take control of her alcohol dependency. As his mother has become stronger, Greg has had to come to terms with a new power dynamic which he finds hard to adjust to. Greg still appears reactive and aggressive on occasions and he also can panic at the thought of meeting new people which presents particular difficulties in considering his future. He is likely to find adjustment from a school where staff know him well to new adult situations where he is not known very challenging.

At this point in Greg’s life it is recognised by his Network of Support that careful forward planning is necessary to help Greg prepare for a future after school. Greg’s Lead Professional, the educational psychologist, suggests that it would be helpful to update an Integrated Assessment and Child’s Plan to make sure that the considerable knowledge and information gained through years of experience of working with Greg is shared appropriately with the adults who might support him in the future. It was also recognised that this process would help Greg to reflect on and review his own progress as part of making plans for his next steps.

The Lead Professional Requested Assistance from children and families social work, Greg’s Named Person, the principle teacher of his school, to jointly visit Greg and his mother to discuss the way forward.
Kerry

Kerry aged 15, transition from secondary school to the world of work

Social work as the Lead Professional in Integrated Working

Kerry attends secondary school and was identified by her guidance teacher as someone who may need support to make a successful transition from secondary to the world of work. She presents as having a low interest in school life. Her attendance had steadily reduced and her worst period recorded as 48% attendance.

Kerry's new guidance teacher, who is her Named Person, was getting to know her over two terms. During a session to discuss Kerry's future, Kerry discloses that she thinks she may be pregnant. Kerry's Named Person explained to Kerry that she had to share this information with Kerry's parents and colleagues in social work because Kerry is under 16. Kerry was clear that her parents would want to be involved in discussions and thinks they may already suspect from hints she has dropped. Kerry's Named Person explains to Kerry that social work will want to talk things over with her. With Kerry's knowledge, the Named Person firstly phones social work and follows up by completing a Request for Assistance form attaching the information she was gathering using Single Agency Assessment Part II (well-being).

Social work establishes that there is no compulsory role for them at this point, but that working voluntarily with the family is appropriate. A social worker takes on the role of Lead Professional and Requests Assistance from colleagues to participate in an Integrated Assessment and Child's Plan. Kerry, her parents, public health, maternity services, education and children and families social work consider each dimension of the My World Assessment Triangle to complete an Integrated Assessment and Child's Plan to make sure that all of Kerry's needs and those of her baby are considered and met. In the meantime, with Kerry and her parents' Informed Consent, a Request for Assistance is made to the teenage pregnancy co-ordinator and the first steps worker to immediately link Kerry to practitioners who can help.

The guidance teacher records Kerry’s strength of character, her confidence and ability to articulate her views and needs. She acknowledges her lack of interest in academic pursuits, evidenced by poor attendance, but also sees potential ability that has not been realised. She also recognises Kerry’s social skills and ability to form relationships and relate to a peer group. There is some knowledge of Kerry’s home situation in that she supports her parents to care for her three younger siblings.

The public health nurse is able to add that Kerry’s own health is good although there is some evidence of sexually risky behaviour through the unplanned pregnancy with a young man her own age. Her two-bedroom home, housing two parents and four children is overcrowded, cluttered and disorganised with very little personal space for anyone in the family. Both
parents have recorded mental health difficulties, the father particularly at this point, and Kerry is relied upon in a caring role with her siblings. This means Kerry has a clear understanding of the responsibilities of parenting and is confident around infants and children, but also means there is less time for her own needs. Kerry’s parents express their desire to support her through pregnancy and expect her to continue living in the family home. Her grandmother is an important part of the extended family support and shows care and concern for Kerry.

Maternity services check Kerry’s health and monitor the unborn baby. The midwife establishes that the baby’s growth and development is progressing well. Kerry has chosen not to drink alcohol during her pregnancy and is open to advice and support from the midwife. Social work confirm public health’s findings in the family home and recognise that Kerry may need support to create some boundaries between her caring for siblings and caring for herself. With Informed Consent from her father, the Lead Professional Requests Assistance to share information with adult mental health and to involve them in planning for Kerry and her baby by supporting her father’s difficulties.

In analysing Kerry’s current situation, the overcrowded house, her role as a carer and her father’s mental health problem are recognised as risks to Kerry and her baby’s current and future well-being and agreed as the immediate priorities which should be addressed.

The answer was not seen as Kerry being moved into her own accommodation and coping with a tenancy, being alone and first time parenting all at the same time. There had to be a transition to build on the supports she had. Supporting dad with his own mental health difficulty was seen as key and finding a solution to the support needed in the family was also recognised. Kerry’s Network of Support agrees that the social worker would remain in the role of the Lead Professional at least until the baby’s birth, whereupon the decision would be reviewed.

- Kerry’s plan outlines the desired outcome for her to improve her well-being and give the baby the best opportunity to grow and develop:
  - Appropriate long term accommodation for Kerry and her baby (safe, nurtured)
  - Evidence of reducing negative impact of Kerry’s dad’s mental health problems and evidence of improving emotional resilience in Kerry (healthy)
  - Evidence of preparedness for the baby’s arrival and improving personal confidence in Kerry to provide for her baby’s needs (healthy, achieving)
  - Evidence of reducing dependence on Kerry as a carer to ensure that adequate time will be available to meet the baby’s needs (responsible)
  - A strong Network of Support to help Kerry as she prepares for the transition to adulthood (nurtured, included)
  - A plan for Kerry’s future beyond the birth of the baby, with incremental goals which are realistic and sustainable (achieving).