

Early Help & Children's Social Care Case Recording Policy & Guidance

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1) Introduction

This recording policy is written with the intention of providing guidance for all social care staff involved in recording information about service users within the Early Help & Children's Social Care Service.

Nothing in the guidance removes the need for staff to exercise professional judgement in regard to recording. The policy provides a framework for staff to operate within, though there is a requirement for judgement and discretion to be used when deciding on the appropriate nature of recording in individual cases.

This policy applies to all Early Help & Children's Social Care records whether paper or electronic. The main case recording tools are "Liquid Logic" (LCS) & "EHM Electronic Recording System" (EHM) where all information and contact with individual children, young people and their families and/ or carers where the threshold has been met for social work intervention or Early Help Intervention is recorded. Additional paper files must only contain documents that need to be preserved in their original form e.g. birth certificates and legal documents setting out orders, such as Placement Orders. Historic case files may still be paper based but all new or current files should be recorded on LCS or EHM.

Recording is an essential aspect of providing a social care service and is a tool for:

- Gathering, organising and analysing key information to inform decision making and planning.
- Reflecting upon and analysing information in order to develop and adjust plans
- Recording the voice of the child and reflecting their wishes and feelings (**Childs voice should be recorded in red in case notes**)
- Demonstrating openness with service users evidencing their views and involvement
- Demonstrating we are following the principles of Restorative Practice and working "with" children and families where possible.
- Maintaining accountability within the organisation
- Transferring information to other agencies

The effectiveness of the recording policy can only be monitored if users of the system i.e. all staff in Early Help & Children's Social Care ensure that their experience (good and bad) is shared with their line manager. The feedback is vital in ensuring the policy is meeting the purpose it was designed for.

2) Background

Lord Laming's Report (2003) identified several key recommendations, which require social workers to maintain accurate, informed and up to date case recordings. Trafford has a clearly stated belief that good case recording is central to good practice.

The Munro Review of Child Protection (2011) stated that: Recording is a key social work task and its centrality to the protection of children cannot be over-estimated. Getting effective recording systems in place to support practice is critical.

Quality recording is central to good practice. It promotes focused work, assists continuity when a variety of personnel is involved and is an essential monitoring tool for managers. Effective recording supports partnerships with service users and carers.

Recording should be considered an important activity, not just for the agency but for service users and / or carers. For young people who are looked after recording serves as a corporate memory. Whilst social service staff move on, the records remain, and later may be used to support a young person to understand their life and why decisions were made. Good recording serves to inform young people about their world and reinforces their identity. In contrast poor recording serves to confuse and can lead to misunderstanding and resentment. Recording therefore should be seen as an integral part of practice, and as time needs to be allocated for direct contact with service users, time should similarly identified for recording where interruptions and diversions are kept to a minimum.

As far as possible, recordings should be contemporaneous or as soon as possible after the event rather than rely on memory, as keeping information in the head to be recorded at some time in the future could mean that key information may be forgotten and lost forever.

3) Recording Keeping Values

Each child must have their own electronic case record from the point of referral to case closure.

Appropriate records must be kept of all contact with children and their families / carers and a clear case summary and chronology should be maintained.

There must be a consistent approach to all recordings and records should be:

- Accurate and concise
- Up to date
- Relevant
- Easy to read and in plain English, with any abbreviations explained
- Easily understood by the service user (whether this is a parent, carer or child)

Record keeping is key to providing integrated services to children, and their families and carers. Consistent recording processes are essential for service planning, decision making and information sharing. Quality recording will assist care planning in the following ways:

- Providing documentary evidence of the authority's involvement with individual service users.
- Providing information to assist with analysis, service / care planning and reviews and evaluation.
- Documenting services provided to individual service users.
- Allowing continuity when workers change or are absent
- Providing information when dealing with investigations or complaints.
- Supporting supervision and employee development
- Providing service users with a complete record of their care and in some circumstances, for looked after children their whole childhood.

All recording must be finalised within the appropriate timescales (see Appendix a). Where possible, children and their families / carers wishes and views (including issues around consent) must be noted and it should be evident they have actively engaged during the activity. Children's views should be recorded on LCS or EHM **in bold red type** to ensure they are clear and evident.

Service users and carers should be informed of their right to access their records and the procedure for doing so (see Access to Records).

All recordings should be evidence based with clear distinction between fact and opinion. Consideration must be given when recording race, culture, age, disability, gender or sexual orientation and how the needs of individual children have been acknowledged and supported.



Restorative principles should be applied to all case recordings, consideration should be given to the use of language and how this may impact on the perception of those reading the case file. Case files should reflect what has happened, who has been affected and what needs to happen now and evidence we are working in a high challenge / high support environment and identify if we cannot work this way at this time what are the reasons for this.

4) Principles

Accuracy: Entries must be accurate and must distinguish between facts, opinions, assessments, hypothesis, judgements and decisions. Records must distinguish between first-hand information and information obtained from third parties.

Clarity: recording should be clear and in chronological order. The reader should be able to interpret the information without misunderstanding.

Relevance: Service user's records should not include unnecessary material, messages or notes. Records should not contain long verbatim disputes between professionals, if the information is relevant the nature of the dispute should be summarised and the outcome noted. A child's file should represent them and they should not be lost in information regarding their siblings or parents.

Timeliness: Case notes should be recorded within three working days of the event, or notification of the event. Entries should be recorded by the date of event not the date the case note is added (see Appendix 1 for timescales for other recordings).

Legibility: All recordings should be written concisely, in plain English and avoid the use of professional jargon.

Responsibility: The management of information about service users is the responsibility of all employees of Trafford Council. The practitioner primarily involved, which is the person who directly observes or witnesses the event that is being recorded and who has participated in the meeting / conversation, must complete records. Where this is not possible and records are completed or updated by other people it must be clear from the record which person provided the information being recorded.

Services Users' Involvement: Entries will reflect that the views of child(ren), young people and their families have been actively sought and fully recorded. Also that they contribute their comments where they agree and/or disagree with professional opinion and these are recorded also. The means by which this information is obtained should also be recorded e.g. direct work with a child through use of play materials. Recording should be undertaken with a clear view of the reader in mind i.e. the service user. Care should be taken with both the content and the language.

Care must be taken when recording to ensure that confidentiality and the principles within the General Data Protection regulation (GDPR) are taken into account: Service users must be confident that information held about them will only be disclosed to others with their consent or when there is a legal duty or power to do so. In practical terms this means that information will be shared with other professionals who are involved in considering and responding to the needs of the individual.

When emailing or faxing information about service users: it is important that staff ensure that information is transmitted accurately and securely. It is important that staff read the I.T. Acceptable Use Policy.



Any emails copied and pasted to 'Case Notes' on LCS or EHM do not contain information relating to any other service user or any irrelevant communication between the sender and the recipient, including any disagreements between them. Uploaded emails must not take the place of case notes.

Confidentiality: Information will only be kept confidential from a service user for specific reasons e.g.:

- Where disclosure of the information is likely to result in serious harm to their physical or mental health or to that of another individual (including a member of staff);
- Where disclosure would identify a third party who has not consented to being identified (this does not apply to third parties who have provided information in a professional capacity);
- Where disclosure would be likely to prejudice the prevention or detection of crime.

Consent: Should be gained from a service user before any personal information relating to them is sought from other sources. However, a service user's consent to disclose their personal information or seek information from other agencies is not required in instances where the law or public interest overrides their right to confidentiality. These include:

- If there is a concern about an individual's safety;
- Where the courts have made an order;
- To prevent, detect or prosecute a serious crime.

Sharing of information: In situations where a request is made to or by another organisation, to share information the decision to share or not to share regarding who made the decision and the reasoning behind this, should be recorded.

Where an interpreter is used: this should be recorded, giving their name and whether they were from a contracted service or a named staff member, family member and/or friend.

Management oversight must be evidenced: The line manager should routinely audit files. The overall responsibility for ensuring all records are maintained appropriately rests with line managers, although the responsibility can be delegated to other staff as appropriate.

The line manager should routinely check samples of records to ensure they are up to date and maintained as required and, if not, that deficiencies are rectified as soon as practicable.

Recording of decision-making: to highlight the reasons for the decision-making and the decisions made, including assessing risk and why other decisions were not made, should be clear. All of the people who take such decisions should be identified and where necessary a copy of the signed decision should be uploaded onto LCS or EHM. Every decision arrived at between supervisor and worker, whether in a formal or informal supervision session, must be recorded in the service user's case recording at the time of the decision being made. Managers must also use supervision to ensure that the case record is being maintained in a reasonable state.

Anti-discriminatory practice: All records must demonstrate an anti-discriminatory perspective and must not include any derogatory comments by the author on ethnicity, race,



culture, gender, age, religion, language, communication, sensory impairment, disability, family make-up and sexual orientation.

Sharing of case records: should be routinely undertaken with children; parents and / or their carers.

5) *Good Practice Recording*

a) *Assessments*

All assessments should be recorded in LCS or EHM and all parenting assessments should be recorded in the Child and Family Assessment (CAFA) and a clear and concise chronology should be part of every assessment (see 6. Chronology)

Understanding the family's circumstances and why they are experiencing difficulty is a fundamental component both in risk assessment and in identifying the extent of intervention and the nature of service delivery.

It is essential that families understand what we are worried about and are involved in the assessment and identifying how the needs of the children can be met, giving consideration to support from extended family and their support network.

A feature of review findings is that whilst social care staff may be very effective in collecting information, they tend to be poor in analysing information and communicating their professional judgement within the record. Research from Serious Case Reviews concludes that there is too little evidence of social workers undertaking analysis, and where analysis has happened it tends to occur in the mind of the practitioner and is never committed to the case file, therefore disabling others who might read the file from understanding how decisions were arrived at.

The link between assessment and planning is well recognized. Poor assessment inevitably leads to poor planning and unfocused intervention with commensurately poor outcomes for families. Conversely, accurate assessments will more likely deliver needs-led planning with a clear focus on intervention enabling the practitioner to focus on the key issues and support families to change.

b) *Statutory Visits (Child Protection, Looked After, Private Fostering) and Child in Need Visits*

Recording Statutory Visits and Child in Need Visits is mandatory. The visits should be undertaken within the relevant timescales and recorded on LCS within 3 days of the visit & EHM within 5 days of the visit.

The social worker should record each visit stating clearly:

- a. Who was seen; include any family members or carers and anyone who is visiting the property.
- b. Whether the child was seen and if not why not. If the child is not seen it cannot be recorded as a statutory visit for that child.
- c. Whether the child was seen alone, and if not why not.
- d. The child's views, the child must be given the opportunity to share how they are feeling, what they think is going well and anything they are worried about. If it is a young child or a young person who cannot verbalise their feelings, the observation of

their mobility, confidence in their environment and response to their carers should be recorded and are key to assessing their wellbeing. If a translator is required they should be present for statutory visits.

- e. Any comments made by the staff/carers/parents
- f. Any issues of concern or difficulties and how they were addressed in the visit, for example if a child was on a Child Protection Plan under the category of neglect it may be necessary check food volume, clothing, beds & locks.
- g. Any observations on the child's welfare and their home life. If the child is on a child protection plan or looked after their bedroom should be seen as part of the visit.
- h. The time and duration of the visit should be recorded in the case note
- i. Was the visit announced or unannounced.
- j. Any requirements for action.

Visits should be recorded in case notes under the relevant heading e.g. Statutory Visit Child Protection, Statutory Visit Looked After, Statutory Visit Private Fostering, Child in Need Visit. If there is no access for the visit it should be recorded as Home Visit No Access and a further visit undertaken to ensure that timescales are met.

c) Recording that is relevant

It is important to record what is relevant. Traditionally, Social Work has adopted a narrative style of recording as it tends to reflect conversation or patterns of speech. This style of recording tends to be open-ended and longer which can lead to pertinent information being omitted or lost within the narrative. It is important to maintain a clear focus and to construct recording around the plan for the family that is informed by robust assessment.

It is particularly important when managing child protection that the risk assessment and analysis needs are clear, simple to follow, easy to understand and unambiguous. It needs to identify the underlying risk factors, high risk indicators, the parents' capacity to change, along with strengths and family resources that can be mobilised to manage the risks and support sustainable change. Significant events or issues need to be identified and understood within the context of the family's functioning and information from research and / or through supervision needs to identify the impact upon the child's wellbeing (e.g. Domestic Violence). Such information can prove crucial for evidence in Court.

It is equally important to record when things don't happen and why, such as:

- Not seeing a child within 24 hours of a child protection referral;
- Decisions not to take a course of action (e.g. not to seek legal advice or not to use an interpreter)
- Failed or missed appointments
- Not in visits
- Missed deadlines

d) Inclusive recording

Case recording needs to be viewed as part of the service Children’s Social Care provides for the service user. It is essentially **the service user’s record** and should be compiled with care and accuracy. Accordingly, the case record should be written in a style that promotes the sharing of the record and engages the understanding of the service users. The case record should be used as a casework tool and in the spirit of partnership should be written with the expectation that the service user will read the record.

A fundamental principle in social work practice is respect for the service user and recording practices similarly need to adhere to this principle. Recording should therefore be evidence-based, differentiating between fact and opinion, should avoid the use of both jargon and statements that are discriminatory, oppressive or gender biased.

The expectation that the record is to be shared does not mean that all parties will always agree, and in these circumstances dissent by the service user should be recorded. Sharing records does provide the opportunity for the practitioner for clarifying issues, correcting inaccuracies and checking the service user’s perception of the circumstances affecting their family. It also promotes a mutual understanding of the issues, encourages partnership, and endorses Trafford’s desire to be transparent and honest in its dealing with the public.

Practitioners involved in open recording have commented that the involvement of service users has improved their recording practices. They have stated that “recording was more factual, focused and opinions were more likely to be substantiated” (Shemmings D (1991) Client Access to Records).

In working with children and families, there are often competing demands and agendas both within the immediate family, the extended family and even amongst other professionals. Against this complex background the child’s voice, opinion and wishes can get lost and sometimes is not represented at all within the record. It is vital that every effort is made to record the child’s perception and child centred strategies are used to capture their views, **which should be recorded in case notes in bold red text**. It also means having an understanding of the special needs of young people e.g. literacy problems; age and understanding; different first language; disabilities in learning, sight or hearing. Strategies may include direct work activity, such as drawings / paintings, models role-play and other techniques. It is important to remember when recording the child’s views to record how the information was obtained. When sharing records with children, consideration needs to be given to their age and understanding.

“Children cannot participate in decisions if they are not fully informed of the options available to them and the implications of those options.” Lansdown G. (1995) Children’s Rights to Participation and Protection.

e) Helpful strategies to aid recording

- Set aside some free time every day to record events of previous day e.g. 1st half hour of the day – that equals 2 and a half hours recording per week;

- Record as soon as possible after the event;
- Try to record directly onto LCS or EHM application where this appropriate;
- Plan visits beforehand and use your plan to structure your recording;
- As far as possible and without disrupting the flow of the interview make contemporaneous notes (See note below)
- Do not leave too much time between the visit and the write up.

f) Contemporaneous notes

It is acknowledged that when workers are visiting families or taking phone calls they may take hand written notes. These do not form part of the primary / official record and should be destroyed as soon as the electronic record is completed, which must be within the required timescales (see Appendix A)

There have been occasions where Courts have requested hand written notes or workers have referred to these when giving evidence. These notes are not part of the primary / official record, have not had management oversight and should not be referred to or disclosed.

g) Co-working and Interagency working

If you are co-working a case agree at the outset who is doing the recording or how the task will be divided up. If you cannot agree – see your Manager.

If two agencies make their own notes, agree which one is the one true record, and deal with any discrepancies at this stage rather than in the Court arena. Only one record of a strategy meeting must be taken if the Police are involved.

h) Case Summary

The case summary provides the opportunity to consolidate events and changes that have occurred within the family over a period of time. Summaries should be seen as a casework tool that supports the work with families in a number of ways.

Sharing summaries with families allows them to reflect upon progress and serves to reinforce the practice of partnership and consultation. Families may not always agree with the practitioner's analysis of their circumstances, but the activity of sharing the record in this way conveys the principle of transparency and enables the service user to challenge the record and have their dissent documented.

Summaries should be written with reference to the aims and objectives identified in the child's plan and should comment upon those areas that have been achieved and those that still have to be realised. It is important that some commentary is given to those areas that have not been achieved and why, and what strategies need to be implemented to achieve these objectives in the future.



Summaries are not only helpful for supervision purposes but provide colleagues with an efficient means of identifying source information enabling continuity of service provision even in the absence of the key worker.

Writing a case summary allows the practitioner to reflect on the effectiveness of intervention and to review progress in achieving the goals identified in the care / case plan. They should be completed at regular intervals (3 months) and particularly where the case is to be closed or transferred to another professional.

i) Management Oversight

There should be regular monitoring and oversight of all case recording by the responsible line manager to ensure that case records are up to date, of a good standard and reflect how needs have been identified and why interventions are required.

All assessments undertaken should have the authorising manager's comments and views included and these should include any areas which require further exploration and whether they have any differing perspectives and the reasons why.

Managers must add their views and comments to all child and family plans and consider the progress being made and its timeliness.

All management decision making should be recorded in case notes and how these decisions were informed, including the views of other professionals where appropriate. This should include clear expectation of any actions required and the timescales.

All case supervision both formal and informal should be recorded on the child's file. All supervision including reflection and analysis should be written in a respectful child focused way remembering this is the child's case file.

Managers should be looking for evidence in the case recording that we are working with families in a Restorative way and demonstrating and understanding of both the strengths and difficulties within the family and working in a high challenge / high support way.

6) Chronologies

The chronology serves to list, in date order, significant events in the family's history. The importance of the chronology as a casework tool cannot be overstated. It provides an important overview of events enabling the worker to stand back and consider the various stages in the family's history and whether current interventions are effective in promoting change and improving the circumstances for children. The chronology should be shared with the service user to provide them with the opportunity to reflect upon the accuracy of the record, provide them with insight as to why social services are involved, and to engage them in considering what achievements and difficulties they have experienced over the period. Similarly a good chronology will enable a service user or care leaver to better understand why social care were involved in their lives and why decisions were made and the impact of actions on children and young people.

An up to date chronology must be kept on LCS or EHM for all children from the point of referral and regularly updated to include any significant event or information, and the impact of these on the child. A significant event is an incident or information that impacts on the child's safety or welfare, home environment or emotional wellbeing. Significant events can have both a positive and negative impact on the child. Positive events are equally important as they can identify the best way to support families to make sustainable changes.

The chronology within the CAFA should be updated whenever the assessment is updated. This chronology will pull through from the previous assessment (from any CAFA started after 9th August 2018). The chronology is in the format required for the Social Work Evidence Template (SWET) therefore the chronology from the CAFA will pull through to the SWET if required in the future.

Example:

Date	What Happened?	Who has been affected and How?
01/10/2015	X was born at Wythenshawe hospital	Ms A now has 2 children to care for which may increase the level of neglect for both X & Y
23/12/2015	Incident of domestic violence reported by the police. Mr B assaulted Ms A and X & Y were at home	X & Y at risk of both physical and emotional harm as a result of the incident. Ms A unable to meet the children's needs as a result of the injury. Children experience further neglect.
24/12/2015	Ms A's mother moved into the family home.	Ms A supported to meet the children's needs and her mother a protective factor.

7/1/2016	X & Y placed on a Child Protection Plan under the category of Emotional Abuse	Multi-Agency Child Protection Plan to support the family to reduce the risk of significant harm
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LCS has a chronology function; this currently will not populate the assessment but can be seen in view only whilst the assessment is completed. To add to the LCS or EHM chronology whilst writing a case note you need to tick the significant event box & add to chronology.

The chronology should enable professionals and families to clearly see patterns of behaviours and actions and the impact this has on the child. A good chronology will prevent “starts again syndrome” and reduce the risk of drift and delay for young people suffering from or being at risk of harm.

To compile a chronology the practitioner should:

- Identify the key events to be recorded
- Identify the sources of information to be used
- Make sure what is recorded is accurate and in date order
- Consider the significance of the events for the child and family in question and what is the impact on the child
- Ensure that the child is evident in the chronology and their voice is heard. If the chronology represents a sibling group all children should be clearly represented.

The chronology should not become confused by recording all visits, meeting and contacts regardless of whether significant information has been shared within the chronology. These should be recorded appropriately within LCS or EHM and Case Note Reports can be run to collate specific recordings if required.

An up to date chronology is crucial in safeguarding because it:

- Gives concise & relevant information about previous history which may be an important indicator of risk
- Provides continuity so it can be seen immediately what has happened
- Presents clear accurate information
- Helps focus on key events so we can understand what is happening in the life of a child or young person and the impact this is having on their daily lived experience.
- Highlights risks & vulnerabilities, but also strengths and resilience.
- May identify patterns in social history and behaviour and events which appear insignificant in isolation however when considered together can identify warning signs and patterns of behaviour
- Can highlight people in the child’s life which may already be known by agencies, or the nature of current relationships between families and their wider social networks. This gives important information about who in the family/network may be protective and which family members may pose a risk to the child/young person

- Can highlight gaps, missing details and inconsistencies that may require further assessment.
- May identify what types of intervention or working produce better outcomes for young people.
- A good chronology can be used as a reflective tool for multi-agency working together, in supervision and for key decision making

a) What should be included in a Chronology?

The lists below describes the events which may need to be included in a chronology, they are not exhaustive. There will be other significant events which will also need to be included. The decision about what other events need to be included will be based on professional judgement and managerial guidance.

b) Suggested Chronology of events

- Date of birth of child
- If there are immigration issues dates when parents arrived in the UK & their immigration status.
- Referrals and their source
- Family history e.g. previous episodes of CP or children/ siblings who are looked after
- Strategy meetings and S47 investigations
- Assessments and outcomes
- Family Group Conference meetings.
- Child's words, views, feelings and behaviour
- Significant other incidents e.g. significant observation during home visits
- Concerns about specific behaviours in the family including sexual behaviour, substance misuse, domestic abuse not reported to the police, housing issues
- CP plans and category / de-planning
- Medical history including accidents/incidents requiring treatment
- Serious illness
- Hospital admissions
- Episodes of being looked after
- Dates of legal planning meetings and PLO meetings
- Change in legal status
- Court Hearings
- Change of name
- Change in birth family household/relationships
- Change in birth family address (if considered to be of concern e.g. frequent moves impacting on providing a safe and secure home)
- Significant family events e.g. pregnancy, miscarriage, deaths
- Change in school/college or absences (if considered to be of concern e.g. on young person's development)
- School exclusions/incidents
- Police logs about family/household

- Criminal proceedings & offences
- Any missing from home or education episode
- Date of SEAM panel and recommendation
- Date and reasons for placement moves

c) Court Chronology

A Court chronology should cover the last 2 years. Reference to events prior to the last 2 years should be brief and concise e.g. Date, Mrs X had child removed; Date from and to Child A was subject a CP plan under the category of neglect

Former President of the FS, Sir James Munby in 2016 reminded social workers of the purpose of chronologies as follows:

'... both the social work chronology and the summary of the background circumstances as set out in the social work statement can – and if they can then they must be kept appropriately short, focusing on the key significant historical events and concerns and rigorously avoiding all unnecessary detail. We do not want social work chronologies extending over dozens of pages. Usually three or four pages at most will suffice. The background summary in the social work statement, particularly if it is cross-referenced to the chronology and avoids unnecessary repetition of what is already set out in the chronology, need be no more than a page or two.'

Munby stated the following should not be included in Court Chronologies:

- Dates of telephone conversations/ attempted telephone conversations
- Dates of visits to parents home
- Dates of office meetings with parents
- Dates of contacts with other professionals
- In chronic neglect cases, the full chronological history of the local authority's engagement with the family.

Appendix A

Case Recording Timescales

Event	Assessment / Activity Recording	Completion Date
Contact or Referral	Contact or Referral Forms	Within 24 Hours
Child and Family Assessment	Child and Family Assessment on LCS	Within a maximum of 45 days of Referral date / Assessment request.
Child in Need Meeting	Update Child in Need Plan	Within 5 days of the meeting
Chronology	Liquid Logic	Update at least every 2 months and Every time the Child and Family Assessment is Updated

Child Protection

Event	Assessment / Activity Recording	Completion Date
Initial Strategy Discussion Meeting	Strategy Discussion Meeting form on LCS	Within 24 hours of Meeting
Review Strategy Meeting	Review Strategy Form on LCS	Within 24 hours of meeting
Initial Child Protection Conference	Initial Child Protection Conference Social Work Report	1 working day before Meeting to Chair & Family
	Child Protection Conference Report- Decisions & Recommendations	Within 24 hours of the meeting
	Child Protection Conference Minutes	Within 15 days of the Conference – circulated to all parties
	Core Group – Update Childs Plan	Within 5 working days of the Core Group
Review Child Protection Conference	Social Work Updated Plan for Review Conference	3 working days before the Review meeting to Chair & Family
	Review Child Protection Report- Decisions and Recommendations	Within 24 hours of meeting
	Child Protection Conference Minutes	Within 15 days of the conference – circulated to all parties

Children in Care / Care Leavers

Event	Assessment / Activity Recording	Completion Date
Looked After Child Plan	Child / Young Person's Care Plan recorded on LCS	Within 10 working days of becoming Looked After
Placement Planning Meeting	Child Young Persons Placement Plan on LCS	Within 5 days of placement meeting
Looked After Child Review Meeting	Social work Report for Looked Review Meeting	3 days before meeting
	Record of Looked after Child Meeting recorded on LCS	Decisions / Recommendations to be completed within 5 working days And Full record of the meeting to be completed within 15 working days
	Child / Young Persons Care Plan updated on LCS	Within 5 days of IRO recommendations
Pathway Plan	Pathway Plan developed on LCS	On or before the young person reaching 15 years 9 months
	Pathway Plan Reviewed and Updated	At least every 6 months

PEP	PEP meeting minutes uploaded on LCS	Within 5 days of the meeting
Placement Support Meeting	Meeting minutes and action plan uploaded on LCS in the children & carers file	Within 5 days of the meeting
Permanence Matching Report	Report to be uploaded on LCS	Within 5 days of placement being ratified

Event	Assessment / Activity Recording	Completion Date
CIN / CIC / Care Leaver / CP Visits	Record of Visit on LCS	Within 3 days of Visit
Case Note Contacts with families / professionals	Case note contacts on LCS	Within 3 days of contact
Supervision	Formal / informal supervision recorded on LCS	Within 5 working days of supervision
Management Decisions	Case note Management Decisions on LCS.	Within 24 hours of Referrals Within 2 working days in respect to other decisions
Legal Planning Meeting	Record of meeting and agreed actions uploaded onto LCS	Within 7 working days of LPM.
Pre - Proceedings	Public Law Outline (PLO) Letter uploaded on LCS	Copy of signed Pre – Proceedings letter to be uploaded within 1

		working day of the letter being sent to parents and carers.
	PLO Meeting minutes uploaded on LCS	Within 3 days of PLO meeting
Care Proceedings	Letter of Intent to issue Proceeding uploaded on LCS	Signed Letter of intent to issue uploaded within 1 working day of letter been sent to parents / carers
	Social Worker Evidence Template (SWET) to be completed on LCS	Within 2 weeks of Decision to Issue
	Court Orders Uploaded in LCS	Within 2 working days of the Order being received from Court
	Expert Assessments & Statements of parties uploaded on LCS	Within 3 working days of receipt.

Early Help Timescales

Event	Assessment / Activity Recording	Completion Date
Visits	Recorded on EHM	Within 5 Working days
Family Support Meetings	Recorded on EHM	Within 7 days of the meeting
Early Help Assessment & assessment tools	Recorded / uploaded on EHM	Within 15 days



Significant Events	Recorded in EHM and marked with red Flag	Within 3 days
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