1. Purpose of Guidance

The Child in Need (CIN) Practice Guidance is designed to be read in conjunction with the overarching CIN Practice Framework – Oxfordshire Children and Families (See Appendix).

The CIN practice guidance has been produced collaboratively in consultation with practitioners and managers across CSC in Oxfordshire to support the consistent implementation of the new CIN working model described within the Framework. It is designed to support staff across the Family Solutions and Children’s Disability Service in working with children in need and their families. Whilst the guidance is not exhaustive and will evolve, it aims to provide workers with an overview of this area of work, provide operational clarity and promote best practice.

The guidance is for supervisors and practitioners supporting children and families with child in need plans across the service. Practitioners include social workers, senior practitioners, early help practitioners, lead practitioners and family support workers working across statutory and non-statutory teams.

This guidance complies with the duties placed on the Local Authority under section 17 of the Children Act and the policy context of Working Together to Safeguard Children 2018.

2. Practice Principles

The principles behind the practice guidance include:

One worker leading and providing interventions

Children and families will have one key worker assigned to work with them to progress the CIN plan; this worker will undertake direct work with children and with parents/caregivers, adopting a “think family” approach. Where it is identified in the plan that additional interventions are required from another part of the service or from a partner agency this work will be in full collaboration with the keyworker.

Children in need and their families should be allocated the worker (or workers) best able to deliver the right intervention at the right time; this could be a Social Worker, Senior Practitioner, Early Help Practitioner, Lead Professional or Family Support Worker.
**Relationship based and Restorative**

It is well established that relationship-based practice is most effective in achieving best outcomes for children and families, and that working with one worker prevents the need for family members to “re-tell” their story to multiple professionals. Restorative approaches work from a needs premise and as such empower families to make the necessary changes and ensure we are working with and in partnership with parents to improve outcomes for children.

*A Pocket Guide to Restorative Practice.*

**SMART and outcome-focussed**

Interventions will be timely and focus in improving outcomes for the child/ren. Goals set will be achievable and should be met in a specific period of time. Planning will be SMART.

**3. Legal Definition**

Section 17 of the Children Act 1989 imposes a general duty on Children’s Social Care to safeguard and promote the welfare of children in Oxfordshire who are ‘in need’ and whose identified needs cannot be met within the child’s immediate or extended family, to promote the upbringing of children in need by their families by providing a range and level of services to meet those identified unmet needs.

Section 17 of the Children Act defines a child in need as a child:
  - who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services;
  - or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services;
  - a child who is disabled.

Working Together to Safeguard Children 2018 provides the core legal and statutory framework for multi-agency work with children in need and their families, setting out what individuals, organisations and agencies must and should do to keep children safe. It emphasises that effective safeguarding is achieved by putting children at the centre of the system and by every individual and agency playing their full part.

**4. Consent**

The Family Solutions and Children’s Disability Services work with children in need and their families based on consent. Agreement will be sought from those with parental responsibility for any intervention or services for their child usually by the assessing social worker. Children of an age and/or understanding, particularly those aged 16 or over will be asked for their consent.
Consent for information about families to be shared will also be established at the outset of any statutory social care involvement, usually following referral.

If parents refuse consent after the worker has made sure that they have been given full information about the benefits of the support, this refusal should be accepted and recorded. If it is considered that the child is suffering or is likely to suffer significant harm without intervention or if relevant information about the child and/or their family is shared, then assessment should be carried out under Section 47 of the Children’s Act 1989. Consent is then not required, but parents should be informed of the change of approach and the reasons for the concerns.

5. Threshold of Needs

Children in Need plans sit within level 3b (Level 3 Complex Needs) of Oxfordshire’s Thresholds of Needs. Children, including disabled/ seriously ill children, whose needs are complex and who require support from more than one agency. They are at risk of social or educational exclusion; their health, welfare, social or educational development is being impaired; and life chances will be impaired without the provision of additional services.

Allocation of cases

Child in need plans will be allocated to suitably qualified and experienced professionals across the Family Solutions Service and Children’s Disability Service. In most cases this will be a qualified social worker, however, some may not hold a recognised qualification in social work, but will have other relevant qualifications or experience to hold such cases. The team manager and children and families centre manager will decide who is best placed to support the family based on their knowledge of the family and their team. Allocations will be guided by what is in the best interests of the child, existing productive relationships and the skill set and expertise required to take the plan forward.

There will be circumstances when children must be allocated to a qualified social worker. These include:

- There is an identified high level of risk.
- The child or family have critical or enduring needs (Level 4).
- The child is at risk of significant harm or removal from home.
- There is a significant risk of familial breakdown and the child is deemed to be at the edge of care.
- There is an Interim Supervision Order or a Supervision Order has been imposed upon the Local Authority at conclusion of care proceedings and a child is deemed to continue to be at risk of significant harm.
- The child is subject to private law proceedings.
- A section 7. report has been or is likely to be ordered by the court.
- An SGO (Special Guardianship Order) assessment has been or is likely to be ordered by the court.
Decisions about Allocation of Children with Disabilities

Families subject to statutory social care intervention should be allocated within one social work team wherever possible; families tell us that they prefer working with a limited number of professionals.

Case supervision is best provided by one manager, to provide consistent oversight, advice and direction based on a good knowledge of the case.

To prevent splitting the allocation of sibling groups across teams where possible, the general guiding principle when one or more of a sibling group has a disability, is that the family will be allocated within the Disabled Children’s Team (CDT) if the child with a disability also presents with a primary social care need. It may be that all siblings, including but not limited to the disabled child or children, have a presenting social care need; in this event, case responsibility and allocation will be agreed between managers, and will be informed by what will work best for the family – if the family has an existing positive relationship with a worker for example, maintaining this relationship will be a primary factor in decision-making on allocation.

For families comprised of large sibling groups, co-working can be helpful, to ensure that the voice, wishes and feelings of each child are captured. If it is the view of managers that a family would benefit from both a CDT worker and Family Solutions Service (FSS) worker, co-working across teams must be supported through joint supervision arrangements, with one manager taking lead responsibility for oversight, supervision and direction on the case. Both social workers will attend supervision together, which will be facilitated by the lead manager. It is important that the manager who is not supervising the case keeps abreast of case progression and significant events throughout.

It is the aim of children’s social care to ensure that allocation decisions are informed by relationship-based practice, consistent and high-quality management oversight, and the individual needs of each family”

6. Pathways to a CIN plan

There are several pathways by which a child can be made subject to a CIN plan.

Children and Families Assessment Teams (CAFAT) to CIN
A child has been assessed by a Social Worker in the Children and Families Assessment/ Hospital Teams as reaching threshold for section 17. statutory planning and support. Case transfers to the FSS via the local Area Transfer Panel.

Stepping down from a Review Child Protection Conference (RCPC)
Where required and threshold for statutory intervention is still met, a CIN plan can be considered as part of the step-down process from child protection planning. There may be circumstances when a child’s needs at the end of a child protection plan can most appropriately be met through a Team around the Family (TAF).

Children’s Disability Assessment:
A disabled child’s needs have been assessed as requiring a CIN plan by a CAFAT or
children’s disability social worker when the child’s outcomes have not improved through an early help assessment and TAF.

It should be noted that many disabled children are supported by the FSS because their needs do not meet the eligibility criteria of the children’s disability service.

The needs of a disabled child must be considered within any assessment carried out by children’s social care, whichever team is assessing. The assessing social worker should consult with children’s disability teams to inform the assessment.

**Escalation of a TAF to CIN within the FSS**

The Children Services Internal Business Processes, which is appended to this guidance, will be followed if the situation has escalated beyond Early Help and there has not been a specific safeguarding incident.

**Supervision Orders**

Where a child is made subject of a Supervision Order at the conclusion of care proceedings the child and family will be supported under the framework of a CIN plan for the duration of the court order. A CIN plan will be drawn up in line with the care plan agreed at court.

**Transfer in from other Local Authority**

Where a request is made to the MASH for a CIN case to transfer in from another local authority that request will be passed to the manager of the Family Solutions statutory team that covers the area the family is moving to who will liaise with the transferring team to ensure that the relevant information is provided and that the transfer process is managed in partnership with children and families.

**Private Law Special Guardianship Order (SGO) and Section 7/37 Report requests**

When the Local Authority is directed to complete a Section 7/37 report, this should be completed by the Social Worker best known to the family. If the family has been/is known to a Social Worker in FSS/CAFAT/CDT within the previous three months, this worker must complete the report for Court.

Private law SGO reports are completed by the FSS statutory teams.

At present plans for children open due to private law proceedings are managed within the CIN workflow on the child’s electronic record.

7. **Initial CIN meeting**

The CIN plan will be managed and progressed through multi-agency core groups. An initial CIN meeting will be held within 2 weeks of completion of a Child and Family Assessment (Single Assessment) wherever possible. The initial CIN meeting should not be unduly delayed due to the unavailability of partner agencies; the need for agencies to attend the initial CIN meeting must be balanced against the need for timely commencement of the CIN plan.
The initial CIN meeting should be set up by the transferring team and will include the child, where appropriate, parents and carers and significant family members and professionals. It is important that those agencies and individuals invited to attend are the ones that the parents and/or the child consider can help, support or assist them and/or those who can best promote the wellbeing of the child. The assessing social worker should discuss potential attendees for the Child in Need Core Group Meeting with the parents/carers and/or the child prior to arrangements being made for the meeting. It is the responsibility of the assessing social worker to ensure consent is in place.

Parents/caregivers’ attendance is crucial; if parents/caregivers repeatedly fail to attend this important planning meeting, consideration needs to be given to their commitment to the CIN framework and capacity to work within this.

It is important that appropriate venues suitable for the child and his or her family are used for the meeting. This may be at the Children and Family Centre, school or in the family home. Consideration must be given to transport, timing and any child care issues.

The meeting is an opportunity for a child and his or her parents/carers, together with key agencies, to identify and agree the package of services required and to develop the CIN plan. The recommended plan should be discussed and agreed by the assessing social worker and the family prior to the transfer meeting.

The receiving allocated key worker and manager should have read the Child and Family Assessment and any relevant historical social care information in preparation for the core group with a view to be clear on the level of risk, bottom lines and what needs to change.

The receiving allocated worker will ensure an attendee list is circulated to capture all of those present within the minutes.

The CIN core group will be chaired by the receiving FSS/CDT team. A decision will be made as to who is best placed to chair depending on the specific issues of the case and the availability of the Team Manager, Centre Manager, Senior Practitioner or Lead Practitioner.

At the end of the meeting, the CIN plan will be drawn up by the chair. The plan will be copied to those involved, including the child and parent/s, who will need to sign their agreement. Minutes of CIN reviews will be taken either by the key worker, another professional within the core group or in more complex cases by an administrator if available. The record of discussion should be a succinct summary of the points raised with the focus being on the review of the progress of the plan measured against the desired improved outcomes for the child.

The CIN core group minutes and plan should be shared within two weeks of the meeting. Parents will be given an outline plan immediately following the meeting. A date for the next core group will be arranged and agreed no later than 6 weeks.

The structure and format of the meeting should include:

- Introductions, identify chair (and possible deputy) and minute taker
- Agree timings (meeting should last no more than 1 hour)
Set ground rules e.g., agencies submitting a report if they are unable to attend.

Asking the child/parent what they hope to get from a plan?

Discussion around what lead to the assessment

Clear expectations on what needs to change

Identifying when services can ‘walk away’ what will cause the case to escalate.

Professional information sharing and updates

Where a child is too young to attend or when there are other reasons for them not to attend, for example because they would become distressed or anxious, their views should be clearly represented in the meeting. Special consideration must be given to how this will happen for children who communicate in non-verbal ways.

8. Child in Need Plan

All child in need plans should follow the quality standards set by Ofsted:

1. Every child/young person who has been assessed as in need under S.17 of the Children Act 1989, and is receiving services from Children's Social Care, must have a CIN Plan.
2. This Plan should be reviewed and updated at a minimum of 3 monthly intervals through a CIN Review meeting. For disabled children receiving a care package about whom there are few concerns reviews can be held 6 monthly.
3. The Plan should be completed with parents/carers and child/young person where age appropriate and should be given a copy of the Plan.
4. The Plan should incorporate actions and services provided by other agencies, in consultation with them.
5. The Plan should be specific about actions to be undertaken by parents/carers and young people, where appropriate and clearly set out the expected outcomes for the child/young people as a result of these actions.

CIN plans need to be informed by the single assessment, drawn up alongside and owned by the family. Plans should be based on agreed outcomes for the child, consider their health, education welfare and social relationships. Plans should not be a wish list or a list of actions for the parents or referrals. They should be realistic, succinct and timebound with a clear expectation set of what it needs to look like for the CIN plan to end.

CIN plans must consider the needs of any disabled children in the family, whichever team is holding the CIN plan. FSS key workers should consult with the children’s disability teams to ensure that the plan addresses these needs and how they might be met. There is a range of provision that can support disabled children, for example, via the local offer.

The plan will update and address the following:

- Needs/risks identified
- Actions to reduce risks/needs
- By whom?
• By when?
• Outcomes (what will be different for the child/young person).

Initial CIN plans should be quality assured and signed off by a statutory manager.

Most CIN plans will envisage the cessation of services within 6-9 months. However, exceptionally, it may be that in order to prevent a crisis from being reached, some children and families may require longer-term support. Where plans are extended this will be informed by an updated or new assessment. Some exceptions may include disabled children, children whose parents/carers are disabled or children of asylum seekers and children subject to Supervision Orders.

Plans should not be left open ended and should achieve outcomes within 9 months. If a CIN plan is envisaged to remain active for over 12 months, the plan will be reviewed and endorsed by a Service Manager or Head of Service and a suitable extension period approved to meet an updated needs assessment.

9. Review CIN / Core Group Meeting

Where the CIN plan is providing a framework for an intensive intervention review CIN core groups should be held every 6-8 weeks.

This may also be the case for disabled children about whom there are concerns because of the complexity of their needs and/or their family situation. The frequency of review of CIN plans for disabled children will vary from 6 weekly to 6 monthly, will be based on ongoing assessment, and will be explicit in the CIN plan.

The record of the CIN review will also include an updated assessment of need and risk for each child and of family strengths and protective factors to be completed by the key worker and shared with the family ideally in advance of the meeting. The worker will also include an update of their analysis and professional judgement and record the view of the child and parent or carer.

The subsequent CIN plan review and record of Core Group includes:

• Revisit initial needs and desired outcomes to ensure focus remains on presenting concerns.
• For disabled children who receive a care package, how is this promoting agreed outcomes and does it meet the child’s needs? Should it continue, be changed, reduced or ended?
  • Updated assessment since last Core Group
  • Updated needs and risks for each child
  • Updated family strengths and protective factors
  • Analysis and professional judgement
  • Recommendations for further work to be done
  • Review of plan and record of discussion
  • Any other information about how the plan is progressing
• Views and Comments What are the child(ren)’s views
• What are the parent / carer’s views?
• Any other views
• How will we know the plan is working?
• What might happen if the plan does not work? (Contingency plan).

10. Reviewing CIN cases

There are a variety of options available for cases which appear ‘stuck’. For example, signs of safety case mapping, one-to-one consultation with REoC Psychologists or complex case panel.

The review will be led by the key worker, who should invite or seek the views of the child, parents and any service providers. The core group will agree who is best placed to minute it.

If at the last minute the key worker is unable to attend and their manager is unable to identify a replacement a decision should be taken about whether the meeting can be rearranged. If it is considered to be in the best interests of the child for it to still go ahead, responsibility for chairing should be delegated to another professional already signed up to the CIN plan.

The purpose of the Review is to ensure that the services provided are contributing to the achievement of the objectives within the time-scales set.

The outcome of the Review will determine whether the child is no longer a Child in Need requiring services, resulting in a recommendation to the manager that the case be stepped down to community based services or closed or whether the child continues to be a Child in Need requiring the same level of services, resulting in the continuing provision of services and amendment, as necessary, of the Plan. Or whether the child appears to be a Child in Need requiring increased services to safeguard and promote his or her welfare, resulting in the possible need for a Strategy Discussion and possible further assessment.

The record of the review should be completed and circulated within the timescales set out for Initial meetings.

11. Frequency of Visits

Visits undertaken as part of CIN plans should be planned and purposeful with objectives that are agreed in partnership with families to improve outcomes for children. Unannounced visits would not usually be undertaken unless in consultation with families as part of the plan or in response to a particular set of circumstances, for example difficulties in making contact with the family, or a potential safeguarding issue.

The frequency of key worker visits will depend on the particular needs of the child and family and the aims and objectives of the plan; however, it is expected that for the majority of new interventions children and families will be visited at a minimum of a fortnightly basis. There will be some interventions with families that will require more
frequent levels of visits at the outset. The balance of visits between children and parents and carers will depend on the needs of the child and the focus of the plan.

Disabled children supported by the children’s disability service because of the complexity of their needs are likely to be on CIN plans for longer than other children. The frequency of visits will be decided by the core group, will be based on ongoing assessment and will responsive to the needs of the child. The minimum frequency of visits will be 3 monthly. Children supported by direct payments may be seen less frequently. Disabled children will often be seen frequently by other professionals such as Children and Family Care Services workers and overnight short break centres.

Children should be seen alone on a minimum of a monthly basis; it is expected that children will be seen more often when direct work with them is the focus of the intervention and it is envisaged that frequent visiting to undertake targeted direct work will reduce the overall duration that statutory planning remains warranted.

It is not appropriate to see some disabled children alone because, for instance, of their complex health or behavioural needs or because they need another adult to support them to communicate. Disabled children will be visited in all settings with parental consent.

Where CIN plans are agreed as part of a step-down process for children subject to child protection the visiting frequency will be informed by the on-going needs of the children and the requirements of the plan.

12. Recording of visits

Practitioners should be respectful, open minded, professionally curious and critically reflective within their CIN visit recording. All recording of visits should be relevant and succinct with a clear distinction between fact, observation and opinion. Recording of CIN visits and direct work should include professional analysis and reflection on plan progression and the impact on and outcomes for children, of the work completed thus far. Visits should be written up on the child’s electronic record as soon as possible and within 1 week of it having taken place.

Children The recording of visits to children should reflect their lived experience and clearly capture the voice of the child whether directly expressed or through observations of interactions of the child with the key people in their life.

Visits to children will be recorded on the relevant episode on the child’s electronic record. Where more than one child is seen visits can be copied over. Visit episodes should not be copied over to the records of children that have not been seen.

Where evidence based tools and interventions are used they should be copied and uploaded to a child’s electronic record with the child’s permission and cross referenced in the visit write up.

Parents and Carers
Visits to parents and carers where children are also seen should be recorded in the CIN visit episode. Where the child is not seen the visit should be recorded in a case note.

13. Review of Assessments for Children in need

Assessment is a fluid, dynamic process rather than a single event and the keyworker will update the assessment as part of the cycle for the review of the CIN plan against the desired outcomes for the child considering the dimensions of the assessment framework. The assessment process will be informed by a genogram to be completed or reviewed at the start of an intervention and the significant events chronology which the key worker should update as a minimum every 3 months.

Where a child has been subject to a CIN plan for more than 12 months it is expected that an updating child and family single assessment will be undertaken following a full management review of the case file by a service manager or head of service.

14. Targeted Work and Interventions with Families

It is expected that the work undertaken by the key worker will be the primary intervention with the family, however there are a range of targeted interventions available both internally and through partners that should be considered depending on the area of need identified within the assessment and plan. They include:

- FGC (Family Group Conference)
- Family Links parenting programme
- Take 3 parenting programme
- Freedom Programme
- Kingfisher
- PAMs Assessment (Parenting Assessment Manual)
- Recovery Toolkit
- Protective Behaviour programme for primary aged children
- DAY programme
- Reducing the Risk (for perpetrators of DA)
- Building Respectful Families (SAFE)
- Aquarius
- Troubled Family Employment Advisors
- REoC, (Residential and Edge of Care service)
- Young Carer’s Service
- Consultation with children’s disability teams

It is important that interventions offered are relevant to presenting concerns.

15. Tools to inform assessment and intervention

Children’s practitioners in Oxfordshire have access to a comprehensive range of resources and approaches accessible through the practitioner toolkit and the learning and development offer.

They include:
• Mind of My Own
• Genograms
• Family Star Plus
• Childcare and development checklist
• CSE/ CDE screening tools (Child Sexual Exploitation, Child Drug Exploitation)
• DASH (Domestic Abuse, Stalking and Harassment checklist)
• Graded Care Profile
• Tools to support the Assessment Framework for children in need and their families (DoH) including Daily Hassles questionnaire, alcohol checklist, home conditions checklist etc..
• Three Houses / Wizards and Fairies
• The Worry Monster/ Bag of worries
• MARAMP (Multi-agency Risk Assessment and Management Plan)
• Who Am I? work book
• It’s About Me work book
• Helping Hands

16. Management Oversight and Supervision

All CIN cases should have management oversight from a statutory manager. In instances where a CIN case is held by a worker from the Early Help team, where possible supervision should be carried out jointly with the worker’s line manager. Managers should record their oversight of the cases every three months.

Where a CIN case is held by a worker who is not a qualified social worker their name will be recorded as Key Worker and the responsible statutory manager will be recorded as Responsible Team and Officer.

In accordance with OCC supervision guidance, CIN cases open to the Family Solutions Service will be reviewed in supervision every month. Those open to the CDS will be reviewed as a minimum every three months.

As well as providing a safe, reflective space to think critically about the child’s experience and the progress of the plan supervision should also be used to review the frequency of visits, the quality of the plan and ensure that the child’s electronic record is accurate and up to date.

Where there is a safeguarding incident or emerging safeguarding concerns, there will be a consultation with a statutory manager who will make a decision about whether to convene a multi-agency strategy discussion.

Management Review of Plans

There should be a comprehensive review of a CIN plan open to FSS by a manager after six months. This should include a review of the progress of the plan against the agreed outcomes for the child and a consideration of the level need with reference to Oxfordshire’s Threshold of Need.
Where CIN plans open to FSS remain active at 9 months, there should be a review by an FSS Service Manager. It will be the allocated worker and their Manager’s responsibility to notify their service manager of CIN open for 9 months or more.

CIN plans for disabled children supported by the children’s disability service is likely to last longer than for other children. Monitoring of outcomes will be undertaken by team managers through monthly supervision.

17. Concluding CIN plans

CIN plans should be concluded once the threshold for statutory intervention is no longer met. The decision to end a CIN plan should be made in consultation with family and professionals and agreed in supervision.

Clear plans need to be put in place to ensure that the on-going support needs of the child and family are met this could be achieved through an FGC, EH led TAF or a TAF held within the community and supported by LCSS.

18. Closure

A letter should be written to the family to inform them of the agreed closure. The letter should include the reason for service involvement, an overview of the work completed, a summary of progress achieved and next steps for the family. This letter should be copied to all relevant professionals and retained on the child’s file.
Links and Appendices

- Multiagency Practitioner Toolkit
- OCC supervision guidance
- Neglect Practitioner Portal
- Procedures manual
- Link to Threshold of Needs
- CIN Practice Framework
- Link to internal business process Templates for CIN reviews