Glebe House

Friends Therapeutic Community Trust

Case Management POLICY

May 2022

CASE MANAGEMENT POLICY

Legislation

- The Children's Homes (England) Regulations 2015
- Health and Social Care Act 2008, section 20 Regulations
- The Civil Contingencies Act 2004
- Children's Act 1989, 2004
- Data Protection Act 2018
- Leaving Care Act 2002, 2010
- The Care Leavers (England) Regulations 2010
- Care Planning Act 2010, 2013

Practice Evidence

Inspection Body	Outcome/ Regulation	Evidence
Ofsted	14, 19, 20, 38, 39, 40, 43, schedule 3 and 4	Admissions and Discharge Record, Case Files, secure storage, Service Level Agreement, Host Authority Updates, Clearcare online recording system, Behavioural Management Plans
CQC	6, 21	Case Files, Lead Agency Forms, Organisation Risk Assessment, Clearcare online recording system, Behavioural Management Plans

Reference

1.1 Referrals and Placements
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Appendix A:
Pen Portrait and matching risk assessment
Behaviour Management form
Information requested from LA
End of assessment report
Pre-Admissions

1.1 Referrals and Placements

1.1 Referrals and Placements

Admission's Criteria
The criteria for admission includes:

- The placement is offered on a voluntary basis
- That the young person agrees to participate in the life of the Community and undertake a therapeutic programme
- Any referral where there is a history or conviction for arson has to be agreed by both the board of trustees and our insurers
- Issues relating to the abduction of a child are viewed as very serious and may preclude a young person from joining the community
- Can they be contained in an open unit, and risks to self and other are of a manageable nature

The admission process, from initial enquiry to the young person becoming a member of the Community, follows a procedure which allows for:

- An initial referral form is received. The referrals team will request further information from the Local Authority which would include relevant assessments, reviews or reports. Glebe House will liaise closely with any relevant professional before making the decision to visit the young person in order to ensure the assessment visit is firstly appropriate and secondly undertaken in an informed manner. ‘Information requested from LA’ form is sent to placements team/social care team.
- The young person is visited by members of the Glebe House Intake and Assessment Team
- The preferred practice would include the young person visiting the Glebe House community over lunch. This would include a resident led tour and meeting community members informally.
- Glebe House will undertake a matching process with the young person’s social worker who will be asked to contribute to and sign ‘pen portrait and matching risk assessment’ form and ‘pre-admissions’ form. Furthermore a ‘behaviour management plan’ is completed by Glebe House and shared with the Social Worker.
- If the young person is considered to be both containable and treatable they are invited to join the community for an assessment at the end of which an end of assessment meeting is held, an ‘. If the assessment concludes that the young person would benefit from a therapeutic placement, a place is offered for a minimum of two years. Most placements are completed between two and three years.
- The young person, their professionals and Glebe House all have to be in agreement with the placement in order for admission and sign contracts at the End of Assessment Meeting.

Planned Placements

Definition of Planned Placement
A Planned Placement is the placement of a child with the agreement of the Placing Authority and Designated Manager (Admissions).

Referral Process and Placement Planning
The decision about suitability of placement will be made by the Designated Manager (Admissions) in consultation with the Placing Authority. Before making such a decision, a Pre-Admissions form must be completed by the Social Worker and taken into consideration.

Though not essential, the following should be undertaken before a decision is reached:

- Arrangements should be made for the Home's Manager or delegate to meet the child, parent(s) or carers.
- An Information Pack and/or brochure about the home should be forwarded to the Placing Authority, parent(s) or carers.
- An Information/Children's Guide should be forwarded to the child
- Up to date Chronology where possible should be obtained

- A copy of the care plan should be obtained or forwarded to the home within 10 working days.
- Other relevant information about the child. For example, recent Looked After Review reports, Pathway Plan, Personal Education Plan, reports from specialists or therapists.
- The contact arrangements that may be permitted between the child and his parents, siblings, relatives and friends where appropriate.

If it is agreed that a placement is offered to the child, the Designated Manager should arrange for a Service Agreement/Contract to be drafted and forwarded to the Placing Authority for signing.

A copy of the completed/signed Service Agreement/Contract, Referral Form and other documents obtained must be given to the Home's Manager to be placed on file.

The documents/information above should be taken into account when completing the child's Placement Plan.

It is for the Home's Manager/delegate and social worker to agree whether the Placement Plan has been completed sufficiently to sustain the child until the first Looked After Review.
If there is no agreement, a Placement Plan Review must be convened within 7 days of the placement to enable the plan to be completed satisfactorily.

The detailed arrangements for admitting the child will depend on the circumstances of the case, these arrangements should be made by the Home's Manager in consultation with the child's social worker.
A copy of the Children's Guide must be given to the child before or upon admission.

Part of the new Behavioural Management Plans include identifying impact risks for residents arriving new to the service and the management of these.

Copies of the forms we use are in **Appendix A** at the end of this document.

1.2 Arrival

On arrival new residents are given a link resident, who will be from the resident chairmen group, a link keyworker and link therapist.

They will also be given an induction pack which the link resident will go through with them.

New residents then sign to say they know where the fire assembly point is; the fact there are boundaries in place to keep things safe; the idea of consequences to breaking such boundaries and the fact we in extreme circumstances may use physical intervention. There is also reference to the internal complaint's procedure and our visiting advocate as well as information about daily routines and the on-site school, with a behaviour for Learning Agreement. Residents also sign a therapy contact and agreement, an assessment agreement and access to files form. In terms of GDPR residents are asked about whether they give consent for their photos to be used in other residents' albums or for our companies marketing purposes. They can change their minds about this at any point and the form is reviewed annually.

Notifications

When new residents arrive, we inform the following services:

Referralcentre.children@Cambridgeshire.gov.uk

Mash.c&f@cambridgeshire.gov.uk

When residents become full residents at their end of assessment review they are then registered at the local medical centre, opticians and dentist.

1.3 Care and Placement Plans Guidance

Care Plans

Every Looked After Child must have a Care Plan completed and updated by the Placing Authority/Social Worker. The Care Plan must be prepared prior to a child's placement, or, if it is not practicable to do so, within 10 working days of the child being placed. The Care Plan must be regularly reviewed at **Looked After Reviews**; it must then be redrafted/updated and circulated within 10 working days of the Review. The overall purpose of the plan is to safeguard and promote the interests of the child, prevent drift and focus work with the child and the family. The Care Plan sets out its overall objectives and timescales (including, by the time of the second Looked After Review, how permanence will be achieved for the child), it summarises the needs of the child, identifies the services required to meet those needs and describes the management and support of the plan by the local authority. Care Plans contain descriptions of children's needs and how these needs will be met while they are living away from home. Before a Court grants a **Care Order** it must be satisfied that a suitable Care Plan has been drawn up.

Placement Information Records

Placement Information Records must be completed by the child's social worker within 5 working days of the child being placed, with a copy being forwarded to the home. The Placement Information Record* is the responsibility of the Placing Authority/Social Worker. The purpose of the Placement Information Record is to set out the arrangements for the placement of the child in residential care or foster care.

Children placed in children's homes, will also have an internal **Placement Plan**, as set out in the next section.

Placement Plans

Every child placed with us must have a Placement Plan drawn up and reviewed by the Home, which sets out the detail of the arrangements, for example, including a behaviour management plan, for the child. The Placement Plan may incorporate a detailed Behaviour Management Plan for some children. This Internal Placement Plan is called an Individual Treatment Plan (ITP)

The responsibility for completing and updating the ITP rests with the resident's therapist and keyworker. As residents reach the last 6 months of their placement they move to the transitions team and their transition ITPs are overseen by this team as part of their moving on process.

Other Key Plans/Records
Education

The school compiles an individual learner profile (ILP) for each resident. This contains a record of prior learning, a summary of learning needs, a summary of findings from the educational psychologist, strategies to support the learner, record of achievement and aspirational targets. This document is reviewed and updated every half term and is used by the teaching staff to inform their differentiation in the content and delivery of each curriculum subject.

The school also keeps records of students' Personal Educational Plans, (PEPS). These documents are produced during meetings between the school, the learner's social worker and their home county virtual school. Most Local Authorities use an online recording system for the information shared in these meetings, such as the 'e-PEP' or 'Welfare Call' systems.

The majority of learners at Glebe House have Education, Health and Care Plans (EHCP). The school cooperates with the relevant individuals to ensure an annual review meeting takes place, including convening the meeting on behalf of the LA if requested.

Members of the care and clinical team are invited to attended the PEP meetings and the EHCP review meetings.

Health Care

All children who are Looked After should have a Care Plan which incorporates a statement of the child's health care needs and how those needs will be addressed (for more information see **Care Policy** section 16 '**Health Care Assessments and Plans Procedure'** **https://www.glebehouse.org.uk/residential-childrens-home-policies-reports**).

Leaving Care

All Children who are preparing to leave care should have a Pathway Plan setting out the route to the future for young people leaving the Looked After service and will state how their needs will be met in their path to independence. The plan will continue to be implemented and reviewed after they leave the looked after service at least until they are 21; and up to 24 if in education.

Some placing authorities incorporate Pathway Plans into Care Plans, some have separate Pathway Plans; authorities will also have their own policies for when Pathway Plans should be drawn up but most authorities start to draw them up after toward Children's 16th birthdays.

Other key records

This summarises the other key records that Children ought to have, it does not address specialist records or plans:

Core Assessment Record: A core assessment provides a structured, in-depth assessment of the child's needs where their circumstances are complex. The Core Assessment Record provides a structured framework for social workers to record information gathered from a variety of sources to provide evidence for their professional judgements, and facilitate analysis, decision making and planning. A core assessment should be completed within 35 working days of its commencement. A completed Core Assessment Record is then used to develop the Child's Plan.

Chronology (or Essential Information Record Part 2): The Chronology is started as part of the process of Core Assessment. It records all significant events and changes in the life of a child or young person. The Chronology is an analytical tool designed to help social workers understand the impact, both immediate and cumulative, of events and changes on the child or young person. The Chronology replaces Essential Information Record Part Two for Looked After Children.

Looked After Review Report: After each Looked After Review, the Chair (Independent Reviewing Officer) should produce and circulate a report within 20 working days of the Review.

1.4 Placement Planning Meetings

Purpose of Placement Planning Meetings

The purpose of Placement Planning Meetings is to ensure that children's placement plans are kept up to date and continue to meet the needs of the child. These are formalised through the end of assessment meeting, then at each statutory review- or review meeting for young people over 18.

Frequency of Placement Planning Meetings

For all children under 18 we require a Placement Plan Provided by the Local Authority. The internal case planning - Individual Treatment Plans (ITP) is an attachment to that placement plan.

This standard is met by the use of Individual Treatment Plans. These plans are reviewed and updated approximately every three to four months. Residents are involved in the process before the ITP meeting in a discussion with their clinical practitioner and their **keyworker** to consider any needs they have identified.

The following areas are considered:

- Case formulation

- Milieu
- Independence
- Therapy
- Risk
- Family
- Personal
- Management Plan
- Education

The ITP process also involves a whole care team discussion, facilitated by a senior clinician, where the individual resident is thought about. The key members of staff including the clinical practitioner, keyworker, ITP chair and others such as independence coordinators when necessary, attend the ITP meeting with the resident that afternoon.

The ITPs are written up highlighting who is accountable for the various pieces of work. These are available for monitoring and guidance by Clinical Practitioners and keyworkers. Copies of ITPs are forwarded to the residents' referring agencies.
Thought is put in to the choice of a resident's keyworker depending the young person's needs.

There is a specialism of training within the staff team, around mental health and learning disability, to support children with communications difficulties. The Therapeutic Community approach of this agency means residents are continually encouraged and empowered in making decisions about their lives.

ITPs are reviewed, revised and updated every four months. For residents under 18 years of age who have statutory reviews under the Looking After Children (LAC) which happen six monthly the two ITPs which will have occurred during this time will compliment, inform and update preparation work for such reviews.

After serious incidents or in the light of significant changes in the child's circumstances an extra-ordinary professional meeting will be called to determine a way forwards which could include a change of placement.

Convening and Chairing Planning Meetings

Placement Planning Meetings must be convened and chaired by the Referring Authority.

Who Should Attend or Contribute to the Meeting

The following people should be invited to attend/have their views represented at the Placement Planning Meetings.

- The child's social worker
- The child's Independent Reviewing Officer (IRO)
- The Child
- The child's parents if appropriate
- The resident's keyworker and therapist.
- Other significant people/agencies

If any of these people cannot attend it does not preclude the meeting from occurring, if the manager/chair agree; in which case, the manager/chair obtain their views

Preparation and Conducting the Meeting

Before the meeting, the chairperson should obtain or be up dated on the following:

- The child's Placement Plan
- Any work which has been undertaken by key professionals involved in supporting the child's placement
- The child's ITP, **Personal Education Plan** and, if relevant, **Pathway Plan**
- Any Dates of Health appointments

The chairperson should also ensure that the child, parent(s) and others who have been asked to contribute understand the purpose of the meeting, how it will be conducted and are given the opportunity to put their views and suggestions.

During the meeting, the chairperson should ensure the following:

- That consideration is given to the continuing appropriateness of the placement within the context of the child's ITP or Pathway Plan and the need for the **Placement Plan** to be amended as appropriate.
- That the child's Placement Plan is updated if appropriate, and new or updated copies are circulated to those who were invited or contributed.

This does not mean that amendments to Placement Plans may only be made at Placement Planning Meetings. When Placement Plans are formulated and at each Placement Planning Meetings, the social worker and manager/chair should agree the extent to which they can be amended, between Placement Planning Meetings or without consultation.

If there are concerns about the suitability of the placement, consideration should be given to the following:

- Whether it is possible to sustain the placement until the next Looked After Review by, for example, providing additional support to the placement;
- Bringing forward the date of the next Looked After Review;
- Ending the placement.

Recording of Outcomes

The Chairperson must ensure the following is recorded at the end of the Placement Planning Meeting:

- The updating or amendment of the child's Placement Plan
- Additional minutes of any discussions and decisions made at the Placement Planning Meeting

Copies of these records should be circulated to those who attended or were invited to contribute

Progress Chasing Outcomes

Where the chairperson is concerned about delay in implementation of aspects of the Placement Plan, he or she should progress chase those responsible and, if necessary, take matters up with relevant managers.

Where the chairperson is concerned that recommendations or agreements have not been incorporated into the child's plan, he or she may take this up with the relevant person/manager and/or consider whether to reconvene the Placement Plan Meeting.

1.5 Looked after Reviews

Purpose of Looked After Reviews

The purpose of Looked After (Statutory) Reviews is to examine the work undertaken with the child, ensure that adequate plans are in place to safeguard and promote the child's welfare and make recommendations or representations on behalf of the child.
It is not the role of the Looked After Review to make decisions about children, that is the responsibility of the social worker.

However, where the **Independent Reviewing Officer (IRO)**, or another person, including the child, is concerned about delay in implementation of the ITP or that recommendations have not been incorporated appropriately, he or she may take this up with the relevant
manager or provider. To this end the child may require assistance from an Advocate or Independent Visitor. In exceptional circumstances, a review date may be brought forward.

Advocacy and access to an Independent Visitor is described further in 1.7 of this policy

Frequency and Arranging Looked After Reviews

Looked After Reviews must take place:

- Before any significant change is made to the child's Placement Plan, unless that is not reasonably practicable;
- Before a decision is taken to cease looking after a child;
- For children who are looked after as a result of a secure remand;
- Before an Eligible Young Person moves into external semi-independent accommodation, a Looked After Review must be held and evaluate the quality of the assessment of the young person's readiness and preparation to move.

In the light of these requirements (above), Home's Managers should consider consulting the Independent reviewing Officer (IRO) for any child where the Placing Authority is considering changing a child's placement on an unplanned basis; or must ensure that the IRO is consulted where the Home's Manager is considering ceasing, ending or changing the placement.

Under normal circumstances, Looked After Reviews should be convened at the following intervals:

- an Initial Looked After Review should be conducted within 20 days of the child being Looked After;
- the 2nd Looked After Review should be conducted within three months of an Initial Looked After Review;
- subsequent Looked After Review should be conducted not more than six months after any previous review.

These are maximum timescales; Looked After Reviews can be convened sooner if consideration is being given to ending or changing the child's placement or the urgency of the case determines they should be e.g. the child's social worker assesses that the child's welfare is not being adequately safeguarded ad promoted.

Looked After Reviews are normally chaired by an Independent reviewing Officer (IRO). Arrangements, including the setting of dates and invitations, are normally made by the Reviewing Officer in consultation with the Social Worker. The Manager of the home should take all reasonable steps to be consulted too. Each authority will have its own procedures on who should be invited, but invitations must be sent out at least 10 days before the Review and the child, the child's parents and all key professionals involved in assisting the implementation of the Plan to be invited.

The social worker is normally responsible for informing, consulting and preparing the child at least 20 days before the review; but home's staff should assist as far as they can in this process and should ensure that children are properly informed and prepared. To this end, the child must be encouraged to contribute to any report prepared by the home. If the child wishes, he should be assisted in preparing his own contribution.

Staff should be mindful that the child may wish to or may benefit from being supported by an Advocate or, if appointed, an Independent Visitor (see Advocacy and Independent Visitors section 1.7).

In time for the review, or beforehand if required, the home should arrange for an up to date ITP to be available demonstrating what arrangements exist to meet the child's needs. If appropriate the home should also produce a report of the work undertaken since the child's last placement review or the last Looked After Child Review. Teaching staff should produce a report of the child's educational attainments and progress.

The Independent Reviewing Officer (IRO) must meet the child before his first Looked After Review.

The Review will consider the extent to which the aims and objectives of the Care Plan, ITP and associated Personal Education Plan and if relevant, pathway plan has been achieved. At the second

and subsequent Reviews, the review must consider whether there is a suitable permanence place in place.

After the review the social worker is responsible for updating and circulating the Placement Plan, Personal Education plan (PEP) and, if appropriate, the Pathway Plan. The Manager of the home is responsible for updating and circulating the child's Placement Plan (ITP).

The independent Reviewing Officer (IRO) normally prepares and circulates a record of the decisions and recommendations within 5 working days, a full record within 15 working days and a full record including decisions within 20 working days of the review.

The Home's Arrangements for Looked After Reviews

Looked After Reviews are organised by the referring authorities. The relevant Glebe House staff will support the young person representing their views at such meetings and provide a detailed report about a resident's progress within the placement and their treatment.

1.6 Preparing for leaving Care

Qualifying Young People

They are over the age of 16 and under the age of 21, and have been Looked After or, if disabled, Privately Fostered after reaching 16, but do not qualify as eligible, relevant or former relevant. They may receive support, advice and assistance.

Personal Advisor

A Personal Adviser is the person appointed to work with every Looked After young person, usually at the first **Looked After Review** after the young person's 15th birthday, and will occupy a key role in preparing the young person for independence and providing support after they cease to be looked after. He or she will hold a pivotal role in the assessment, planning and review of services as set out in the **Pathway Plan**.

Pathway Plan

The Pathway Plan sets out the route to the future for young people leaving the Looked After service and will state how their needs will be met in their path to independence. The plan will continue to be implemented and reviewed after they leave the looked after service at least until they are 21; and up to 24 if in education.

Key Responsibilities

Each local authority should have its own procedures for young people Leaving Care, which should be consulted in relation to relevant young person. In the absence of such procedures, the following may be applied.

A Personal Advisor should be appointed for every looked after young person before their 16th Birthday. The Personal Adviser's appointment will continue while the young person remains eligible, relevant or former relevant young person.

All eligible, relevant and former relevant young people must have received a multi-agency assessment of their needs and abilities to live independently. This will be informed by the ongoing assessment, planning and review which takes place throughout the period they are Looked After.

They must also have a Pathway Plan, which will be drawn up having regard to the above assessment. The Pathway Plan must be owned by the young person who must have a copy of the Plan for safekeeping.

The Pathway Plan should complement the ITP and be regularly reviewed.

Where the young person continues to be Looked After, there should additionally be a Placement Plan which should describe what arrangements have been made within the home to support the Pathway Plan. The Placement Plan will continue to be the responsibility of the home where the young person is placed, and must outline the arrangements in place for supporting the Pathway Plan.

The Pathway Plan will continue in place for eligible, relevant and former relevant young people.

Administration on Leaving Care

All move on Placements will be provided with appropriate leaving information to ensure successful handover of care, this is co-ordinated through our Head of Transition. Glebe House will also liaise with Risk Management procedures such as liaising with MAPPA and Police in respect of Young people leaving our service.

The Local Authority will be notified of all young people who leave our care, this will include information on the legal Care Status, referring authority, move on address and date of move.

Leaving Celebrations

Leaving ceremonies are very important at Glebe House. This rite passage for residents is a celebration of their time with us and a recognition of the progress they have made during the successful completion of their programme. It is important to mark these occasions for many reasons not least because ending may have been traumatic for the young people in previous settings.

The celebrations are usually around a meal with speeches, exchange of gifts and planting a tree**.**

Transition - Circles of Support and Accountability

All young people leaving Glebe House after successfully completing their placements are provided with 18 months of outreach support; this transition support is designed and managed by our Glebe House Transition Team, which includes a qualified social worker. In that majority of cases the transitional support is through a Circle of support and accountability. The Circles model uses trained volunteers within the young person's home area to provide the young person with assistance and support moving from a heavily supportive residential environment into the wider community. The circle's aim is to help with reintegration, provide a support network that understands the young person's particularly risks and needs and also provides a degree of monitoring.

1.7 Advocacy and Independent Visitors

Children's Rights Director and Advocates

Glebe House uses CORAM VOICE to provide independent advocacy.

All children have access to independent advice, from an independent advocate from Coram Voice and are provided with information about how to contact the Children's Rights Director.

The advocate can represent or assist a child at a meeting (for example a Looked After Review), assist in making a complaint or bringing a matter to the attention of staff and managers or the Regulatory Authority.

Our advocate visits approximately every three weeks. The young people have access via phone to them if needed in the interim.

Independent Visitor

The Placing Authority must appoint an Independent Visitor where it appears to them that it would be in the child's best interest to do so.

Where an appointment is considered necessary, the child's social worker will identify whether there is a person already known to the child and independent of the local authority who may be suitable. If there is not, each authority will have its own procedures for appointment.

Independent Visitors must be suitably qualified and have undergone necessary checks with the Disclosure and Barring Service, Children's Services records.
The child must be consulted about the appointment and if he or she objects, the appointment should not be made.

Duties of Independent Visitor

The independent visitor should undertake regular visits to the child and maintain other contact, by telephone and letter as appropriate.

The main purpose of the visits and contacts will be to befriend the child and give advice and assistance as appropriate.

- The IRO should be notified and consulted if a child persistently absents him/herself or has been missing from the home;
- Children have a right to contact their IRO if they are concerned about their placement or Care Plan.

Home's managers should be aware of these wider responsibilities and should ensure that children are informed of their right to consult or notify the IRO; and Home's Managers should also consult the IRO if they are concerned about the child's placement.

1.8 Case Recording Policy and Staff guidance

Records Must be Kept on All Children

Records must be kept on all children: in electronic format or on paper files- audio or video recordings may also be kept.

Information held within paper files must accurately reflect the corresponding information recorded in electronic records.

The Design of Records and Forms Must be Approved

Records and forms must be designed to fit their purpose and used consistently across the organisation. With the introduction of the on line Clearcare recording system we update forms in line with the evolving practice.

The design of all records and forms must be approved by company before coming into use.

Children and their Families must be informed about and have access to their Records

Children and their families have a right to be informed about the records kept on them, the reasons why and their rights to confidentiality and of access to their records.

Information must be provided in a form that children and their families will understand - in their preferred language or method of communication. An interpreter will be provided if needed.

The Practitioner Primarily Involved Should Complete the Record

The practitioner primarily involved, that is by the person who directly observes or witnesses the event which is being recorded or 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 who has provided the information being recorded. Preferably the originator should read and sign the record. Records of decisions must show who has made the decision and the basis on which it has been made.

All Relevant Information about Children must be recorded

All visits, meetings or appointments made in relation to children must be recorded, stating who was present or seen, the relevant discussions which occurred, actions or decisions taken and by whom; the reasons for taking any decisions should also be recorded.

All other relevant contacts with children, their families, colleagues, professionals or other significant people must be recorded. When recording such contacts, it will be necessary to state who was present or seen, the relevant discussions, which occurred, actions or decisions taken and by whom; the reasons for taking any decisions should also be recorded.

Children should be involved in the Recording Process

Children must be routinely involved in the process of gathering and recording information about them. They should feel they are part of the recording process.
They should be asked to provide information, express their own views and wishes, and contribute to assessments, reports and to the formulation of plans.
Generally, they must be asked to give their agreement to the sharing of information about them with others - but there are exceptions.

Information about children and their families can normally be shared with them

Information obtained about children and their families can be shared with them unless to do so would place them or others at risk.

For example, where the sharing of the information may place the child or another person at risk, or where the Police request that information should be withheld in order to enable them to investigate or prosecute a serious offence.

Records of sanctions and other measures of control or incidents e.g. where physical intervention is used or if children are absent/missing must be carefully recorded with full details by the staff involved within 24 hours in a record* kept for the purpose*
Where information is recorded which should not be shared with the child concerned, it should be placed in the Confidential Section of the child's file and a note of the lodging of the document should be recorded.

Where records contain information about third parties (for example, other family members or other children), this information cannot usually be shared, unless permission is gained from the person concerned. In such cases efforts must be made to separate the information relating to third parties from that concerning the child/parents.

Subject Access Request SAR

If service user or ex-service user wishes to see their file this can be facilitated by the Data Management Officer Anil Kalbag. We use Chris Albert Consulting DPO, priviness ltd. This process involves data redacting and establishing proof of identity in the case of ex-residents. SARs are responded to within one month.

Managers Must Monitor Information in the Confidential Section of the Child's File

Managers must monitor information held in the Confidential section of files, ensuring that the reason for holding it there is valid; if not, it should be shared with the child and/or moved to another section of the file.

However, before sharing any information previously deemed to be confidential, the manager must take all reasonable steps to consult the originator and take account of their views and wishes.

Records Must be Legible, signed and Dated

If possible, manual records should be typed or handwritten in black ink and all records must be signed and dated. Those completing computerised records must show their name and the date when the recording was completed.

Any handwritten records must be produced so that readers not familiar with the handwriting of the writer can read the records quickly and easily. It must be possible to distinguish the name and post

title or status of the person completing the record. If there is any doubt of the identity of the writer from a signature, the name should be printed.

Records Must be Up to Date

Records should be updated as information becomes available or as decisions or actions are taken as soon as practicable.

Records Must be Written in Plain English and Prejudice Must be Avoided

Records must be written concisely, in plain English, and must not contain any expressions that might give offence to any individual or group of people on the basis of race, culture, religion, age, disability, or sexual orientation.

Use of technical or professional terms and abbreviations must be kept to a minimum; and if there is likely to be any doubt of their meaning, they must be defined or explained.

Records Must be Accurate and Adequate

Care must be taken to ensure that information contained in records is relevant and accurate and is sufficient to meet legislative responsibilities and the requirements of these procedures.

Every effort must be made to ensure records are factually correct.

Records must distinguish clearly between facts, opinions, assessments, judgements and decisions. Records must also distinguish between first-hand information and information obtained from third parties.

Other Agency involvement

Where a young person may be receiving additional Care, treatment or Educational Needs from an alternative service then a Lead Agency Form will be completed. This ensures that all parties are aware of how information will be shared between agencies, who has co-ordinating role and when there will be reviews.

Managers Must Oversee, monitor and Review Records

The overall responsibility for ensuring all records are maintained appropriately rests with managers with day to day responsibility, delegated to other staff as appropriate.
The 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.

Records are reviewed at the biweekly Frontline Managers Meetings

Records should be kept securely and must be tamper proof

All records held on children must be kept securely and must be tamper proof.
Children's files should normally be stored in a locked cabinet, or a similar manner, usually in an office which only staff/carers have access to.

Other day to day records, such as handover, should also be kept securely in a manner authorised by the manager and in keeping with the principles of good practice laid out in this Chapter.

These records should not be left unattended when not in their normal location.
*This can be an electronic record, but this must be accessible to all who have a need to see the record including children to whom the record refers. All records must be in formats that cannot be tampered with after the events e.g. bound numbered or electronic entries that are then ‘barred’ so they cannot be amended at a later date and in a manner that they can be accessed later e.g. for historical investigations.

Removal of Records Must be an Exceptional Occurrence

Records should not normally be taken from the location where they are normally kept.

If it is necessary to remove a record from the home, a manager, who should stipulate or agree how long it is necessary to remove the record, should approve this. The manager must also be satisfied that adequate measures are in place to ensure the security of the record(s) whilst they are removed.

For example, records must never be left in unattended vehicles.
The authorisation for a record to be removed must be recorded and those who may have need to see the records should be informed of their removal.
The manager must then ensure the record is returned as required/agreed.

Records Must Usually be Retained After Closure

Records must be retained for 75 years from the date of birth of the child or 15 years from the date of death in the case of a child who dies before the age of 18
When a file is closed, the date for its destruction should be put on the cover and on the computer record. Records should be destroyed on the relevant date unless the person concerned has been re-referred. Each home and team should maintain a list of records which have been destroyed, the date when they were destroyed and by whom.

Appendix A

Pen Portrait and matching risk assessment:

Name		D.O.B.	
Date of referral:			
Date of Arrival:			
Social Worker:			
Placements officer:			
YOT Officer/Probation:			
Link Resident:			
Link Keyworker:			
Link Clinical Practitioner:			
Pen Portrait			
Legal Status			
Convictions			
Current Situation			
Background information			
Educational Ability			
Harmful Sexual Behaviour			
Psychological/Social/Health			
Assessment visit			
Young Persons Profile:			
Presentation during assessment:			
Potential pathway to offending:			
Professional contact			
Family dynamics			
Outcome of visit			
Matching risk assessment			
Presenting Risks:			
Presenting Needs:			
Impact assessment:			
Integration plan for 6-week assessment:			
Signed by author			
Signed by social worker			

Behaviour Management form:

Name		D.O.B.	
D.O.A.		Date form started	

Risk Assessment- every three months or if risk changes
S-Severity/ F-Frequency H-High, M-Medium, L-Low

	Arrival Date		Date		Date		Date		Date		Date		Date	
	S	F	S	F	S	F	S	F	S	F	S	F	S	F
Missing														
Self-harm														
Aggression														
Sexual behaviour														
RPI														
	Date		Date		Date		Date		Date		Date		Date	
	S	F	S	F	S	F	S	F	S	F	S	F	S	F
Missing														
Self-harm														
Aggression														
Sexual behaviour														
RPI														

Monthly Summary	
Month	**Update of changes**

Arrival Behaviour Management Plan	
Identified risks prior to arrival	
Impact risk assessment prior to arrival	
Initial behaviour management plan	
Additional information	

Missing from Care	
What triggers missing episodes	
When is behaviour seen	
What are the early signs	
What diversion techniques work	

Where do they go and why	
What can be done to prevent missing episodes	
Additional information	
Self-Harm	
What behaviour is seen	
What triggers self-harm episodes	
What are the early signs	
What is used to self-harm	
What should the response be to self-harm	
What can be done to reduce/prevent self-harm	
Additional information	
Aggression	
When is this behaviour seen	
What triggers aggression episodes	
What are the early signs	
Who is this likely to be direct at	
Would should the response be to aggression	
What should be done to reduce/prevent aggression	
Additional information	
Sexualised behaviour	
What behaviour might be seen and where does it occur	
Who is this behaviour likely to be directed to	
What triggers sexualised behaviour	
What are the early signs	
What should be the response to sexualised behaviour	
What can be done to prevent/reduce sexualised behaviour	
Additional information	
Restrictive Physical Intervention	
Individual factors	
Environmental factors	
Staffing factors	

Techniques that work	
What happens after a Restrictive physical intervention	
What is the best way to debrief	
Additional information	
Family contact	
Who can attend/who should not attend	
Identified risks	
Contact management plan	
Additional information	
Form completed by	
Name	
Date	

Information requested from LA:

Name (or initials)		D.O.B.	
Date of referral:			
Social Worker:			
Placements officer:			
Date Requested		Requested by	

Please can you provide the following documentation in order to progress the referral for your young person. Not every young person will have each of the documents below, please record this in the 'not applicable' column. If a young person does have the document however it is not shared for any reason, please record this in the 'not provided' column. Please feel free to complete this electronically.

Documents requested	Provided	Not applicable	Not provided (please state why)
Pre-Sentence Report			
Social Care Chronology			
EHCP/care plan			
LAC/CIC minutes & Reviews			
CAMHS assessment			
Psychiatric assessment			
Report relating to any diagnosis stated in the referral paperwork (*ASD,LD, ADHD etc*)			
AIM2/AIM-3			
ASSET			
Current/Previous placement reports			
Health assessment: *(health needs/specialist consultancy, allergies, dietary needs, current medication, immunisations etc)*			
Independent assessment			
Copy of any legal orders (*SHPO, RO, YRO, Licence conditions etc*)			
Education report (*attendance, level of development etc)*			
Other (please specify)			
Other (Please specify)			
Other Please specify)			

Information provided by	
Signed:	Date

End of Assessment:

Name		**D.O.B.**	
Date of admission			
Clinical Practitioner			
Keyworker			
Social Worker			
YOT Officer/Probation			
Purpose of Report	To assess whether **** is suitable to reside at Glebe House to participate in our Treatment Programme. Factors taken into consideration include: • level of engagement • contain-ability • co-operation • level of risk		

This report is confidential. This report cannot be used for any other purpose than that for which it was commissioned, without prior consent from the author(s) or Director of Friends Therapeutic Community Trust. Information from this report cannot be disclosed to third parties. Risk Assessment incorporates factors relating to current lifestyle. It is therefore time limited and situational. Any significant change in circumstances is likely to lead to a change in the level of risk an individual might present.

Overview of service

The Glebe House Therapeutic Treatment Programme integrates Psychoanalytic, Person-centred and Cognitive Behavioural approaches, embedded in a Therapeutic Community model based on Rapoport's Four Cornerstones of: Democracy, Communalism, Reality Confrontation and Permissiveness. The experience of developmental deficits and relational trauma caused by neglect, lack of care, physical, emotional or sexual abuse, violence and significant loss, can cause severe problems, which affect regulation, creating a child who is insecurely attached, unable to trust adults and can display a range of destructive behaviours.

We understand, and believe, that a supportive environment, combined with specific interventions, which address the most destructive behaviours and the most distorted beliefs, can repair some of the worst effects of early adverse experience. There is a natural drive towards growing up healthily, which includes the potential for resilience and recovery from traumatic and harmful experiences. Research indicates that resilience seems to be the developmental result of sufficient access to support and protection; including the development of positive, self-shaping experiences within the context of consistent and healthily pro-social relationships.

At Glebe House, we provide an integrative Therapeutic Programme designed to provide these experiences, with the philosophy that, over time, they can allow the young person to unlock their natural drive towards development and recovery that has been severely derailed. We are optimistic and practical in the delivery of our service. We believe that change is possible.

As a young person moves through their placement, the emphasis on developing future relapse prevention plans increases. This process is actualised through the completion of a relapse prevention folder, known as a 'Toolkit', that will summarise the abuse-specific work, making links to early years experiences and outline strategies to manage risk in the future. The young person will take the folder that they have created with them to support their transition to a new environment and be part of their relapse prevention plan.
Within the programme addressing sexually abusive behaviours there will be a number of areas of offending lifestyle explored in detail, these will include:

- Engaging within a framework that recognises age and developmental stage
- Taking responsibility for abusive behaviour and reducing the sense of the abuser as the victim
- Sex education
- Understanding the role of sexual fantasy in the abuse pattern - and restructuring sexual fantasies to encourage appropriate sexual relationships
- Developing an understanding of the effects of sexual abuse on victims
- Improving Social Skills and developing methods for reducing social isolation
- Linking offending theory to 'real life' experience
- Developing a plan for Relapse Prevention

Clinical Case Formulation:	
Background information, analysis of behaviour	**Summary:**
	Pre-disposing factors:
	Triggers:
	Protective Factors:
	Maintaining Factors:
Assessment Process	
The assessment process is designed to orientate the young person, acquaint them with the boundaries and culture at Glebe House, and to assess their containability and suitability for treatment. The residential aspect of the assessment offers the opportunity to experience all aspects of community life, and gives practitioners the chance to observe the young person in their interactions with peers and adults.	
Care-Milieu Environment	
Behaviour in the community- level of engagement, involvement in activities **Relationships in the community-** Relationships with Peers and Staff **Integration into the community-** Impact on the group and impact of group on young person **Achievements-** Any person achievements **Cultural and Religious Needs-** Identify and specify how they are met **Identity Needs-** Sexuality, gender, race, ability and specify how they are met	**Behaviour in the Community:**
	Relationships in the Community:
	Integration into the Community:
	Achievements:
	Cultural and Religious Needs:
	Identity:
Independence	
Health- details of medical appointment, general health and wellbeing **Self-Care-** Personal Hygiene **Living Skills-** cooking, laundry, **Self-Motivation-** focus, engagement and drive **Safety Awareness Skills-**crossing roads, household safety **Leisure and Hobbies-** interests and activities	**Health:**
	Self-Care:
	Social Skills:
	Living Skills:
	Self-Motivation Skills:
	Safety Awareness Skills:

	Leisure and Hobbies:
Family and Support Networks	
	Telephone Contact:
	Family Contact:
	Other Support Networks:
Therapy	
	1:1 work:
	Offence Specific Group work:
	Social, Emotional Welfare Group (SEW):
	Community Meetings:
	Additional Therapy:

Psychometrics

The purpose of the administration of these assessments was to construct a cognitive profile for ****, which will inform the understanding of the function of his sexually harmful behaviour. It is important to note that each of these assessments use self-report questionnaires and so can at times be reflective of the young person's own distortions rather than an objective measure.

University of Rhode Island Change Assessment (URICA)- McConnaughy, Prochaska & Velicer (1983)

The University of Rhode Island Change Assessment (URICA) is a self-report measure consisting of 32 items, yielding separate scores on four continuous scales: precontemplation, contemplation, action, and maintenance. The items were written to be relevant to changes in a general problem area defined by the subjects and rated by them on a 5-point Likert-type scale**.**

Stage	**Score**
Pre-contemplation Stage	
Contemplation Stage	
Action Stage	
Maintenance Stage	
Readiness to Change Score	
Stage	

Culture Free Self Esteem Inventories Third Edition - CSFE1-3 (Battle, J.(2005))

The revised CFSEI-3 is a self-report inventory used to determine the level of self-esteem in children and adolescents aged 6 -18.11 years. It can be used to identify children and adolescents in need of psychological assistance due to self-esteem problems, assess therapeutic progress, and evaluate post-therapy effects. The Adolescent Forms provide self-esteem scores in four areas: Academic, General, Parental/Home, Personal and Social.

Domains	**Score**	**Description**
Academic		
General		
Parental/Home		
Social		
Personal		
Defensiveness		
Global Self Esteem Quotient		

Beck Youth Inventories™ - Second Edition (BYI-II) (Beck, J., Beck, A., Jolly, J. (2005)

The *Beck Youth Inventories -Second Edition (BYI-II) for Children and Adolescents* are designed for children and adolescents aged 7 to 18 years. The assessment consists of five self-report inventories designed to assess symptoms of depression, anxiety, anger, disruptive behaviour and self-concept. Each inventory contains 20 statements about thoughts, feelings and behaviours associated with emotional and social impairment in youth.

Assessment	**T score**	**Description**
Self-Concept		

Depression		
Anxiety		
Anger		
Disruptive Behaviour		

Difficulties in Emotion Regulation Scale – DERS (Gratz. K. & Roemer, E., (2004))
The Difficulties in Emotion Regulation Scale is a self-assessment tool designed to obtain an overall measure of how much difficult emotions are impacting daily life. The DERS not only provides an overall score of difficulties with emotion regulation, but also allows for the assessment of six specific factors related to emotion dysregulation. These factors include: Non-acceptance of emotional responses; Difficulty engaging in goal-oriented behaviours; Difficulty controlling impulses; Lack of emotional awareness; Lack of access to emotion regulation strategies; Lack of emotional clarity.

Domain	Score	Description
Non-acceptance of emotional responses		
Difficulties engaging in goal-directed behaviour		
Impulse control difficulties		
Lack of emotional awareness		
Limited access to emotion regulation strategies		
Lack of emotional clarity		

Assessment of Sexual Knowledge in Adolescents (ASKA) (Adapted from Butler, Leighton & Galea, 2003)
The Assessment of Sexual Knowledge in Adolescents (ASKA) is a seventy-six item self-report measure designed to assess general sexual knowledge across nine broad areas. These areas include: parts of the body; public and private places; puberty; masturbation; relationships; social-sexual boundaries; sexuality; safe sex practice; sex and the law. The assessment uses pictorial cues to each question, making it appropriate for use with both learning disabled and non-learning disabled populations.

Section	Score	Max Score
Parts of the body		
Public and Private Places		
Puberty		
Masturbation		
Relationships		
Social-Sexual Boundaries		
Sexuality		
Safe Sex Practices		
Sex and the Law		
Total		

Risk Assessments

Protective + Risk Observations For Eliminating Sexual Offense Recidivism (PROFESOR Worling, 2017):
A structured checklist to assist professionals to identify and summarize protective and risk factors for adolescents and emerging adults (i.e., individuals aged 12 to 25) who have offended sexually. The PROFESOR is intended to assist with planning interventions that can help individuals to enhance their capacity for sexual and relationship health and, thus, eliminate sexual recidivism. The PROFESOR contains 20 bipolar factors (i.e., both protective and risk characteristics) that were chosen based on a review of the available literature and on clinical experience with adolescents and emerging adults who have offended sexually. After applying the coding rules in the following pages, protective and risk factors can be summarized into one of 5 categories. The categories are intended to reflect the intensity of services that may be required.

The J-SOAP II (Prentky & Righthand, 2003)
A checklist whose purpose is to aid the systematic review of risk factors associated with sexual and criminal offending. There are 28 items that together fall into four categories.

Static Scores

- Sexual Drive/Preoccupation
- Impulsive/Antisocial Behaviour Scale

Dynamic Scores

- Intervention Scale
- Community Stability/Adjustment Scale

.

Static/Historical Scales

1. Sexual Drive/Preoccupation Scale Score: /16 = %
   (Add Items 1 – 8 [range: 0-16])
2. Impulsive/Antisocial Behaviour Scale Score: /16 = %
   (Add Items 9 – 16 [range: 0-16])

Dynamic Scales

3. Intervention Scale Score: /14 = %
   (Add Items 17 – 23 [range: 0-14])
4. Community Stability Scale Score: /10 = %
   (Add Items 24 – 28 [range: 0-10])

Static Score (Add Items 1 – 16) /32 = %
Dynamic Score (Add Items 17 – 28) /24 = %

Total J-SOAP Score (Add Items 1 – 28) /56 = %

The ERASOR (Worling & Curwen, 2001) is an empirically based clinical assessment used to assess sexual re-offence in adolescent sex offenders who offended between the ages of 12 to 18. There are twenty-five risk factors that together fall into five categories. Each factor is coded according to the likelihood of its presence in the history or current presentation of the adolescent in question

- Sexual Interests, Attitudes, and Behaviours:
- Historical Sexual Assaults:
- Psychosocial Functioning:
- Family/Environmental Functioning:
- Treatment:

Risk Analysis:

There is currently no actuarial risk analysis system that offers reliable results for predicting risk in teenagers who have committed sexual assaults. This is partly due to the general difficulty of predicting an individual's behaviour and is combined with low recidivism rates due to the challenges of identifying and convicting sexual abusers. Risk assessments undertaken by Glebe House take into account the range of research exploring relevant issues in both the adult and juvenile forensic field and combines research with clinical judgement.

Risk assessment tools developed within adult services should be considered with some caution if used to inform assessments of teenagers. This risk assessment considers static and dynamic factors and incorporates research-based information and the clinical judgement of experienced practitioners. Risk assessments are necessarily time limited and subject to change as the individual matures; they should be repeated following significant life changes.

Results from both the JSOAP II and *ERASOR* risk assessment tools suggest that *** risk of sexual recidivism should be considered as ….

Risk Analysis	
Legal Mandates- orders and registration	**Legal Mandates:**
Significant Events- Consequences/ PI/ Absences/ Safeguarding concerns	**Significant Events:**

Assessment of Risk- Assessment tools **Factors that increase Risk-** risk analysis **Factors that decrease Risk-**risk analysis **Supervision Level-** current level **Risk Management Plan-** Strategy for reducing risk	**Assessment of Risk:**
	Factors that increase Risk:
	Factors that decrease Risk:
	Supervision Level:
	Risk Management Plan:
Education - See separate report	
Conclusions and recommendations	
Young Persons Wishes for the next three months	
Young Persons Views on Placement	

Area of Focus	Actions	Desired Outcome	Who by?	When by?
Milieu				
Independence				
Therapy				
Risk				
Family and Support				
Personal Development				
Education				
Management Plan				

Signed (Resident) Signed (Clinical Practitioner)

Signed (Keyworker) Date:

Pre-Admissions:

Name		D.O.B.	
Address of previous placement			
Contact details of previous placement			
Care status			
National Insurance number			
Does the young person have a bank account/passport/ driving licence?			
Who has parental responsibility			
Contact details for person with PR (if not parent/social worker)			
Social Worker's Name			
Social Worker contact details			
Out of hours telephone number			
Family Contact Details (please include mobile/ landline/address for all family members the young person has contact with, please provide details of specific contact arrangements if appropriate)			
Any contact restrictions			
Legal Orders (Referral order, YRO, Licence, SHPO) and order restrictions			
Health information			
NHS number			
Current GP details (including contact details)			
Details of other medical professionals involved (including contact details)			
Any current medical conditions or diagnosis?			
Any medication that the young person is currently taking (please can you			

ensure that the young person has an adequate supply of medication when they arrive at Glebe House	
Allergies/dietary requirements	
Date of last dental check	
Date of last eye check	

Educational information

Current education provision	
Contact details of current education provision	
Point of contact for current education provision	
Does the young person have an EHCP (has it been provided)	
Is there an educational psychology assessment	
Does the young person need additional aids- overlays, word processor etc.	
Current subjects studying, exam boards and expected grades	
Any completed qualifications	
SATs results	
Attendance	
History of exclusions/ suspensions	

Contracts information – Glebe House offer a minimum of a two-year therapeutic placement, funding needs to be agreed in principle at the commencement of the placement

Local Authority	
Contact details for contracts officer	
Who is funding the placement (Health, Social Care, Education)	
Point of Contact for each funder	

Safeguarding Screening Assessment

Concern	Present	Potential/Vulnerability	Not Present	Unknown
HSB				
CSE				

Peer Abuse				
Technology related abuse				
Experience of Sexual Abuse				
Experience of Physical Abuse				
Experience of Emotional Abuse				
Experience of Neglect				
Domestic Violence				
FGM				
Honour Based Violence				
Drugs and Alcohol				
Parental Drugs and Alcohol				
County Lines				
Bullying (victim)				
Bullying (perpetrator)				
Radicalisation (Prevent)				
Any other relevant information				

Form Completed by:	
Name	
Date	
Signed	