Practitioner Guidance: Please see information in red for guidance

This guidance is intended to support the professional undertaking the EHA which will take place in conjunction with the child [ren] and parents/family members. Please complete all areas.
Please note that facts MUST be obtained at the time of the EHA and analysis should be included based on these facts. Subsequent meetings / reviews will be able to expand upon these facts and professional opinions. Use your engagement and communication skills to make a complete assessment and always strive to be solutions focused, highlighting the strengths and protective factors you observe discussing areas for improvement allowing the family, children's and your own views to be expressed in an open and honest environment. If information concerning significant harm to a child [ren] transpires during the assessment then Child Protection procedures must be adhered to.

The EHA can only be taken forward and shared when consent has been gained from parents – this must take place at the end of the EHA.

DATE: Please complete

EARLY HELP ASSESSMENT — Practitioner Guidance

FAMILY DETAILS Please put children first

SURNAME	FORENAME	DOB	GENDER	ROLE WITHIN FAMILY	D	P/R	E	P

- Complete all boxes
- Ensure all family details and addresses/phone numbers are correct and current.
- Record any changes and draw attention to any new information
- Ensure all the information is up to date.
- Ensure you complete the disability and ethnicity codes-found on page?
- It is imperative to record exactly who was present at the time of the assessment.

To submit an Early Help Assessment front sheet complete the online **Early Help Assessment form front sheet.**

Use the key to complete the boxes above (KEY: D = Disability P/R = Parental Responsibility E = Ethnicity P = Present for Assessment)

FAMILY ADDRESS	Contact telephone number
*Please complete all areas	*
	Emergency contact number

DETAILS OF ASSESSOR/LEAD PROFESSIONAL (If joint assessment please complete section B.)

- Add all the details of the assessor(s) clearly

*Main assessor will be lead professional until first meeting/review as a minimum	Y/N	Date	Lead Professional
Multi-agency Meeting within 20 working days from assessment			
Single agency Review within 3 months of assessment			

- Be clear whether it is single or multi agency and when the meeting/review is planned for?

REASON FOR EARLY HELP ASSESSMENT (DATA COLLECTION)

SUPPORT REQUIRED AS AGREED BY PARENT/CARER	TICK		TICK
Child with disability or complex health needs		Behaviour support-(including risk taking behaviours)	
Parent/carer with disability or complex h		arer support	
Identified health and/or development ne **assessment**		er Mental Health support	
DV within family		Child mental Health Support	

Please tick the most relevant boxes

Substance misuse within the family		Housing issues	
Other		Financial issues	

ASSESSMENT AND ANALYSIS

REASON FOR ASSESSMENT (Brief Outline)

Make this very brief, how have you got to this point of assessing the emerging need

CHILDREN / YOUNG PERSONS HEALTH & DEVELOPMENT (CHILD SPECIFIC AS NECESSARY) & PARENTING CAPACITY (PARENT SPECIFIC AS NECESSARY) & FAMILY & ENVIRONMENT (all separate on the form)

Please include strengths

Please identify what the problems are asking the parent to identify themselves then you adding your interpretation of the situation e.g.

- **The parent is unable to get the child to school on time due to their chaotic lifestyle choices**

Identify strengths

e.g.

- **The parent is getting the child to school and this is a strength but in the analysis below you should identify the impact**

What does that information mean? –

Please ensure some analysis is made, not a summary of the issues but what this means for the child (ren) now and in the future if support is not given to the parents/carers?

e.g.

- **If the child is going not going to school on time, how might this impact on his education, mental health, employability self-esteem, ability to make friends?**
- **If the child does not have a dentist or does not attend appointments for his health needs how will this impact on his health and development?**
- **If there are housing issues how will this impact on the child and family?**

Ethnicity coding for page 1

White British	**WB**	**Caribbean**	**CA**	**Indian**	**IN**	**White & Black Caribbean**	**WBC**
Chinese	**CH**	**White Irish**	**WI**	**African**	**AF**	**Pakistani**	**PA**
White & Black African	**WBA**	**Traveller of Irish Heritage**	**TIH**	**Any other Black**	**AOB**	**Bangladeshi**	**BD**
White & Asian	**WA**	**Gypsy/Roma**	**GR**	**Any other Asian**	**AOA**	**Any other Mixed**	**AOM**
Any other White	**AOW**	**Other Ethnic Group**	**OEG**	**Not Given**	**NG**		

Disability coding for page 1

Disability	**CODE**	**Disability**	**CODE**
None	NONE	Mobility – getting about the house and beyond	MOB
Hand Function – holding & touching	HAND	Personal Care – eating, washing, going to the toilet, dressing etc	PC
Incontinence – controlling the passage of urine or faeces	INC	Communication – speaking and /or understand others	COMM
Learning – having special educational needs, etc.	LD	Behaviour – a condition entailing behavioural difficulties, includes Attention Deficit Hyperactivity Disorder (ADHD)	BEH
Hearing	HEAR	Consciousness - seizures	CON
Vision	VIS	Other DDA – one or more of the child's disabilities under the Disability discrimination Act 2005 does not fall into any of the above categories.	DDA

Diagnosed with Autism or Aspergers Syndrome – diagnosed by a qualified medical practioners as having classical Autism or Asperger syndrome. Do not include children who have merely been identified as having an Autistic Spectrum Disorder (ASD) e.g. by their school. This can be associated with the behavior and learning categories above.	AUT

EARLY HELP PLAN Must be SMART

OUTCOME	No.	WHAT NEEDS TO CHANGE?	HOW CAN THESE CHANGES BE MADE?	BY WHO?	BY WHAT DATE? (please agree an achievable/specific date)
HEALTH e.g.	1	Child Bloggs needs a dentist	Information of local dentists taking on patients to be provided for parents To register with chosen dentist	John Smith, Health Visitor Mrs Bloggs, mother	15th February 2016 DO NOT USE ASAP OR BY NEXT MEETING 25th February 2016
EDUCATION OR EMPLOYMENT e.g	1	Child Bloggs needs to get to school on time every day	Use of alarm to wake parents	Mr and Mrs Bloggs, parents	10th February 2016
SAFETY					
POSITIVE LIFESTYLE					
PARENTING					
OTHER					

What does the child think of the plan?

Where appropriate, please use any relevant observations of the child if too young

What does the parent/carer think of the plan?

Ask them to write on the assessment or quote exactly what they say-ensure they complete a service user form following assessment

Significant Others-
(Other people associated with the family but do not live with them)

SURNAME	FORENAME	DOB	ADDRESS	RELATIONSHIP TO FAMILY

Please add anyone not living in the family home who has an influence or provides support for the immediate family

AGENCIES AND SERVICES

Use NL Helping Children and Families (Threshold Document) appendices for local services and contact details
Please routinely include and share with:-
Schools/Colleges and School Nurses for school aged children within the family
Health Visitors if under 5's in the family
Midwives if any member of the family is pregnant
***routinely gain consent and share as applicable**

Name of agency/service	Contact details	Currently Involved Y/N	Share assessment with Y/N
Please name all agencies who are involved with the child (ren) or who need to be involved as identified in the plan If you do not add all agencies here you cannot share the information in this assessment with them without gaining consent again at a later date			
***Your own services 'Early Help Lead' for Audit/Quality Assurance**	**These are already written on the assessment and should be shared with routinely unless the parent dissents**		**Y**
***Local Safeguarding Children's Board-Audit**			**Only if selected for audit purposes**
***G.P.**			**Y**
***Early Help Administrator**			**Front sheet only for central data collection**

CONSENT

We need to collect the information in this assessment form so that we can understand what help you may need. If we cannot cover all of your needs we may need to share some of this information with the other organisations specified above, so that they can help us provide the services you need.
If we need to share informat ou more help we will ask you about this before we do it.
We will treat your informati y other organisation unless we are required by law to share it o rm if we do not share it.
In any case we will only ever re.

Please ensure the parent is happy with the assessment and they consent to share with the identified agencies and services and they sign a copy

I agree to the sharing of information between the services identified in the plan and agencies and services list.

Parent/carer:	Signed:	Date:
Child/Young Person	Signed:	Date:
Assessor/Lead Professional	Signed:	Date:

Review /meeting documentation available as separate document