



RBWM Early Help Hub

Early Help Assessments

Early Help Assessments (EHA's) identify what help a child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989 – Single Assessment or Child Protection Enquiries.

The 'Working Together' document states:

The Early Help Assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services.

The lead professional role could be undertaken by a General Practitioner (GP), family support worker, teacher, health visitor and/or special educational needs coordinator. Decisions about who should be the lead professional should be taken on a case by case basis and should be informed by the child and their family.

Before making a Request for MASH and Early Help, there will be an expectation that universal services and/or school support has already been put in place and measured for its effectiveness. Examples of universal support are ELSA, self-referral to school based counsellor, peer mentoring, universal parenting group.

In addition, if the child is eligible for pupil premium or has SEN support, it will be important to show how the interventions offered have been evaluated.

If the outcome measures produced suggest that the current support or intervention that was put in place is not meeting the needs of the child or family, it will then be appropriate to complete the 'Request for MASH and Early Help' form ticking the Early Help Hub box, and where available, send a copy of the 'Early Help Assessment' (part 1 and part 2).

If you have discussed with the family or young person and they would like to refer directly (to services that take self referrals, (such as the youth counselling service), they can continue to do this.

Early Help Hub Function

The function of the Early Help Hub is to identify what help a child and family require to prevent needs escalating and ensure the most appropriate plan and support is put in place in a timely manner. The Early Help Hub will have a shared set of priorities for the allocation of existing resources and as far as possible is a single point of access for the following additional services.

A data base will be kept of requests to the hub and the services to be involved. This will enable a systematic review of the types of need for which additional resources are required

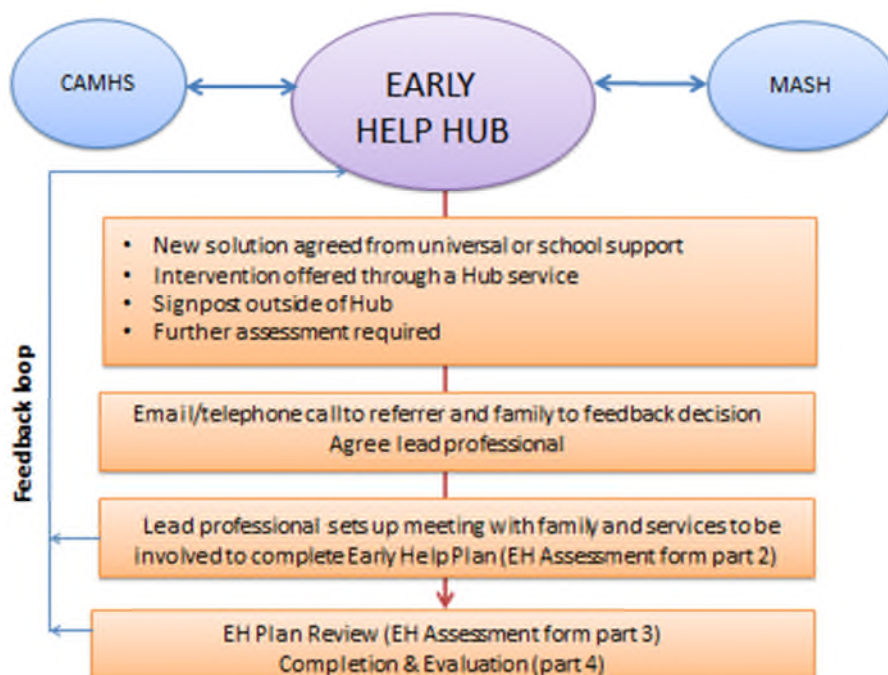
and any patterns in the requests, to enable future planning to meet the needs of the community.

Early Help Hub Services

The following services will form the Early Help Hub:

- Early Help Social Workers
- Wellbeing Practitioners
- Youth Counselling Service
- Youth Service
- Intensive Family Support Service
- RISE Alternative Provision
- Behaviour Support
- Educational Psychology Service
- Voluntary services including Family Friends, Young Carers
- Children's Centres
- Health Visitors
- DASH
- DAAT
- Shine (Autism outreach service)
- Health visitors and school nurses
- Education Welfare Service
- Youth Offending Service

The Early Help Hub will also work closely with CAMHS to ensure that the child's needs are most effectively met. The Single Point of Entry for CAMHS will continue to operate for children and young people with significant mental health concerns.



The Early Help Hub will meet each Wednesday in Maidenhead Town Hall and will consist of a core group of decision making managers.

RBWM Request for MASH/Early Help



Safeguarding (MASH)	<input type="checkbox"/>
Early Help Hub	<input type="checkbox"/>

Early Help Assessment (part 1 of 4) or MASH request

Child/Young Person's Information					
First Name(s): enter text		Surname(s): enter text.			
DOB: enter a date. Age: enter text.		Gender: Choose an item. School/Pre-school: enter text.			
Ethnicity: Choose an item.		If other, please state: enter text.			
Contact Details: enter text.					
Parents/Carers Details					
Name(s): enter text.		Home address: enter text.			
Email: enter text.		Main contact number: enter text.			
Referrer's Details					
Name of Referrer: enter text. Agency: enter text.		Address: enter text.			
Email: enter text.		Main contact number: enter text.			
Current family and home situation (siblings and previous information may be helpful to include)					
enter text.					
Family Composition					
Name	Relationship	Address (if different from above)	DOB (for children only)	Gender (for children only)	School (for children only)
enter text.	enter text.	enter text.	enter date.	Choose an item.	enter text.
enter text.	enter text.	enter text.	enter date.	Choose an item.	enter text.
enter text.	enter text.	enter text.	enter date.	Choose an item.	enter text.
enter text.	enter text.	enter text.	enter date.	Choose an item.	enter text.
Additional family members: enter text.					
What has led to the request for involvement at this time?					
enter text.					

What support/intervention has already been provided?							
What has worked well?							
enter text.							
What is happening? Please include the views of the family							
What are you worried about?		What is working well?			What needs to happen next?		
enter text.		enter text.			enter text.		
What positive outcomes are you hoping for?							
<ul style="list-style-type: none"> • enter text. • enter text. • enter text. 							
Other Agencies Involved Please give details and include other information							
Agency/ link name		Contact details		Date	Detail of involvement		
enter text.		enter text.		enter date.	enter text.		
Risk Factors Please tick if any of the following factors affect this child/ young person							
	Present	Within last 12 months	In the wider family		Present	Within last 12 months	In the wider family
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioural Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Known to CAMHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child Sexual Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression/low mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School absence <90%	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text" value="%"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text" value="%"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School absence-anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exclusion from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Genital Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment (adult)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Youth Offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	At risk of offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radicalisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Young Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk To Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16/17 Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)	enter text.						
Additional Information regarding any of the above: enter text.							

Consent	
<i>Please ensure that the young person and/or parents have agreed to the referral and the points below:-</i>	<i>Please tick</i>
I agree for the referral to be made to MASH/Early Help Hub	<input type="checkbox"/>
I understand that the information will be stored electronically, and that only authorised persons will have access to this information.	<input type="checkbox"/>
I agree that information already held by other agencies and information from this referral can be shared in order to develop an early help intervention plan.	<input type="checkbox"/>
I have been given a copy of the leaflet, including details of how information is stored and shared.	<input type="checkbox"/>
Parent/carer's Name: enter text.	Signature:
Date: enter date.	
Young Person's Name: enter text.	Signature:
Date: enter date.	
Is there any individual or organisation that you would not wish information to be shared with?	
enter text.	

*When completing the form, please provide enough detail to enable MASH or the Early Help Hub to offer the best range of services to support the child and their family. Unfortunately, if there is **no parental/young person's agreement** or **not enough information** to make a decision, **the form may be returned** for further completion.*

Questions for the child or young person to complete

Name:

Date:

How did you feel last week? Circle the number that fits how you felt.

		<i>Never</i>	<i>On one day</i>	<i>On a few days</i>	<i>Most days</i>	<i>Every day</i>
a)	I felt happy	1	2	3	4	5
b)	I felt sad	1	2	3	4	5
c)	I enjoyed my school work	1	2	3	4	5
d)	I had no-one to play with/hang out with	1	2	3	4	5
e)	I had lots of energy	1	2	3	4	5
f)	I kept waking up in the night	1	2	3	4	5
g)	I got on with my friends and family	1	2	3	4	5
h)	I felt good about myself	1	2	3	4	5

Did anyone help you answer these questions?

If yes, please write the name of the person that helped you:

Adapted from: A Guide to Measuring Children's Wellbeing - Action for Children

For queries please phone: 01628 685991

Send completed (password protected) form to: mash@rbwm.gov.uk or mash@rbwm.gcsx.gov.uk

All MASH/EH documents should be emailed securely

**Children's Services
Town Hall, St Ives Road
Maidenhead
SL6 1RF**

Form to be reviewed: July 2016



RBWM Early Help Assessment (Part 2)

Early Help Plan

Set Up Meeting for:
Persons present at the meeting:

Date:
Review Date:

Form completed by:

Lead Pprofessional			
Name of Lead Professional:	LP contact number:	LP email:	Organisation:
Early Help Hub involvement agreed?	Name of Early Help Service(s)	Name of link person(s)	Contact number(s)
Yes <input type="checkbox"/> No <input type="checkbox"/>			

Early Help Plan

Protective factors		
Child/young person:	Family:	Wider family:

What is the problem you want to make better?	Goal- What do you want to achieve (outcome for the child)?	Action – What tasks/activities will be done to achieve this goal?	Who will do this?	By when?

Please email a copy of the completed form to: EH@rbwm.gov.uk password protected



RBWM Early Help Plan Review (Part 3)

Team around the child/family

Review meeting for:
 Persons present at the meeting:
 TAC/TAF number:

Form completed by:
 Date:
 Next review date:

Lead Professional			
Name of Lead Professional:	LP contact number:	LP email:	Organisation:
NEW Services Involved			
Name of Service			
Name of link person			
Contact number			

Early Help Plan Review

Action – Agreed tasks and activities from planning meeting/previous TAC	Goal achieved- Include all measurable outcomes for the child?	Who helped to achieve this?	Completed If not completed, new date to be agreed

Have all the actions been completed? Yes No

Are there any outstanding needs? Yes No

Are there any new needs? Yes No

Comments:

Additional comments from child/young person and family

New and continued goals to be agreed (if required)

What is the problem you want to make better?	Goal- What do you want to achieve (outcome for the child)?	Action – What tasks/activities will be done to achieve this goal?	Who will do this?	By when?

Next Steps

	Yes		Yes		Yes
Continue with new goals	<input type="checkbox"/>	Step up to Social Care	<input type="checkbox"/>	Consent withdrawn	<input type="checkbox"/>
Step down to universal support	<input type="checkbox"/>	Step up to CAMHS	<input type="checkbox"/>	Child moved out of area	<input type="checkbox"/>
Other	<input type="checkbox"/>				
Additional Comments:					

Please email a copy of the completed (password protected) form to: EH@rbwm.gov.uk

RBWM Completion of Early Help Plan (Part 4) Evaluation

Completion meeting for:

Date:

Persons present for completion of evaluation:

Risk Factors <i>Please tick if any of the following factors that NOW affect this child/ young person</i>							
	Present	Within last 12 months	In the wider family		Present	Within last 12 months	In the wider family
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioural Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Known to CAMHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child Sexual Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression/low mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School absence <90%	%	%	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School absence-anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exclusion from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Genital Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment (adult)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Youth Offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	At risk of offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radicalisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Young Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk To Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16/17 Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)							

Any additional concluding Information:

Questions for the child or young person to complete

How did you feel last week? Circle the number that fits how you felt.

		<i>Never</i>	<i>On one day</i>	<i>On a few days</i>	<i>Most days</i>	<i>Every day</i>
a)	I felt happy	1	2	3	4	5
b)	I felt sad	1	2	3	4	5
c)	I enjoyed my school work	1	2	3	4	5
d)	I had no-one to play with/hang out with	1	2	3	4	5
e)	I had lots of energy	1	2	3	4	5
f)	I kept waking up in the night	1	2	3	4	5
g)	I got on with my friends and family	1	2	3	4	5
h)	I felt good about myself	1	2	3	4	5

Completed independently by the child or young person Yes/No

Completed with support: *Name of person*

Adapted from: A Guide to Measuring Children's Wellbeing - Action for Children

Please email a copy of the completed (password protected) form to: EH@rbwm.gov.uk