**Early Help Assessment – Signs of Well-being**

Complete this form electronically, use the TAB key to create more rows in the tables.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date assessment started** |  | **Date** **registered** |  | **Date coordinator changed** |  | **Date** **Closed** |  |

**Details of Child/ren.** The child that is identified first with needs must be in the first row of the table below. Followed by siblings then the family members and people who are important to the child/ren. **All information is essential.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full name**(Enter all children first) | **DOB or****Due date**  | **Sex** | **Gender identity**(Optional) | **Family member?****e.g. mother, father, child** | **Ethnic origin** | **Nursery/****School/****College** | **Is this child part of the assessment?****Y or N** | **Parental responsibility****Y/N** | **Address****Telephone number**(if different) |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Support network /current family and home situation**

Who is in the support network? E.g., family structure including siblings, other significant adults such as grandparents, neighbours and friends; tell us who lives with the child/young person or who does not live with the child or young person, but provides support to the family, (genogram/spider diagram). Significant family history, (chronology). Practitioners need to be professionally curious.

|  |
| --- |
|  |

**Assessment**

Summary and analysis of what is working well and what you are worried about – start from the centre column to reinforce the positives

|  |  |  |
| --- | --- | --- |
| **What are you worried/concerned about?** | **What is working well/strengths?** | **What will well-being look like? (What outcomes do you want for the child/young person)?** |
|  |  |  |
| **Worry Statement** *
*
*
 | **Well-being Goal (s)***
*
*
 |
| **Scaling -** On a scale of 0 to 10 – where 10 means that everything that needs to happen for the child/young person in order for them to have wellbeing is happening and no additional support is needed. 0 means that the TAF are worried there is nothing in place to improve well-being and reduce the worries. Where would you each rate the situation right now?  |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **What are the child/young person’s views? How do you know?**  |
| What I am worried about? | What is good in my life? | What things will look like when it is better.  |
|  |  |  |
| **What are the parent/carer’s views?** What are you worried about? What is working well? What will well-being look like?  |
|  |

**Family Action Plan and Review – Date:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full name**(Enter all children first) | **DOB or****Due date**  | **Sex** | **Gender identity**(Optional) | **Family member?****E.g. mother, father, child** | **Ethnic origin** | **Nursery/****School/****College** | **Is this child part of the assessment?****Y or N** | **Parental responsibility****Y/N** | **Address****Telephone number**(if different) |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**What will wellbeing look like? What outcomes do you want for the child or young person?**

The well-being goals on page 2 must be taken directly from the assessment into the Action Plan. Actions/tasks to achieve the goals should be recorded in the appropriate column. A review date must be agreed and progress recorded.

This is the overarching Early Help Plan - for children with SEND an IEP or other individual school record can be used to inform the Early Help Action Plan.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Well-being Goal**  | **Action/Tasks** | **Who will do this?** | **By when?** | **Progress and Comment on Action/Tasks****For completion at TAF Scale 0-10**How are things now? 0-1-2-3-4-5-6-7-8-9-10 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Services supporting this child/ren or young person and family. This information must be completed to inform planning**

Agencies involved: (E.g., GP, midwife, nursery, school, access and inclusion officer, youth provision, other).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Agency** | **Role** | **Contact Details** | **Date Started** | **Date ended** |
|  |  | Initiator of EHA /coordinator of EHA |  |  |  |
|  |  |  |  |  |  |

**Date of next TAF:**