Chronology Guidance

The purpose of a chronology is to record **significant** concerns, events or incidents that impact (positively or otherwise) on a person's wellbeing.

A **single agency chronology** provides a brief description and summarised account of significant events relevant to an individual. It should be used as an analytical tool to support the understanding of the impact of life events. A single-agency chronology is created when there are concerns about an individual that will impact on their wellbeing. Where appropriate, a single-agency chronology should accompany a referral to another agency/service.

A **multi-agency chronology** is produced as part of a specific multi-agency intervention and will include information extracted from single agency chronologies that is **relevant**, **necessary**, **legitimate**, **appropriate** and **proportionate.**

A chronology:

- ✓ is an essential tool for best practice in assessment, analysis, and decision making
- ✓ is an aid to effective partnership working and discussion with families
- ✓ is factual, accurate and evidence based
- ✓ supports workers to maintain focus on the individual
- ✓ is in a neutral language, suitable for practitioners and families to understand
- ✓ is presented in time and date order starting with the earliest available information
- ✓ is concise – if every concern, event or milestone and circumstance is recorded then the chronology loses its value and impact
- ✓ provides an early indication of an emerging pattern of need, concerns, and/or risks.

Chronology of Significant Events

(Start at the most relevant point in family history.

Date or period of event	Significant Event	Source	Impact/Outcome
The date the event occurred (if this differs from date informed or reported – include this in the narrative)	**A brief description of the event should be recorded here. The language should be in plain English, non-judgemental, clear and concise. Entries could be a summary of a pattern of behaviour e.g. failure to attend/rearranged appointments or services;; refused access to household.** **An entry may include significant changes (both positive and negative) in:** • **the person's wellbeing;** • **the carer's wellbeing which impacts on the person;** • **the family household/housing circumstances, e.g. separation, divorce, bereavement, birth, new partner, house move;** • **the person's legal status** • **professional staff or services accessed by the person or family** **An entry may also include information received from other services e.g. Police VPD Report.**	**Record who/where the information has come from.**	**Note the impact on the individual. This could be updated at a later date if the impact is not immediately apparent.** **Include what happened as a result of the event and actions taken**