|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Single Agency involved 🞎 Multi-Agency involvement 🞎 (please tick to indicate) Date of Completion | | | | | | | | | |  |
|  | | | | | |  | | | | |
| Name of child / young person | | | | | |  | | | | |
|  | | | | | |  | | | | |
| Other known names | | | | | |  | | | | |
|  | | | | | |  | | | | |
| Address | | | | | |  | | | | |
|  | | | | | |  | | | | |
|  | | | | | | Post code |  | Contact telephone number | |  |
|  | | | | | | | | | | |
| Male | |  |  | Female |  | Date of birth |  | | | |
|  | | | | | | | | | | |
| Religion | |  | | | | Ethnicity |  | | First language |  |
| Please provide details of any disabilities | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Is an interpreter or signer required? Please provide details | | | | | | | | | | |
|  | | | | | | | | | | |

**Details of Worker completing this form**

|  |  |
| --- | --- |
| Name |  |
| Role |  |
| Organisation |  |
| Address |  |
| Telephone |  |
| Email |  |

**Important**

This document belongs to the child or young person named above and their family or carers. Please ensure the child or young person is given opportunity to chair or lead the review meeting to which it refers wherever possible. The child or young person’s views regarding actions and progress should be sought and recorded as a priority and before any professionals present whenever possible.

**Complete as applicable for single or multi-agency review**

**List all people invited to attend the meeting and others from whom information was requested**. This section should show that services that are in regular contact and able to add support have been invited to attend or comment. Examples include, but not exclusively, midwives, health visitors, school nurses, children’s centres and schools. Most plans are likely to be multi-agency.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name – list Lead Professional first** | **Agency / family relationship** | **Contact number** | **Comment – State ‘New LP’ if Lead Professional has changed** | **Attended?**  **Yes No** | | **Update sent?**  **Yes No** | |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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IMPORTANT - If more than one professional is named above – please tick multi-agency on page 1

| **Long term Goal Statement - How will things look for the child/young person/family when you are ready to end Early Help?** |
| --- |
|  |

**Strength Score Review**

If an Early Help Part 1 Assessment has been completed, please review the strength scores to show change in levels of need below

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Outcome** | **1 – Excellent** | **2 - Good** | **3 - Needs Early Help** | **4 - Needs Intensive Early Help** |
| General Health | □ | □ | □ | □ |
| Personal Development | □ | □ | □ | □ |
| Enjoy and Achieve | □ | □ | □ | □ |
| Parenting | □ | □ | □ | □ |
| Family / Environment | □ | □ | □ | □ |

**Review Delivery Plan – Current Actions:**

Use the table below to record actions ensuring they are **Specific, Measurable, Achievable, Realistic and Time Based** (SMART) and relate to conclusions reached during assessment. Detail the changes or outcomes that people want as well as the specific actions

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Action Number** | **What changes (outcomes) do people want to see?** | **Who will benefit from this change?** | **How will it happen? What is the specific action?** | **Who will do this?** | **When will it be done by?** | **Progress and Comments** | **Action Achieved** |
|  |  |  |  |  |  |  | Yes □  Partially □  No □ |
|  |  |  |  |  |  |  | Yes □  Partially □  No □ |
|  |  |  |  |  |  |  | Yes □  Partially □  No □ |
|  |  |  |  |  |  |  | Yes □  Partially □  No □ |

|  |  |
| --- | --- |
| Agreed review date (approx. 6 weeks or according to service specific guidelines) |  |

|  |
| --- |
| **Review notes / minutes / housekeeping** |
|  |

|  |  |  |
| --- | --- | --- |
| Additional Case Notes |  |  |

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Has a new lead professional been allocated since the previous meeting? Has the agency changed? |  |  |
| Has consent been given for change by the family? |  |  |
| Do both the lead professional and the new lead professional agree to change? |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| New Lead Professional |  | | | |
|  |  |  | |  |
| Agency |  | Job title | |  |
|  |  |  | |  |
| Email address |  | Contact number | |  |
|  |  |  | |  |
| Previous Lead Professional and agency |  | | | |
|  |  |  |  | |

**Comments:**

| **Child / young person comments and responses** | **Parent / carer comments** |
| --- | --- |
| *Useful (age dependant) questions could include:*  *What’s happened since our last meeting/visit?*  *What’s making you happy?*  *What still needs to change?*  *Who does your worker need to speak to?*  *Have we made the right plan?*  *Draw a face/smiley of how you feel today*  *Professional to record non-verbal responses to change in younger children* |  |
| **Practitioner comments** | **Other comments** |
|  |  |

Are we ready to close Early Help? Yes 🞎 No 🞎

|  |  |
| --- | --- |
| If Early Help is to continue, please state next review date (approx. 6 weeks or according to service specific guidelines) and send to the Early Help Hub |  |

**Closing Early Help** (skip to end if Early Help is to continue)

If the family meet the criteria for Confident Families please indicate the strength score at assessment and closure against the criteria below

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Assessment** | **Closure** |
| Crime and Anti Social Behaviour |  |  |
| Attendance |  |  |
| Children who need help |  |  |
| Work and Debt |  |  |
| Domestic Violence |  |  |
| Health |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Closure date |  |  | Detail of closure  (essential) | *Please include a sentence or two briefly describing the episode of help and how it reached a conclusion* | | | | | | |
|  | | | | | | | |  |  | |
|  | | | | | | | | Yes | No | |
| Early Help success – back to Universal Support | | | | | | | |  |  |
| Child left area | | | | | | | |  |  |
| Escalated to Social Care | | | | | | | |  |  |
| Consent withdrawn | | | | | | | |  |  |
|  | |  | | | | | | | | |
| Other (please specify) | |  | | | | | | | | |
|  | |  | | |  |  |  | | | |
| Continuing Universal Support to be provided by (name / agency) | |  | | | | | | | | |

**This completed Review / Closure must now be sent to the Early Help Hub**

**Email** [**EarlyHelp.logging@wigan.gov**](mailto:EarlyHelp.logging@wigan.gov) **Tel** 01942 828520

**Address –** Multi Agency Safeguarding team,Ground Floor,College Avenue,Wigan, WN1 1NJ