

Action Plan Review



Photocopy for additional reviews

EHAP No.

Date of review: _____

Child/young person's full name: _____ Date of birth: _____

Lead Professional: _____ Tel: _____

Attendee (full name)	Role	Organisation/service	Tel
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were actions effective in achieving desired results? (Number points in relation to action plan and use effectiveness rating below)

Ineffective: No noticeable/measurable outcome/improvement. **Partly effective:** Small noticeable/measurable outcome, but still much to do to achieve the desired result. **Mostly effective:** Most of the desired result has been achieved. A little extra effort is needed to achieve/sustain all the desired results. **Completely effective:** Desired result achieved and can be maintained without further support.

Continuing needs and desired result (Number in order of priority)	Further actions (Indicate name/service)	Desired completion date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of next review meeting: _____

Consent for agreed further actions (if applicable) or closure of the EHAP

- I understand and agree with the proposed further action and consent to my information being shared with the services identified for the purpose of accessing these services.
- The desired results have been achieved and I consent to the EHAP closing.
- I no longer wish to continue with the EHAP and ask for it to be closed.

EHAP closed by LP as level of need has escalated to Level 4/ statutory services.

Family comment on progress, agreed further actions or closure:

Full name (BLOCK CAPITALS): _____ Signature: _____ Date: _____

I am the young person (aged 12-16) the parent/carer of the child/young person the Lead Professional