Supplementary information for 6th October 2011 Scrutiny Board (Children and Families)

Pages 1 – 26: Agenda item 7 – Further information and data in relation to the Scrutiny Board's inquiry into external placements.

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Scrutiny Board (Children and Families)

External Placements Inquiry

List of information requested/provided

1. Data including number of LAC by ward, ethnicity information, numbers of asylum seeking LAC and LAC placed in Leeds by other authorities

2. Staffing information

3. Financial information in relation to placements, including costs of in house and external placements

4. Family Contact Centres

5. Multi Systemic Therapy Pilots

6. Family Group Conferences

7. Foster Carer Recruitment Campaign – *already provided*

8. The Sufficiency Action Plan – *already provided*

9. Information on David Thorpe's research – *verbal update to be given at the Board meeting*

10. Evidence of the impact of the early adopter programmes for the cluster based model – *verbal update to be given at the Board meeting*

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Number of Looked After Children by Area and Ward 30/06/11

Area	Ward Name	Count Of LAC at 30/06/2011
Out of Leeds / Could not map		66
East North East		
Outer North East	Alwoodley	12
Outer North East	Harewood	Less than 5
Outer North East	Wetherby	Less than 5
Inner North East	Chapel Allerton	54
Inner North East	Moortown	10
Inner North East	Roundhay	14
Inner East	Burmantofts and Richmond Hill	145
Inner East	Gipton and Harehills	152
Inner East	Killingbeck and Seacroft	61
West North West		
Outer North West	Adel and Wharfedale	Less than 5
Outer North West	Guiseley and Rawdon	12
Outer North West	Horsforth	29
Outer North West	Otley and Yeadon	20
Inner North West	Headingley	13
Inner North West	Hyde Park and Woodhouse	48
Inner North West	Kirkstall	47
Inner North West	Weetwood	11
Inner West	Armley	86
Inner West	Bramley and Stanningley	88
Outer West	Calverley and Farsley	9
Outer West	Farnley and Wortley	43
Outer West	Pudsey	22
South East		
Outer East	Cross Gates and Whinmoor	36
Outer East	Garforth and Swillington	Less than 5
Outer East	Kippax and Methley	24
Outer East	Temple Newsam	39
Outer South	Ardsley and Robin Hood	7
Outer South	Morley North	19
Outer South	Morley South	20
Outer South	Rothwell	19
Inner South	Beeston and Holbeck	93
Inner South	City and Hunslet	133
Inner South	Middleton Park	98
	Total	**1364**

All Children Looked after as at 30/06/2011, excluding those on Short Term Breaks (V4).

Note: Where there are less than 5 children or young people in a ward who are looked after children the number has not been provided for data protection reasons.

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External Placements – Scrutiny Board Enquiry

A number of lines of enquiry were established at the first Children's scrutiny Board review meeting in respect of placements of Looked after Children. This report details the statistical information requested at the last meeting and should be read in conjunction with the report presented to the meeting on 8th September 2011.

Ethnicity data

Children Looked After at 2010/11 year end

MainEthnic	SubEthnic	female	male	Grand Total
Any Other Ethnic Group	Any Other Ethnic Group	5	20	25
	Chinese	1	1	2
Asian or Asian British	Any Other Asian Background	2	14	16
	Bangladeshi		2	2
	Indian	3	2	5
	Pakistani	15	15	30
Black or Black British	Any Other Black Background	3	2	5
	Black - African	24	20	44
	Black Caribbean	7	9	16
Mixed / Dual Background	Any Other Mixed Background	21	30	51
	White and Asian	11	27	38
	White and Black African	10	10	20
	White and Black Caribbean	36	35	71
White	Any Other White Background	14	11	25
	Gypsy / Roma	4	6	10
	White - British	485	600	1085
	White - Irish	2	1	3
Grand Total		643	805	1448

MainEthnic	SubEthnic	Total
Any Other Ethnic Group	Any Other Ethnic Group	1.7%
	Chinese	0.1%
Asian or Asian British	Any Other Asian Background	1.1%
	Bangladeshi	0.1%
	Indian	0.3%
	Pakistani	2.1%
Black or Black British	Any Other Black Background	0.3%
	Black - African	3.0%
	Black Caribbean	1.1%
Mixed / Dual Background	Any Other Mixed Background	3.5%
	White and Asian	2.6%
	White and Black African	1.4%
	White and Black Caribbean	4.9%
White	Any Other White	1.7%

	Background	
	Gypsy / Roma	0.7%
	White - British	74.9%
	White - Irish	0.2%
Grand Total		100.0%

Children Looked After as at 26th September 2011

Ethnic Type	No of CLA	% of CLA
White	1136	78.30%
Black or Black British	61	4.20%
Mixed	179	12.30%
Asian or Asian British	46	3.20%
Information Not Yet Obtained	4	0.30%
Middle Eastern	10	0.70%
Any Other Ethnic Group	12	0.80%
Chinese	2	0.10%
Chinese or Other	1	0.10%
Total No of CLA	**1451**	**100.00%**

Asylum Seeking Looked After Children

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10
Total LAC	1,406	1,426	1,440	1,424	1,419	1,415	1,430	1,420
UASC (included in total LAC count)	58	57	59	61	61	58	55	53
UASC as % of total LAC population	4.1%	4.0%	4.1%	4.3%	4.3%	4.1%	3.8%	3.7%

	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
Total LAC	1,420	1,425	1,439	1,443	1,432	1,440	1,440	1,447	1,437
UASC (included in total LAC count)	45	50	n/a	51	47	45	43	44	44
UASC as % of total LAC population	3.2%	3.5%	n/a	3.5%	3.3%	3.1%	3.0%	3.0%	3.1%

Placements in Leeds from other Local Authorities

There are 194 children on the list of placements in Leeds made by another Local Authority. Other Local Authorities have a duty to inform us when a child is placed in Leeds but do not have a statutory duty to inform us when they leave. This number may therefore include a number of children who are no longer living in Leeds.

These children will have universal service provision as children living in Leeds and will be known to individual service providers but as we are not the responsible Local

Authority we do not collate information on their needs and this would be difficult to achieve within existing resources.

A number of independent children's homes, providing services for children from other Local Authorities have recently opened in Leeds. These homes do not require planning permission unless provision is for more than 6 children. A meeting between LAC Services and City Development services has been arranged to discuss this issue and seek improved communication.

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Scrutiny Board (Children and Families)

External Placements Inquiry

Staffing figures:

Total CYPSC Staff numbers	**1,057**
Total FTE Social Workers	**188**
Total number of Social Worker posts on Structure	**210**
Total Social Worker Vacancies	**22**
Total number of agency Social Workers	**62**

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In-house versus Independent Sector Foster

Payments made to in-house foster carers are primarily made up of 2 elements:

- a professional fostering fee – which depends on the level of skills/experience of the carer (and the number of children placed in their care)

- a weekly allowance – based on the age of the child (and the number of children placed in their care)

A schedule of the current scale of fees and allowances is attached as an Appendix.

Typically the payment made to a professional in-house foster carer with one child ranges from £371 per week (if the child is aged 0 to 4 years old) through to £458 per week (if the child is 16+). NB These figures do not take account of the cost of in-house services engaged in recruiting/supporting Children's Service's own in-house foster carers. If the cost of these in-house services are taken into account then the typical cost of a child placed with an in-house professional carer is estimated to be circa £500 per week.

The cost of purchasing foster care for a child through an independent Fostering Agency is typically £800 per week.

Fostering Fees and Allowances

Effective from Monday 4th April 2011/12

1 Basic Weekly Allowance

Age Group	Fostering Placements £
0-4	111.00
5-10	124.00
11-12	155.00
13-15	155.00
16+	195.00

2 Professional Fostering Fees

	£
1 child in placement	261.00
2 children in placement	429.00
3 children in placement	538.00
4 or more children in placement	604.00
Individual agreed fee	168.00

3 Payment for Skills Level 2

	£
First Child in Placement	52.00
Each subsequent Child	26.00

4 Maximum Initial Clothing Allowance

	£
Under 10	326.00
11-13	394.00
14 and over	436.00

5 Birthday and Christmas Allowance

One weeks basic allowance linked to age of young person and type of care.

6 Holiday Allowance

Two weeks basic allowance linked to age of young person and type of care.

JB – 04/08/11

Unit Costs for Residential Children's Homes - Outturn 2010/11

	Inglewood	Cranmer Bank	Easdale	Lingfield Approach	Luttrell Crescent	St Cath's Dr	Wood Lane	Bodmin Road	Squirrel Way	Total
	(£)	(£)	(£)	(£)	(£)	(£)	(£)	(£)	(£)	(£)
Expenditure										
Employees	622,633	361,367	381,490	336,946	383,866	402,667	492,065	683,808	864,548	**4,529,390**
Premises	52,232	16,085	16,901	35,390	35,086	12,584	57,958	58,539	98,564	**383,339**
Supplies & Services	39,775	24,141	27,259	16,340	26,112	37,522	40,706	74,195	62,986	**349,036**
Transport	9,612	3,579	4,211	1,529	5,292	4,128	4,670	8,839	16,969	**58,829**
Other	5,214	3,118	4,489	5,720	2,957	5,139	17,941	11,341	6,555	**62,474**
Total Expenditure	**729,466**	**408,290**	**434,350**	**395,925**	**453,313**	**462,040**	**613,340**	**836,722**	**1,049,622**	**5,383,068**
Income	(32)		(1,200)				(57)		(610)	**(1,899)**
Net Managed Expenditure	**729,434**	**408,290**	**433,150**	**395,925**	**453,313**	**462,040**	**613,283**	**836,722**	**1,049,012**	**5,381,169**
Maximum Occupancy	9	5	5	5	5	5	8	12	14	**68**
Actual Occupancy (Average)	8	5	5	5	5	5	8	11	10	**62**
Unit Cost Per Week (Max Occupancy)	1,559	1,570	1,666	1,523	1,744	1,777	1,474	1,341	1,441	**1,522**
Unit Cost Per Week (Actual Occupancy)	1,753	1,570	1,666	1,523	1,744	1,777	1,474	1,463	2,017	**1,669**

Indirect Costs/Overheads	(say 20%)	**334**
Total Unit Cost Per week		**2,003**
Average External Residential Place		**2750**
Difference		**747**

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The child and family contact service

The child and family contact service supports Looked after Children to have good quality contact with parents and other family members within a safe and supported environment.

Following the evaluation of a pilot contact service Children & Young People's Social Care agreed that the model should be endorsed and "rolled out" across the city. Three locality based contact services have been developed

The model is designed to support a framework for the delivery of a high quality dedicated contact service which works to a consistent service specification.

Central are the principles are that contact should be;

For the benefit of the child
Organised in a setting which is child centred
Supervised at the lowest level assessed as safe
Arranged so children travel as little distance as possible
Supervised wherever possible by the child's carer or consistent adult

Not all contact is supervised within the contact service, many children do benefit from support from their carers and subject to risk assessment, some contact with family members is unsupervised.

The service specifications for the contact service set out a referral model where Social Work staff refer to a Contact Coordinator, the detail in the referral informs an initial risk assessment and the contact agreement. The risk assessment assists in identifying an appropriate venue and the level of supervision, management and support the contact requires to make it a safe and positive experience for the child and siblings or adult attending.

Contact agreements are promoted as an effective way of ensuring arrangements for contact are clearly stated and communicated to all parties and form the basis for subsequent review and amendment to reflect changing circumstances and needs.

Contact recording is to be completed and supplied to the Social Work team within agreed timescales to ensure accurate and timely communication.

The team promote and support the quality of contact as well as ensuring contact venues are clean, welcoming, well equipped with access to basic refreshments. Staff will suggest activities, games, which those attending contact may find helpful. They will also actively support life story work and "memory box" work to enable children to have access to information about their family should direct contact not continue.

Contact staff use basic Webster Stratton materials to support "parenting in contact" to assist parents in managing aspects of their child's behaviour which they may find difficult or challenging.

They have a strong focus on user participation and involvement welcoming feedback and suggestions as they are committed to continuous service improvement and development.

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What Is MST?

Executive Summary

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple influences that contribute to serious antisocial or illegal behavior in youth. The MST approach views individuals as being part of, and influenced by, a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. In MST, this "ecology" of interconnected systems is viewed as the "client." To achieve successful outcomes with these youth, interventions are generally necessary within and among a combination of these systems.

MST addresses the multiple factors known to be related to juvenile delinquency across the key settings, or systems, within which youth are embedded. MST uses the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to promote behavior change in the youth's natural environment.

The ultimate goal of MST is to empower parents, that is, assure they have or develop the skills and resources needed, to address the difficulties that arise in raising children and adolescents and to similarly empower youth to cope with family, peer, school, and neighborhood problems. This is done in part through the mobilization of indigenous (i.e., naturally occurring or preexisting) child, family, and community resources that support the long-term generalization and maintenance of changes that take place during MST treatment.

How Is MST Different?

Describing the differences between MST and other treatment approaches is difficult without a clear understanding of the program or treatment with which MST is being compared. Generally however, there are four major points that separate MST from other treatments for antisocial behavior:

- Research: Proven long-term effectiveness through rigorous scientific evaluations
- Treatment theory: A clearly defined and scientifically grounded treatment theory
- Implementation: A focus on provider accountability and adherence to the treatment model
- Focus on long-term outcomes: Empowering caregivers to manage future difficulties

Research: Proven Long-term Effectiveness Through Rigorous Scientific Evaluations

- MST is a well-validated treatment model (Kazdin & Weisz, 1998) with 16 published outcome studies (14 randomized, two quasi-experimental) and several others underway.
- Studies with violent and chronic juvenile offenders showed that MST reduced long-term rates of rearrest by 25 percent to 70 percent compared with control groups.
- Studies with long-term follow-ups showed that MST reduced days in out-of-home placements by 47 percent to 64 percent compared with control groups.

Treatment Theory: A Clearly Defined and Scientifically Grounded Treatment Theory

- MST, which is described in a treatment manual (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), is put into operation through adherence to nine treatment principles.
- This research has shown that youth antisocial behavior is multi-determined from factors across the youth's social network. Thus, treatment must have the capacity to address a broad range of problems.

Implementation: A Focus on Provider Accountability and Adherence to the Treatment Model

- The MST therapist, the MST team, and the host agency are responsible for removing barriers to service accessibility and for achieving outcomes with every case (e.g., responsibility of the therapist to engage the family, accountability of the therapist and provider organization to achieve sustainable outcomes that the family can maintain after treatment ends).
- Treatment adherence is optimized by stringent quality assurance mechanisms that include goal-oriented, on-site supervision; measurement of adherence to the treatment model using research

validated instruments; and intensive training for all MST staff, including a five-day orientation training, weekly case consultation with an MST expert, weekly on-site clinical supervision for treatment teams and supervisors, and quarterly booster training.

- In practice, MST is analytical yet pragmatic and goal-oriented. By building on individual, family, school, and community strengths, MST therapists focus on designing interventions that will have the most immediate and powerful impact on the problem behavior. Before each intervention is implemented, MST therapists document the anticipated effect of the intervention by describing the observable and measurable outcomes that they are aiming to achieve. This information is used to assess the advances made or the barriers encountered during treatment.
- Specific treatment methodologies that are used as part of MST interventions are empirically-based (e.g., cognitive behavior therapies, behavioral parent training, and the pragmatic family therapies, such as structural family therapy and strategic family therapy).

Focus on Long-term Outcomes: Empowering Caregivers to Manage Future Difficulties

- The ultimate goals of MST are to provide the youth's primary caregivers with the skills and resources they need to independently address the difficulties that arise when rearing teenagers with behavioral problems and to give youth the skills to cope with family, peer, school, and neighborhood problems.
- MST focuses on changing the known determinants of offending, including characteristics of the individual youth, the family, peer relations, school functioning, and the neighborhood.
- MST treatment plans are designed jointly with family members and are family-driven rather than therapist-driven.

MST in Leeds

In 2008 Leeds City Council successfully applied for funding from the Department of Health for a Pilot MST project. This project contributed to a randomised control trial of MST. The project in Leeds has been cited as a national model of excellence and we have been successful in a recent application for further funding from the DFE to support the development of an additional two MST teams.

Initial findings in respect of MST in Leeds are supportive of this model as an effective edge of care preventative approach.

Each team is expected to work with 40 families per year. The potential cost of the MST intervention based on 3 teams is approximately £860k pa. As each team would support 40 families, 120 families in total, the cost per young person would be £7k pa.

In 6 cases MST was used to assist children to return home safely after a period of time in care. A comparative group were given 'services as usual'.

The MST cohort returned home on average after 300 days in care and the Services as usual cohort after 700.

Of the children deemed to be on the edge of care, 3 of the MST sample did require some time in Local Authority care, however 6 of the services as usual sample required days in care.

An expectation of the service provision is that each team will work to return 6 appropriate young people home from an external residential placement, the full year effect of the saving would be £2.8m.

What is a Family Group Conference?

A Family Group Conference (FGC) is a decision making meeting in which a child's wider family network come together to make a plan about the future arrangements for the child. The plan will ensure that s/he is safe and his/her wellbeing is promoted.

FGCs are intended as a respectful and empowering process in which parents, children and members of the wider family are given clear information about the agency's concerns and are asked to produce a plan that addresses those concerns and answers specific queries.

The expectation is that the family's plan will be agreed by the referring agency provided it adequately addresses the concerns which the agency has identified and is safe for the child.

Every family is unique and has its own community values, culture, personalities, dynamics and history. A FGC uses the family's own skills, strengths and personal knowledge to resolve difficulties. Using the family's own expertise and ensuring their involvement in the FGC process can help to redress the power imbalances that are experienced by children / young people and their families. A major strength of the FGC is that the child or young person normally participates in the meeting and can therefore have a major influence on the plans that are made for him / her.

Referrals to the Family Group Conference Service

Referral for a Family Group Conference will require:

- Someone with parental responsibility must agree to the referral and to the sharing of information. Parental responsibility could be held by the birth parents or the local authority (under a court order). The views of a Gillick competent child will need to be considered.
- The existence of a network of Connected Persons. (This may include relatives, significant family, friends or community members). The network may not be immediately apparent and this should not prevent a referral being made.
- The need for a decision or a plan to be made to address specific concerns identified.
- The commitment of the family to find a solution to the concerns identified.

Referral for a FGC can come from either Children and Young People's Social Care (CYPSC) for children who are already part of a social worker/assistants caseload or from the Intensive Family Support Service.

Where a crisis or chronic situation has developed that could ultimately result in a referral being made to CYPSC or the child has needs as identified described within the Vulnerability and Risk Windscreen at Level Three.

Situations where a referral for a FGC should be considered include the following:

- Creation of a safe plan to avoid the need for a Child Protection Plan
- Following a Child Protection Conference to include wider family in the plan
- By notice, where Care Proceedings are being initiated in non acute situations, a FGC must be automatically explored with the family and discussed at any pre proceedings meetings (Pre PLO).
- Where there is a request for accommodation or respite care
- Where there is a negative outcome following a pre birth assessment
- Where there is an application for the discharge of a Care Order to bring a child home

There are some situations where A FGC is contra-indicated. These include:

- Where a family has a history of intergenerational Sexual Abuse.
- Where there is an on-going Section 47 Child Protection Enquiry.
- Where there is high risk of violence at the conference.

Each case would need to be discussed on its merits and through consultation with the relevant Social Work team manager, Children's Services Delivery Manager and the FGC team manager.

The Family Group Conference Co-ordinator

FGCs services will always be co-ordinated independently from the service or team which has concerns about the child's safety and wellbeing. The Co-ordinator is neutral i.e. that they have no case holding, statutory or decision making responsibilities in relation to the child. The co-ordinator should not have had any previous involvement with the family or represent the views of any agency working with the family nor would they attend other meetings connected with the child so as not to compromise their independence.

The role of the independent co-ordinator is vital in negotiating attendance at a FGC and in informing all participants about the process involved. This role is separate from other professionals' involvement with the family.

This will mean preparatory visits to family members, children and professionals. Written consent to hold the FGC will be obtained by the co-ordinator with the person with parental responsibility and the young person sufficiently capable of providing consent (Frazer Rule). No contact with any other family members can occur until this consent has been obtained.

The co-ordinator organises the meeting in conjunction with the child / young person and those with parental responsibility and / or immediate carers.. The child / young person must be enabled to

participate fully within the process and it is the co-ordinator's role to find flexible and imaginative ways of achieving this. If the child /young person requires an advocate then the co-ordinator will match them with an independent advocate. If the co-ordinator feels that it would be inappropriate for a particular family member to attend, then a decision can be taken to exclude them from the FGC.

This will be an exception and if exclusion was to take place it would be based on the child's best interests. Examples could include: a person being a Schedule 1 Offender, risk of harm to the child/ young person attending, a history of domestic violence and a severe power imbalance in the family such that the victims would be too intimidated if the perpetrator was present.

Should this be the case, their input to the meetings must be achieved in alternative ways, for example through letters or tape recordings. The grounds for exclusion must be clear and must be put in writing to the particular family member.

The co-ordinator liaises with the referrer and other relevant agencies to ensure family members have appropriate information about:

- The child welfare and / or protection issues which need to be considered at the FGC. This includes identifying any "bottom line" about what is and what is not acceptable in terms of a plan for the child from the agency's perspective.
- Services that could assist the child or family.

How does a Family Group Conference Plan Integrate with Child Protection Planning?

Where a Child Protection Plan is in place or is being considered, it is essential to discuss how the FGC plan will contribute to keeping the child safe and reduce the risks that have been identified in the Child Protection Plan.

The Family Plan drawn up at the FGC must be sent to the Safeguarding IRO so it can be included in the review of the child protection plan.

Family members who have agreed to monitor the Family Plan should be invited to the child protection review conference to ensure that there is continuity between the two processes.

Where the FGC process uncovers new information that there is a risk of significant harm to the child, the co-ordinator must inform the child's social worker immediately. If the child does not have or was not referred by a social worker then a Request for Service must be made to CYPSC.

Stages of the Family Group Conference

The Family Group Conference is held with the following three stages:

Stage 1: Information giving

Professionals will not need to provide a written report but will be expected to provide a verbal contribution detailing the strengths of the family, issues of concern, services available and the "bottom line". Agencies must also be prepared to respond to any queries that the conference members may have (This could include questions from family members and advocates).

The type of information that is helpful to present to the family includes the following:

- Current concerns and the reason for the conference rather than a detailed history.
- Experience of the family's strengths and successes as well as concerns.
- Clarity about what needs to change for the child and within what timescales.
- Information about what resources could be available to support the family plan, any limitations on resources (including resources of time), timescales for accessing resources and any procedures that need to be followed to obtain resources.
- Any child welfare concerns that will affect what can be agreed in the plan such as the child not having contact with a particular person or a schedule one offender.
- What action will be taken if the family cannot make a plan or the plan is not agreed or agency concerns are not addressed in the plan. This could vary from 'remaining concerned' to evoking statutory powers such as an application for a care order.

The child / young person and family members may also provide information via an advocate or other supporter, ask for clarification or ask questions.

Stage 2: Private Family Time

The co-ordinator and professionals withdraw from the meeting after the information sharing stage and professionals, apart from the referrer, can leave the meeting at this point. The family members must have time and privacy to talk among themselves and come up with a plan that addresses the concerns raised in the information giving part of the conference, identifying resources and support which are required from agencies, as well as within the family to make it work.

Stage 3: Plan and Agreement

The family then produce their plan. The referrer and the co-ordinator meet with the family to discuss and agree the plan and negotiate resources. It is expected that the family plan is accepted by the

referring agency unless the issue of the child's safety and well-being has not been satisfactorily addressed and the child is deemed to be at risk of significant harm.

Any reasons for not accepting the plan must be made clear immediately and the family should be given the opportunity to respond to the concerns and change or add to the plan if necessary. It is important to ensure that any child / young person present has a clear understanding of what is decided and that their views are understood.

Validation/presentation of the Plan

The family's plan will be presented to the referrer at the end of the conference. It is expected that the referrer will remain at the FGC until the family have made their plan. Discussion will take place between the co-ordinator and referrer and other agencies that may have been requested by the family to provide services.

Distribution of the plan

The co-ordinator distributes the plan to all relevant agencies and the family within three days of the conference.

Implementation of the Plan

All those concerned need to implement their parts of the plan within agreed timescales and communicate and address any concerns which arise. The family will be asked to nominate a family member / friend, or ideally two people, who will take responsibility for informing the referrer if the plan is not working and / or needs adjustments.

Review of the Plan

A review date for the FGC will be agreed and is usually planned to be held no later than six weeks after the initial FGC.

The review enables the family and the referrer to check if the plan is working and to adjust the levels of support or resources necessary.

All families will be offered a review but it is the family's decision as to whether a formal review takes place. Families may choose to review the plan themselves informally and will update workers on progress.

The FGC services involvement will end once the initial and review FGC's have taken place.

Involvement will also end if:

- The referral has been assessed as inappropriate.
- The family withdrew or did not provide consent for the FGC to proceed.
- A decision was made that it was inappropriate to proceed i.e. if safety issues were too great.