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**NOT NEEDED!!Early Years Inclusion Support Funding**

**Exceptional Circumstances Review**

This review is due 6 months after Exceptional Circumstances funding was awarded to monitor the impact and progress to date and to support you to plan next steps of support for the child.

**Child’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s name** |  | **DOB** |  |
| **Setting name** |  | | |
| **Date Funding Awarded** |  | **Banding Level**  **(B or C)** |  |

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| --- |
| **How is the funding being used?**  (Has the funding been used for staff training, to enhance the adult ratio in the setting, for resources etc) |
|  |

|  |  |
| --- | --- |
| **What progress has been made towards achieving the outcomes (as stated on application)** | |
| **Outcomes stated on application** | **Progress/impact at 6 months**  **Include has the outcome been ‘*fully, mostly, partly, not*’ met** |
|  |  |
| **Child’s voice** | **Parents/Carers voice** |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Which professionals (or new referrals for support) have been involved during the funding period?** | | |
| **Professional** |  | **Additional advice / recommendations / additional information on child’s needs** |
| Community Paediatrician |  |  |
| SALT |  |  |
| Educational Psychologist |  |  |
| Other |  |  |

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| **How Confident are you that the child’s needs have been met using this funding (please highlight)?** |
| Very Confident Satisfied Concerned needs are not met  **Additional Comments:** |

|  |
| --- |
| **Are there any significant changes in the needs of the child?**  **(This could be evidenced in the professional's section)** |
|  |

|  |  |
| --- | --- |
| **Next Steps for this child (please tick)** | |
| **Child’s needs can now be met at SEND support** |  |
| **Early Years Inclusion Support Funding funding is requested**  (An application for EYISF will now need to be completed) |  |
| **EHCP needs assessment request** |  |

**By signing this form, you are confirming you are following the Graduated approach (APDR) to support the individual child and have evidence of APDR cycles.**

|  |  |  |
| --- | --- | --- |
| **Practitioner name** | **Practitioner signature** | **Date** |
|  |  |  |
| **Parent/carer name** | **Parent/carer signature** | **Date** |
|  |  |  |

|  |
| --- |
| **Please submit this review form to** [**accessandresponse@southglos.gov.uk**](mailto:accessandresponse@southglos.gov.uk) |