Liquidlogic

A System for Children with Disabilities

Specification of Client Requirements	
Date	July 2004
Version	1.5
Author	Anne Parker

Document Distribution

Name	
Ed Jones	Manager of Management Information Systems Team Newcastle Social Services
Joan Debnam	Manager for Multi Agency Integration, Newcastle Social Services
Len Anderson	Project Manager
Ted Brierley	Director, Liquidlogic
Simon Carrol	Development Team, Liquidlogic
Tom Miekeljohn	Consultant, Liquidlogic
Darren Smith	Training Manager, Liquidlogic
Martin Hide	Consultant, Liquidlogic

Document History

Date	Version	Produced By	Comments
09.02.2004	1.0	AP	Draft for comment
22.04.2004	1.1	AP	Update following review
11.05.04	1.2	AP	Update following Newcastle project team review
21.05.04	1.3	AP	Minor change to assessment form text Addition of appendix 6
01.06.04	1.4	AP	Changes as requested by Len Anderson
07.07.04	1.5	AP	Amendment to approvals list and removal of parent access requirement

Document References

This section contains references to any other documents that are relevant or referred to by this document including the document name and version number.

Document	Version	Author

Approval

Name	
Andy Roberts	Project Board Chair

Acknowledgements

The authors would like to thank the following people for help in the preparation of this document.

Name	Organisation
Joan Debnam	Manager for Multi Agency Integration, Newcastle Social Services
Ed Jones	Manager of Management Information Systems Team Newcastle Social Services
All the practitioners and administrators involved with the pilot system.	

Table of Contents

1 Project Summary

This project aims to deliver a system to help improve the delivery of care to children with disabilities in Newcastle. The system will support multi-agency business processes and allow Health, Social Services and Education professionals to share information about the children, according to agreed protocols. The system will allow professionals to have a complete picture of the child's record including current and planned activity relating to all open episodes of care. As part of the overarching FAME Project this strand will make a major contribution to the Framework for multi agency working.

The system will be developed in 'Protocol 'and deliver the following key functions:

- electronic referral system
- shared electronic children's record accessible by all involved agencies
- real time case management
- secure messaging
- facility to store scanned documents against the child record
- full audit trail including access to records

The system will integrate information from Social Services core system, Care First and will enable security access to information to be controlled in line with Information Sharing Protocols and parent/carer/child consent.

2 Purpose of Project

The project purpose and scope is defined in the Project Initiation Document (PID) prepared by Alan Burns dated 16th June 2003. The main problems to be addressed through this project are those of communication and information sharing. The needs of the children are often complex requiring input from a number of different services. The different professionals do not currently have access to a complete picture of the child's situation and are often unaware of the involvement of other services. As a result parents and carers are often asked to repeat their stories over and over again. The lack of knowledge about the involvement of other services makes coordination of appointments impossible, and this impacts on both the child and the family. Without effective coordination, single assessment and review cannot be achieved.

3 Scope of Project

This section summarises the main system functions to be included in the system and the agencies that will take part in the pilot.

3.1 In/Out List - What

Function	In	Out
Electronic system to support single (unified) referral process	X	
Electronic system to record summaries of multidisciplinary assessments	X	
Electronic system to allow recording of full details of individual assessments and ongoing therapy		X
Electronic system which enables multiple agencies involved with the child to share information	X	
Electronic system which holds scanned documents against the child record	X	
Electronic system which can access scanned documents held in a separate document management system not part of Protocol		X
Electronic child diary and appointment management facility	X	
Full audit trail facilities including audit of access to child record.	X	
Integration with the Newcastle Social Services Care First system	X	
Integration with health or education systems		X
Exploration of the potential integration with EMS	X	
Replacement of existing partner communications and networks infrastructure		X
Changes to partner legacy systems		X

3.2 In/Out List Who

User group	In	Out
Children's community nurses	X	
Specialist school nursing service	X	
Children with disabilities social work team	X	
Short break services	X	
SENTASS	X	
SENCOs	X	
EWOs	X	
Loan Equipment	X	
CTLD	X	
Educational psychology	X	
Speech therapy	X	
Welfare rights	X	
Physiotherapy	X	
Occupational therapy	X	
Child development centre	X	
Community paediatrics	X	
CAMHS	X	
Tertiary services		X
Secondary care specialists		X
GPs		X
Health visitors		X
Non-CWD social work teams		X

4 Stakeholders, Actors and Users

4.1 Stakeholders & Actors

This is a list of all people and organisations affected by the project and involved in the decision making and implementation processes.

Actor/stakeholder	Task/Goal
Disabled Child/young person	A child or young person with one or more disabilities requiring health, social services or educational support.
Parent or Carer	Looks after child or young person.
Community paediatrician	Provides specialist health care for children.
CWD Social Work team member	Provides social care support for disabled children and the families and carers.
Short break team member	Arranges breaks for disabled children and their families.
Children's community nurse	Provides nursing care and support to children with disabilities and complex health needs.
Specialist school health nurse	Provides nursing care and support to enable a child with a disability or complex health need to access education.
Educational psychologist	Provides specialist assessment and support for children or young people with academic, behavioural, social or emotional problems.
Physiotherapist	Provides specialist assessment and physical therapy for children or young people with health problems.
Occupational therapist	Provides specialist support to children or young people with disabilities, helping them to developing skills.
Speech & language therapist	Provides specialist assessment and treatment for children with speech, language or swallowing problems.
CTLD member	Provides specialist assessment and support, according to their specialty, for children with learning difficulties.
SENTASS member	Provides specialist assessments, support and intervention for children with special educational needs.
SENCO	Coordinates the development and implementation of IEPs for children with SEN, monitors progress and coordinates reviews.
CAMH team member	Provides specialist assessment and therapy for children and young people with emotional and behavioural problems.
Loan equipment team member	Arranges the loan or purchase of nursing/daily living equipment to help with the care of disabled children.
Departmental/Team managers	To organise and prioritise the work of the section.
Admin Staff, Secretary	Provides administrative service for operational team business
Newcastle Social services	Provides Community Care Services to the people of Newcastle.
Newcastle City PCT	Provides community health services.
Children's Trust	Brings together health, education and social services for children, young people and families.
Newcastle upon Tyne Hospitals Trust	Provide secondary healthcare services.
Northgate & Prudhoe NHS Trust	Provide secondary healthcare services.

4.2 Pilot System Users

Agency	Sites	Number of users
Community paediatrics	Newcastle General Hospital Child Development Centre, Royal Victoria Infirmary	To be decided
Social Services Children with Disabilities Service	Raby Cross Centre	To be decided
Short break services	Shieldfield Centre, Hartburn Walk	To be decided
Children's community nursing	Newcastle General Hospital	To be decided
Specialist school health nursing	Newcastle General Hospital	To be decided
Educational psychology	Springfield Centre	To be decided
Physiotherapy	Newcastle General Hospital	To be decided
Occupational therapy	Newcastle General Hospital	To be decided
Speech & language therapy	Newcastle General Hospital	To be decided
CTLD	Sanderson Centre	To be decided
SENTASS	Springfield Centre	To be decided
SENCOs	School based (4 special schools)	To be decided
CAMHS	Fleming Nuffield Unit Tynedale House (Annex) St Nicholas House	To be decided
EWO	Springfield	To be decided
Loan Equipment	Geoffrey Rhodes Centre	To be decided
Welfare rights	Newbiggin Hall Estate	To be decided
Parents/carers	Home based	To be decided
Children/young people	Home based	To be decided

5 Business Rules Catalogue

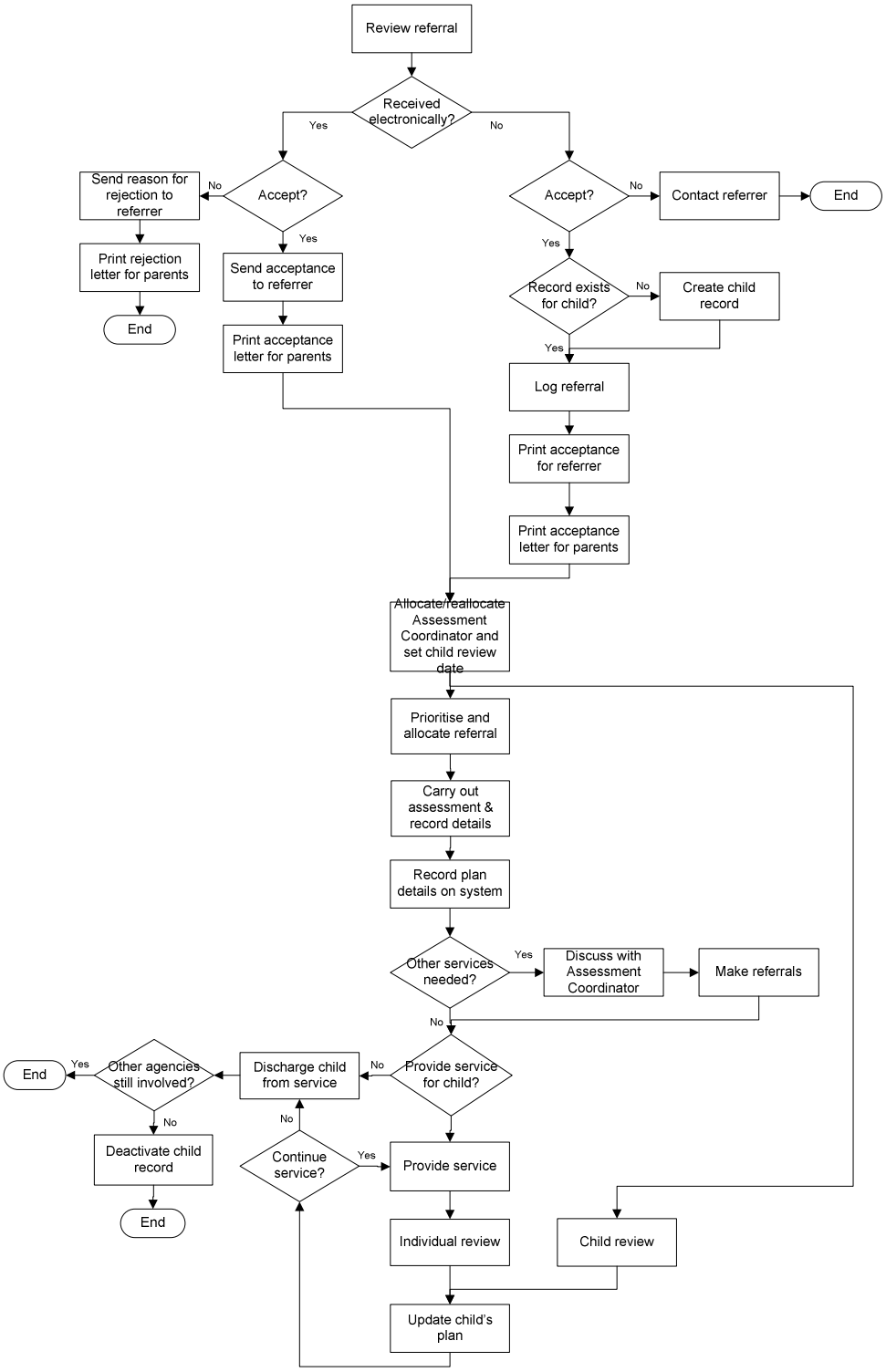
The Business Rules Catalogue defines rules that project procedures and applications must adhere to. Acceptance testing must review conformance in detail.

No.	Rule Definition	Type	Source
1	Information Sharing protocols	Structural Fact	Locally agreed
2	A social services initial assessment must be completed within seven working days of the receipt of the referral	Structural Fact	DOH/DfES
3	A social services core assessment must be completed within 35 working days of the decision to commence such an assessment.	Structural fact	DOH/DfES
4	All diagnoses, problems and categories of disability must map to SNOMED	Structural Fact	NHSIA guidelines
5	The system must allow start and expiry dates to be recorded for staff. Staff access to the system must be terminated when the expiry date is reached.		Children's Trust Policy

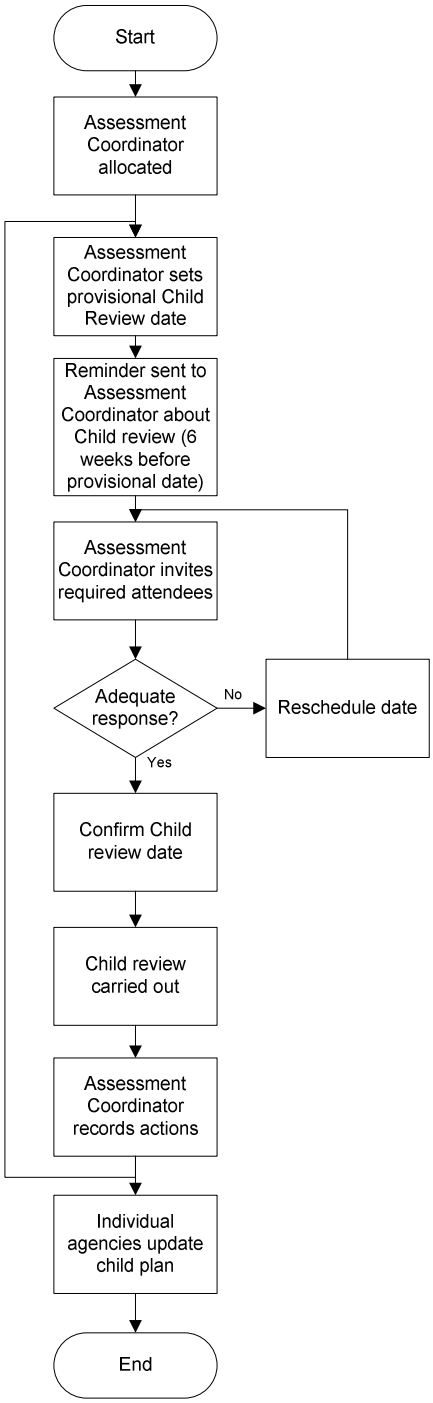
6 Process maps

The process maps describe the basic generic functions of the system. The maps for processes that hold prior to system implementation may be found in the “As Is” document for this project which is available from the project manager.

6.1 Generic Process for Referral, Assessment & Review



6.2 Assessment co-ordinator Allocation



7 Acceptance of Client Requirements Specification

This document has been issued by Liquidlogic in May2004. It is the proposed specification for the FAME Children with Disabilities application.

The document provides a definition of the system's framework and basic functionality. Following the installation of the prototype, further amendments to the functionality or scope of the system may be required. Timing of delivery will depend upon business issues (like service user consent, Information Sharing Protocols) and technical issues.

Your agreement to this document will allow us to start development and conduct the final analysis iterations.

Acceptance by Client Representative _____

Role on Project Board _____

Date _____

Acceptance by Technology Provider _____

Role at Liquidlogic _____

Date _____

8 Use Cases

8.1 Introduction to use cases

Liquidlogic uses a development methodology based on 'Use Cases', as a way of defining processes.

Use Cases are written in 'real' English, so analysts and customers can work through and agree detail together using a document that will be the key source of developers' work. These Use Cases' are converted to 'State Charts', the direct input to 'Protocol', Liquidlogic's own software development environment.

This section contains a table which summarises all processes that the project team believes are key to the new system and presents an idea of how they interrelate.

8.2 Use Case Matrix

No.	Use Case Title	Level	Summary	Dep.
CWD01	**Log on**	**UG**	A user logs onto the system	**none**
CWD02	**Add referral**	**UG**	A user adds a new referral to the child's record.	**CWD08**
CWD03	**Update referral**	**UG**	A user amends an unsent referral.	**CWD08**
CWD04	**Delete referral**	**UG**	The user deletes an unsent referral.	**CWD08**
CWD05	**Send referral**	**UG**	A user sends a referral and a monitoring process is created for the referrer.	**CDW08 CWD02 CWD03**
CWD06	**Process incoming referral**	**UG**	The receiving team manager picks up the referral from the team tray, reviews the referral details and acknowledges it. The receiving team manager allocates the accepted referral. If the referral is not picked up within a preset time period, the referrer and the receiving team manager are notified.	**CWD07**
CWD07	**Log referral**	**UG**	A user records details of a referral received on paper.	**CWD08**
CWD08	**Search for and display child record**	**UG**	A user searches for the child's record.	
CWD09	**Create child record**	**UG**	The user adds a new child record to the system.	**CWD08**
CWD10	**Update child details**	**UG**	A user changes one or more of the child's details held on the system.	**CWD08**
CWD11	**Deactivate child details**	**UG**	A user deactivates a child's record as they are no longer receiving services.	**CWD08**
CWD12	**Assign Assessment co-ordinator**	**UG**	The Assessment co-ordinator is allocated and a provisional child review date set.	**CWD08 CWD06**
CWD13	**Reassign Assessment co-ordinator**	**UG**	The current Assessment co-ordinator manager selects a new Assessment co-ordinator.	**CWD08**
CDW14	**Create diary entry**	**UG**	A user creates a diary entry for the child.	**CWD08**
CWD15	**Update diary entry**	**UG**	A user changes the diary entry details.	**CWD08**

CWD16	**Display diary entries**	**UG**	The user chooses to display diary entries for the child, the team or the individual.	**CWD08**	
CWD17	**Delete diary entry**	**UG**	A user cancels the diary entry.	**CWD08**	
CWD18	**Add assessment**	**UG**	A user adds the details of an assessment they have carried out.	**CWD08**	
CWD19	**View or Update assessment**	**UG**	A user views or changes the assessment details	**CWD08**	
CWD20	**Delete assessment**	**UG**	The user deletes the assessment details.	**CWD08**	
CWD21	**Discharge child from service**	**UG**	Following an assessment or review the professional decides that the child no longer requires the service and discharges them	**CWD08**	
CWD22	**Add or update child plan**	**UG**	A user adds the details of their care plan for the child to a new or existing plan.	**CWD08**	
CWD23	**Add activity**	**UG**	A user adds activity details to the child record.	**CWD08**	
CWD24	**Update or delete activity**	**UG**	The user updates the activity details added to the journal.	**CWD08**	
CWD25	**Manage child review**	**UG**	The manager of the Assessment co-ordinator organises the child review.	**CWD08**	
CWD26	**Attach scanned document**	**UG**	The user scans a paper document and attaches the file to the child record	**CWD08**	
CWD27	**Produce reports**	**UG**	A user runs the required report and prints it or saves it to disk.	**CWD01**	
CWD28	**Browse service details**	**UG**	A user browses the service details for information on a service that may be available to the child.	**CWD01**	
CWD29	**Merge records**	**UG**	Duplicate records are identified on the system. The system administrator selects the master record and then merges the details from the other records into the master record.	**CWD08**	

8.3 Individual use cases

CWD001 Log On		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional logs onto the system.	
Primary Actor:	Professional logging on.	
Other Actors:	none	
Preconditions:	None	
Trigger:	The professional needs to access the system.	
Linking use case:	CWD 08	
Concurrency	none	
Success Guarantee:	The professional logs on	
Minimal Guarantee:	As for the success guarantee.	
Frequency:		
Basic Course of Events		
1	The professional enters their user id and password.	
2	The professional accesses the system.	
3	The user searches for and displays a record (CWD08)	
Alternative paths		
3a	The user produces a report (CWD27)	
3b	The user browses service details (CWD28)	
Data		
Business rules and non-functional requirements		
.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP

CWD002 Add Referral		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional records the details of a referral against the child's record.	
Primary Actor:	Professional recording the referral	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:	The professional needs to record the details of a referral for the child.	
Linking use case:	CWD 08	
Concurrency	none	
Success Guarantee:	The referral details are added to the system.	
Minimal Guarantee:	As for the success guarantee.	
Frequency:		
Basic Course of Events		
1	The professional selects the type of referral(s) they wish to add.	
2	The professional enters the core and referral specific details.	
3	The user sends the referral (CWD05).	
Alternative paths		
3a	The user elects to save the referral without sending allowing the user to update the referral (CWD03) at a later time.	
Data		
	Details of referral forms are included in Appendix 1	
Business rules and non-functional requirements		
.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		

CWD003 Update Referral		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional amends or completes an unsent referral.	
Primary Actor:	Professional amending referral	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:	The professional needs to amend referral details.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The referral is updated.	
Minimal Guarantee:	As for the success guarantee.	
Frequency:		
Basic Course of Events		
1	The professional selects the unsent referral and amends the details.	
2	The professional saves their changes.	
3	The professional sends the referral (CWD05)	
Alternative paths		
4a	The professional does not send the referral. .	
Data		
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2	11.05.04	AP
3		
4		

CWD004 Delete Referral		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional deletes an unsent referral.	
Primary Actor:	Professional deleting referral	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. ** Do we need higher security on this?	
Trigger:	The professional needs to delete referral details.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The referral is deleted.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The professional selects the unsent referral and deletes it.	
2	The professional enters the reason for deletion.	
Alternative paths		
	.	
Data		
Business rules and non-functional requirements		
A user cannot delete a referral that has been sent.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD005 Send Referral	
Scope:	CWD system
Level:	User goal
Summary:	A professional sends a referral.
Primary Actor:	Professional sending referral
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	The professional has completed the referral details.
Linking use case:	CWD02, CWD03, CWD08
Concurrency	
Success Guarantee:	The referral is sent.
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The user selects the option to send the referral.
2	The system checks the communication method for the receiving agency.
3	The system sends the referral electronically where the communication method is set to electronic for both sender and receiver and the referral is sent to the receiving team's work tray.
4	A referral monitor is started for the referrer.

Alternative paths	
1a	The system warns the user that they have not completed the mandatory information for the referral. The user completes the referral details and chooses the option to send the referral.
1b	The system warns the user that they have not completed the mandatory information for the referral. The user saves the referral to complete at a later time. The use case terminates.
3a	The system prints the referral form where the communication method for the receiver is set to manual and the user sends the referral by post or fax.

Data	

Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD006 Process Referral	
Scope:	CWD system
Level:	User goal
Summary:	A professional responds to an incoming referral
Primary Actor:	Professional receiving referral
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	The professional receives a referral
Linking use case:	CWD07 + need one for non log referrals
Concurrency	
Success Guarantee:	The referrer is notified that their referral has been accepted by the receiving team.
Minimal Guarantee:	A case monitor informs the professional of the status of their referral.
Frequency:	

Basic Course of Events	
1	The receiving team manager (or designate) picks up the referral from the team tray and reviews it.
2	The receiving team manager accepts the referral and enters the referral acceptance notification which is sent back to the referrer and to all other involved agencies.
3	An acceptance letter for the parents is printed.
4	An episode of care is opened.
5	The list of involved agencies is updated to include the agency.
6	The receiving team manager confirms the Assessment co-ordinator is assigned.
7	The receiving team manager allocates the referral to a team or individual and sets the warning interval. If the assessment is not begun within this time interval a warning is sent to the person who has been allocated the case.

Alternative paths	
2a	The receiving team manager rejects the referral and enters the reason for rejection which is sent to the referrer.
3a	A rejection letter for the parents is printed and the use case terminates.
6a	The receiving team manager assigns the Assessment co-ordinator (CWD12)

Data	
	See appendix 1 for acceptance and rejection details

	Parents acceptance letter Parents rejection letter
Business rules and non-functional requirements	
Owner	Anne Parker
Iteration Dates and person(s) completing iterations:	

1	01/03/04	AP
2		
3		
4		

CWD007 Log Referral		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional with access to the CWD system receives a paper based referral from another team and records the referral information on the system.	
Primary Actor:	Professional logging referral details	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:	The professional needs to add referral details to a child's record.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The referral details are added.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the option to log a referral.	
2	The user completes the referral details.	
3	The user processes the referral (CWD06).	
Alternative paths		
Data		
	Details of referral forms are included in appendix 1	
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		

CWD008 Find and Display Child Record	
Scope:	CWD system
Level:	User goal
Summary:	A professional searches the system for a child's record.
Primary Actor:	Professional searching for record
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	The professional needs to access a child's record.
Linking use case:	
Concurrency	
Success Guarantee:	The child record is found.
Minimal Guarantee:	The system notifies the professional that no record for the child can be found.
Frequency:	

Basic Course of Events	
1	The professional selects the person finder option.
2	The professional enters the search criteria.
3	The system displays a list of children whose details match the search criteria.
4	The user displays the child's record.
5	The user Adds a referral (CWD02).

Alternative paths	
3a	The system displays a message informing the user that no records matching the search criteria were found. The user must create the child record (CWD09).
3b	Multiple records are found. The user checks the child id and the system manager merges the records (CWD29).
4a	The user is not currently involved with the child. The system displays a warning and asks if the user wishes to proceed. If they answer yes they must enter a reason before the record is displayed.
5a	The user updates a referral (CWD03).
5b	The user deletes a referral (CWD04).
5c	The user sends a referral (CWD05).

5d	The user logs a referral (CWD07)
5e	The user updates child details (CWD10).
5f	The user deactivates child details (CWD11)
5g	The user re-assigns the Assessment co-ordinator (CWD13)
5h	The user creates a diary entry (CWD14)
5i	The user updates a diary entry (CWD15)
5j	The user displays a diary entry (CWD16)
5k	The user deletes a diary entry (CWD17)
5l	The user adds an assessment (CWD18)
5m	The user views or updates an assessment (CWD19)
5n	The user deletes an assessment (CWD20)
5o	The user discharges the child (CWD21)
5p	The user adds or updates the child plan (CWD22)
5q	The user adds an activity (CWD23)
5r	The user updates or deletes an activity (CWD24)
5s	The user manages the child review (CWD25)
5t	The user attaches a scanned document (CWD26)

Data	
	Search criteria: Client id First name Last name Date of birth Address

Business rules and non-functional requirements
The system must allow the use of * and % as a wildcard.

Owner	Anne Parker

Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD009 Create Record		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional creates a new child record.	
Primary Actor:	Professional creating for record	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:	The professional needs to access a child's record.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The child record is created.	
Minimal Guarantee:	The system notifies the professional that they do not have access rights to create a new record.	
Frequency:		
Basic Course of Events		
1	The professional selects the Create new record option.	
2	The system prompts the user for the child's details.	
3	The user completes the details and the system asks the user to confirm that they wish to create the record.	
4	The user confirms that the record should be created; the system creates the record and assigns a unique client id.	
Alternative paths		
4a	The user does not confirm that the record should be created. The child details are deleted and this use case terminates.	
Data		
	See appendix 2 for child record details	
Business rules and non-functional requirements		
If a duplicate date of birth is entered the system displays a warning and allows the user to continue with the registration or quit.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP

2	11.05.04	AP

CWD10 Update Child Details	
Scope:	CWD system
Level:	User goal
Summary:	A professional amends the details within the child record.
Primary Actor:	Professional amending record
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	The professional needs to amend a child's details.
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The child record is amended.
Minimal Guarantee:	The system notifies the professional that they do not have access rights to create a new record.
Frequency:	

Basic Course of Events	
1	The user amends the child's details as required.
2	The user saves their changes.

Alternative paths	

Data	
	See appendix 2 for child record details See appendix ** for audit record details

Business rules and non-functional requirements

Owner	Anne Parker

Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		

4		

CWD11 Deactivate Child Details	
Scope:	CWD system
Level:	User goal
Summary:	A professional deactivates the child record.
Primary Actor:	Professional deactivating record
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	Child is no longer receiving services.
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The child record is deactivated.
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The professional chooses the option to deactivate the record and enters the reason for deactivation from the list displayed.
2	The reason for deactivation is copied to the reason for discharge for each involved agency and the respective episodes are closed.
3	The record is deactivated.
4	The reason for deactivation is Transfer to Adult Services/Moved out of Area and a report containing all the information in the child record is printed.
5	Notification is sent to each involved agency to inform them of the deactivation.

Alternative paths	
4a	The reason for deactivation is death. A report is not created or printed.
5a	The Assessment co-ordinator is the only involved agency and notification is not sent.

Data	
	Reasons for deactivation: **Text** **Code** Moved out of area 05 Patient died 10 Transfer to adult services ?

Business rules and non-functional requirements

Only the Assessment co-ordinator may deactivate when there are additional currently involved services.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD12 Assign Assessment co-ordinator	
Scope:	CWD system
Level:	User goal
Summary:	
Primary Actor:	Professional accepting referral.
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	A new referral has been accepted.
Linking use case:	CWD06
Concurrency	
Success Guarantee:	The Assessment co-ordinator is allocated and its identity made known to the professional
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The system checks the child's record and a designated Assessment co-ordinator is not found.
2	The user checks the system for any other involved agencies.
3	No other involved agencies are found and the receiving team manager sets their team as Assessment co-ordinator.
4	The system prompts for a child review date.
5	The user adds a provisional date and the number of weeks before that date that they wish to receive a reminder about the review.
6	At the appropriate time the reminder is sent to the Assessment co-ordinator manager, enabling them to manage the review (CWD25).

Alternative paths	
1a	The designated Assessment co-ordinator is found and the receiving team manager is prompted to contact them to plan activities. The use case terminates.
3a	One or more involved agencies are found. Following discussion between the agencies the chosen Assessment co-ordinator allocates themselves as Assessment co-ordinator.

Data

	Assessment co-ordinator allocation must allow for but not enforce the allocation of a lead worker.
Business rules and non-functional requirements	
The system does not allow any information other than referral information to be added until the Assessment co-ordinator is allocated.	
Owner	Anne Parker
Iteration Dates and person(s) completing iterations:	
1	01/03/04 AP
2	
3	
4	

CWD13 Reassign Lead		
Scope:	CWD system	
Level:	User goal	
Summary:	The Assessment co-ordinator must be reassigned because the involvement of the current lead is changing.	
Primary Actor:	Assessment co-ordinator.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:	The involvement of the current lead with the child is changing.	
Linking use case:		
Concurrency		
Success Guarantee:	The Assessment co-ordinator is reallocated.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The Assessment co-ordinator manager discusses the child's case with the other involved agencies.	
2	The Assessment co-ordinator manager displays the child's record and chooses the option to reallocate the Assessment co-ordinator.	
3	The new Assessment co-ordinator is chosen from the list displayed and the reason for the change is entered.	
Alternative paths		
Data		
	Assessment co-ordinator allocation must allow for but not enforce the allocation of a lead worker.	
Business rules and non-functional requirements		
Only existing lead manager can reallocate Assessment co-ordinator role.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		

3		

CWD14 Create Diary Entry	
Scope:	CWD system
Level:	User goal
Summary:	A user creates an entry in the system diary for a child
Primary Actor:	Professional adding diary entry to record
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.
Trigger:	The professional needs to add a diary entry to a child's record.
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The diary entry is added.
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The user checks the child's calendar and family preferences.
2	The user creates the diary entry and completes the diary entry details.
3	Do we want multiple attendees for simple diary entries?

Alternative paths	

Data	
	Diary entry details: Date Time Place Purpose Required attendees

Business rules and non-functional requirements
The system does not allow any information other than referral information to be added until the Assessment co-ordinator is allocated.

Owner	Anne Parker

Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD15 Update Diary Entry		
Scope:	CWD system	
Level:	User goal	
Summary:	A user changes one or more details of a diary entry.	
Primary Actor:	Professional changing diary entry.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.	
Trigger:	Circumstances require that a change to be made to a diary entry.	
Linking use case:		
Concurrency	CWD08	
Success Guarantee:	The diary entry is updated.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the diary section and changes one or more diary entry details.	
2	The user saves the changes and the changes are confirmed.	
3	Notification of the change is sent to the required attendees. .	
Alternative paths		
3a	There is only one required attendee and they are the individual making the change. No notification is sent.	
Data		
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		

CWD16 Display Diary	
Scope:	CWD system
Level:	User goal
Summary:	A user displays diary entries for a child, team or professional.
Primary Actor:	Professional displaying diary entries.
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.
Trigger:	The user wishes to view diary entries.
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The diary entries are displayed.
Minimal Guarantee:	As for success guarantee.
Frequency:	
Basic Course of Events	
1	The user selects the diary section of the child's record.
2	The diary entries are displayed using the default filter.
3	The user changes the viewing filter.
Alternative paths	
1a	The user selects the system diary.
Data	
	Filter options Child User – individual user, users department, specialty Purpose Status Date Place
Business rules and non-functional requirements	
Owner	Anne Parker
Iteration Dates and person(s) completing iterations:	

1	01/03/04	AP
2		
3		
4		

CWD17 Delete Diary Entry		
Scope:	CWD system	
Level:	User goal	
Summary:	A user deletes a diary entry.	
Primary Actor:	Professional deleting diary entry.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.	
Trigger:	Circumstances require that a diary entry must be deleted.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The diary entry is deleted.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the diary section and deletes the diary entry.	
2	The user enters the reason for deletion.	
3	Notification of the change is sent to the required attendees. .	
Alternative paths		
3a	There is only one required attendee and they are the individual making the change. No notification is sent.	
Data		
Business rules and non-functional requirements		
Only the user that created the diary entry or a member of the department may delete the diary entry.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		

3 **4**		

CWD18 Add Assessment		
Scope:	CWD system	
Level:	User goal	
Summary:	A user records details of an assessment.	
Primary Actor:	Professional recording assessment.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.	
Trigger:	A child has been assessed by a professional.	
Linking use case:		
Concurrency		
Success Guarantee:	The assessment is recorded.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the appropriate assessment form.	
2	The user enters the assessment details.	
3	The user saves the assessment details.	
4	The user completes the assessment	
Alternative paths		
4a	The user is not able to add the full details. The assessment is saved for completion at a later time.	
Data		
	See Appendix 3 for assessment form details	
Business rules and non-functional requirements		
Assessment must be linked to original referral		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP

CWD19 View or Update Assessment		
Scope:	CWD system	
Level:	User goal	
Summary:	A user amends the details of a child's assessment.	
Primary Actor:	Professional updating assessment.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated. The assessment has not been completed	
Trigger:	An incomplete assessment exists for the child.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The assessment is updated.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the assessment they want to update.	
2	The user adds or amends the details as required.	
3	The user completes the assessment.	
Alternative paths		
3a	The user is not able to add all the report details so the report is saved and closed for completion at a later time.	
Data		
Business rules and non-functional requirements		
It is not possible to update a completed report.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP

CWD20 Delete Assessment		
Scope:	CWD system	
Level:	User goal	
Summary:	A user deletes a child's assessment.	
Primary Actor:	Professional deleting assessment.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The user has system administrator rights. The Assessment co-ordinator is allocated. The assessment is not complete	
Trigger:	A user needs to delete an assessment.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The assessment is deleted.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the assessment they want to delete.	
2	The user deletes the assessment.	
3	The user enters the reason for deletion.	
Alternative paths		
Data		
Business rules and non-functional requirements		
It is not possible to delete a completed report. A user can only delete a report that they or a member of the same department has added.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		

CWD21 Discharge Child from Service	
Scope:	CWD system
Level:	User goal
Summary:	A professional decides that the child no longer requires the service they are receiving and discharges them from the service. If the child is receiving a single service the user has the option to deactivate the child record.
Primary Actor:	Professional discharging child.
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.
Trigger:	A child no longer needs the service he or she is receiving.
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The child is discharged.
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The professional chooses to discharge the child. ? from child plan
2	The professional records the date and reason for discharge.
3	The professional's agency is removed from the list of involved agencies.
4	The episode of care is closed.
5	The remaining involved agencies and the referrer are notified of the discharge.

Alternative paths	
1a	The system warns that the agency is the current lead and may not discharge the child until the Assessment co-ordinator has been reallocated. Use case terminates.
5a	There are no other involved agencies so the child's record is deactivated. (Should this be automatic?)

Data	

Business rules and non-functional requirements
Assessment co-ordinator cannot discharge child.

Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD22 Add or Update Plan		
Scope:	CWD system	
Level:	User goal	
Summary:	A professional has assessed a child and now needs to record the plan for their involvement with the child. If the professional decides not to provide a service, this is recorded as an outcome and the child is discharged. If the child is to receive a service the details of this service are recorded on the plan.	
Primary Actor:	Professional dealing with child.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.	
Trigger:	A child has been assessed by a professional.	
Linking use case:		
Concurrency	CWD08	
Success Guarantee:	The child plan is added.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The professional chooses to add a plan.	
2	The professional records the details for their service and saves the changes.	
Alternative paths		
2a	A plan already exists and the user selects the plan to update it with their details.	
Data		
	See appendix 4 for child plan details	
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP

CWD23 Add Activity	
Scope:	CWD system
Level:	User goal
Summary:	A professional records the details of professional contact with the child
Primary Actor:	Professional dealing with child.
Other Actors:	none
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated. There is an open episode of care for the users agency.
Trigger:	A professional has contact with a child.
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The activity is added.
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The professional chooses to add an activity? from involved agencies/open referral screen
2	The professional records the details for their service and saves the changes.

Alternative paths	

Data	
	Activity related data: Date of contact IP/OP Venue (coded see appendix 6) Time in contact (mins) Travel time (mins) Contact type (Code see appendix 6) Contact type reason (Code see appendix 6) Activity type (Code see appendix 6) Discharge code (see appendix 6)

Business rules and non-functional requirements

Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD24 Update or Delete Activity		
Scope:	CWD system	
Level:	User goal	
Summary:	A user updates the details of professional contact with the child	
Primary Actor:	Professional dealing with child.	
Other Actors:	none	
Preconditions:	User logs on successfully and the username and password are verified by the system. The Assessment co-ordinator is allocated.	
Trigger:	A professional needs to change the contact details for the child.	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The activity is added.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The professional chooses the activity? from involved agencies/open referral screen	
2	The professional amends the details for their service and saves the changes.	
Alternative paths		
2a	The user deletes the activity and enters the reason for deletion.	
Data		
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		

CWD25 Manage Child Review	
Scope:	CWD system
Level:	User goal
Summary:	The manager of the Assessment co-ordinator organises the child review
Primary Actor:	Manager of Assessment co-ordinator
Other Actors:	Managers of lead agencies
Preconditions:	User logs on successfully and the username and password are verified by the system.
Trigger:	
Linking use case:	CWD08
Concurrency	
Success Guarantee:	The referral details are added.
Minimal Guarantee:	As for success guarantee.
Frequency:	

Basic Course of Events	
1	The Assessment co-ordinator manager receives a Child Review Reminder.
2	The Assessment co-ordinator manager completes the review details and sends invites, according to the recorded contact method, to all involved agencies plus any other agencies selected by the manager.
3	Each recipient picks up the invite and responds.
4	Sufficient responses are positive and the child review details are confirmed.
5	The child review is carried out and the outcome recorded. Any actions are recorded by the Assessment co-ordinator and a new review date is set.

Alternative paths	
1a	The Assessment co-ordinator manager chooses the option to organise the child review.
3a	A required attendee does not respond within agreed time scales and the initiator is notified, enabling them to chase up the response.
4a	Insufficient responses are positive; the review cannot be scheduled so it is cancelled. Return to step 2, if required.

Data	
	Review details: Date, time, venue, basic child details See appendix 4 for review outcome and action data.

Business rules and non-functional requirements
The system does not allow any information other than referral information to be added until the

Assessment co-ordinator is allocated.		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD26 Attach Scanned Document		
Scope:	CWD system	
Level:	User goal	
Summary:	A user scans a document and attaches it to the child record.	
Primary Actor:	User scanning document	
Other Actors:		
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:		
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The scanned document is attached to the record.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user scans the document.	
2	The user chooses the option to attach a document to the child record.	
3	The user selects the document using the browser and completes the document details. .	
Alternative paths		
Data		
	Document details: Type, Comments, Date received	
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		

CWD27 Produce Reports		
Scope:	CWD system	
Level:	User goal	
Summary:	A user runs a report and prints the results or outputs them to disk.	
Primary Actor:	User running report	
Other Actors:		
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:		
Linking use case:		
Concurrency		
Success Guarantee:	The reports runs and the output is received by the user.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user selects the report to run.	
2	When the report is complete the user prints the report results.	
Alternative paths		
2a	The user outputs the results to disk.	
Data		
	See appendix 5 for report details	
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		
4		

CWD28 Browse Service Details		
Scope:	CWD system	
Level:	User goal	
Summary:	A user wishes to view the details of a service that may be beneficial to a child.	
Primary Actor:	User browsing details	
Other Actors:		
Preconditions:	User logs on successfully and the username and password are verified by the system.	
Trigger:		
Linking use case:		
Concurrency		
Success Guarantee:	The user is able to view the details.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The user searches for the service they need more information on.	
2	The user selects the service and displays the details.	
Alternative paths		
Data		
	Most of the required details are the department details added as part of the user/department maintenance function. In addition to those, there is a requirement for an additional piece of text information to be linked to each department. This information will include: The nature of the service Contact details Opening times Whether the service is free or not Referral information	
Business rules and non-functional requirements		
Some departments will have details but no system users		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP

CWD29 Merge Records		
Scope:	CWD system	
Level:	User goal	
Summary:	The system manager is notified that duplicate records exist. They then merge the details into one record.	
Primary Actor:	System manager	
Other Actors:		
Preconditions:	System manager logs on successfully and the username and password are verified by the system.	
Trigger:	Duplicate records identified	
Linking use case:	CWD08	
Concurrency		
Success Guarantee:	The records are merged.	
Minimal Guarantee:	As for success guarantee.	
Frequency:		
Basic Course of Events		
1	The system manager identifies the main record.	
2	The system manager identifies subsidiary records.	
3	The system copies the details from the subsidiary records to the main record.	
4	The system deletes the subsidiary records.	
Alternative paths		
Data		
Business rules and non-functional requirements		
Owner	Anne Parker	
Iteration Dates and person(s) completing iterations:		
1	01/03/04	AP
2		
3		

9 Hardware Requirements & Hosting

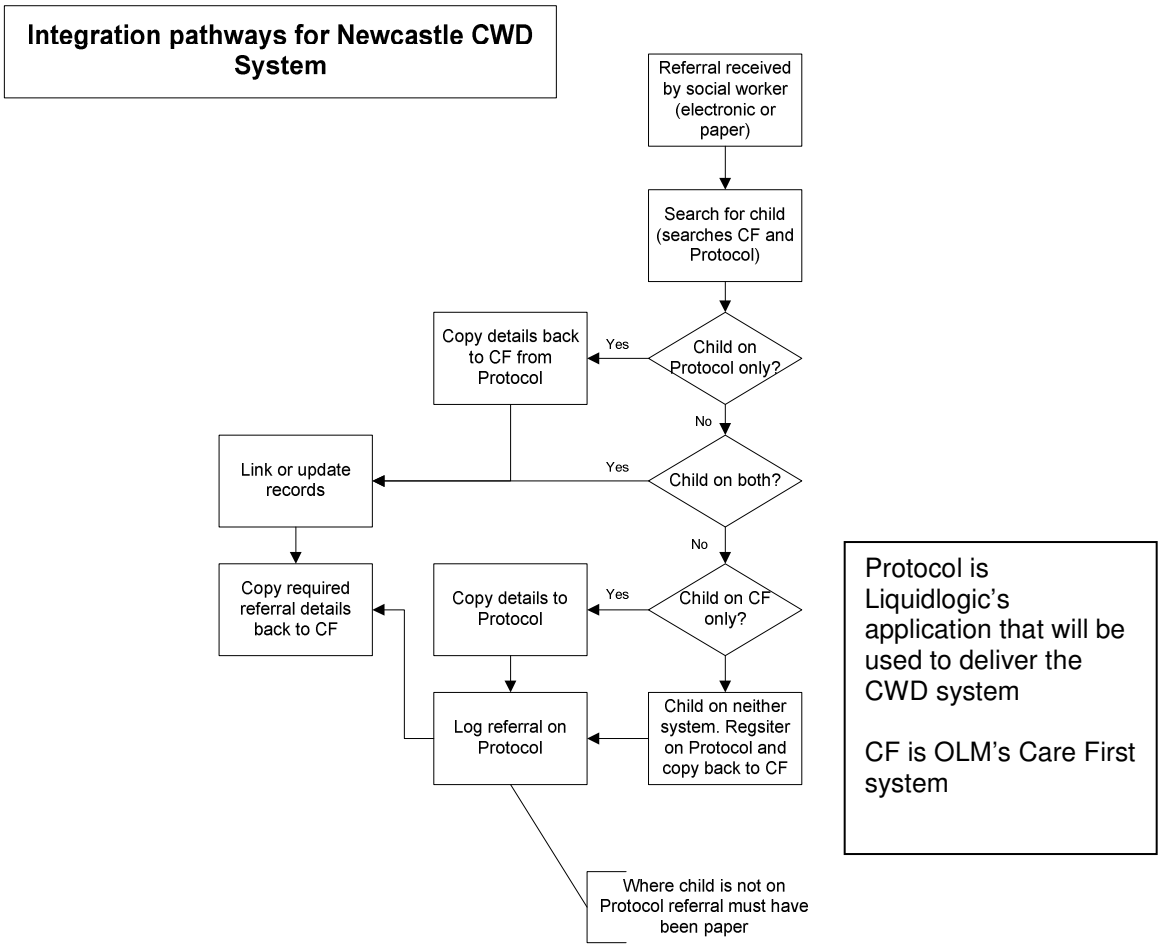
Specification for server:
Processor: Dual Intel Xeon 2.8 GHz
Memory: 4GB
Disk and configuration: 2 x 36.4 GB mirrored hard drives
Redundant power supply: Dual 1 + 1 redundant hot plug power supplies
Network cards: Network adaptor
Operating system: Microsoft Windows 2003
Applications: Microsoft SQL Server
?? What about backups

Specification for client PCs TBA

Hosting
Confirm hosting details. Server to be hosted by Newcastle social services with private circuit to NHS net.

10 Integration Requirements

For the system to work seamlessly for the social work CWD team and for all the information relating to the child to be available to non social work professionals without the need for double entry, the system must integrate with OLM's Care First system. To date no technical details of the integration mechanism have been determined but the following diagram illustrates the basic pathways. The entry of a child's death on either system must update the other system in real time.



11 Additional requirements

11.1 Viewing Assessments

The ability to display relevant information quickly and easily is crucial to the success of the system. Because there will potentially be lots of information per child it will be necessary to filter the assessment information in some way. It is expected that the system will provide a chronology of all assessments with the ability to view the detail of each, in turn. In addition to this the following views have been suggested:

i) latest entry under each assessment heading, including who did it and when.
ii) entries within a specified date range under a heading
iii) most recent “n” entries under each heading

11.2 Waiting lists for Speech and Language Therapy

The system must provide team related holding trays for the Speech and Language Therapy service. For this agency the referrals will come into one central, departmental tray. They are picked up and reviewed/assessed an allocated to a team. The referral then waits in the team tray until a place is available for the child.

11.3 Printing Requirements

It must be possible to print any referral form, assessment form, plan or review outcome:

i) As a blank form to be completed by hand
ii) After completion

It must be possible to print the child record.

11.4 Audit Trail

The audit trail must record the details (date, time, user id, child id) of each access to a child’s record and the details of any changes and deletions made. Where the record is accessed by an individual from a team that is not currently involved the system must display a warning to the user and force then to enter a reason if they proceed with viewing the record.

11.5 Addresses

The system will use a copy of the Care First address gazetteer which will be provided in electronic format.

11.6 Referral Criteria

Where provided by the agency, the system will make available help text to support users in making a referral to that agency.

11.7 Unresolved Issues

Is it possible to provide a hot key link between Care First and Protocol?

Backup arrangements and system management – disaster recovery

Appendix 1 Referral Details

Referral forms by specialty

Team	Referral form to use	Comments
Children's Community Nurses	Core form + coded reason for referral	
Specialist School Health Nursing Service	Core form + involvement question + school nurse question	
CWD social work team	Core form	Remaining child details are held within the child's record.
Short break services	Core form + additional details	
SENTASS Young Children's Team	Core Form + additional questions for nursery support	
SENTASS Sensory Team	Core Form	
SENTASS Dyspraxia	Core Form	
EWO	Core Form	
Loan equipment	Requisition form Special purchase request	
Educational psychology	Core Form	
CTLD	Core form + learning disability question	
CAMH	Core form	
Speech and language therapy	Core form + specialist section	
Community Paediatric Therapy (Physiotherapy)	Core form	
Community Paediatric Therapy (OT)	Core form + specialist OT section	
Community paediatrics	Core form	After selecting specialty, user selects consultant
Welfare rights	Core Form	Consent text will be different for this form.

Core Referral Form

Referrer Details
Name (from system details)
Address (from system details)
Telephone no (from system details)
Mobile (from system details)
Designation (from system details)

Referral Details
Date
Reason for referral
Expected outcome
Any other relevant information

Consent Details
Consent to record and share

Specialist referral form sections

Children's Community Nurses

Reason for referral/Referrers expectation of service

Reason	Code
Constipation management	01
Clinical monitoring	02
Enteral feeding management	03
Oxygen therapy management	04
Tracheostomy management	05
Ventilation	06
Coordination of care	07
Play therapy	08
IVT	09
Technical support	10

Specialist School Health Nursing Service

Has the main stream school nurse been informed? y/n

What level of involvement would you like to maintain with the team on this referral? (text response)

SENTASS Young Children's Team

Request for additional support for children in nursery school, nursery classes and community projects

Type of placement Full Time/ Part Time

Does/will the child attend the same sessions each week throughout the school year? If not please outline the way in which nursery attendance is organised in your school.

Consideration for support will be based on the information given in this form, discussion with the professionals involved and observation of the child in one or more settings. Support will not be offered without parental approval.

1. Brief account of the difficulties the child faces

2. Help given by the nursery
3. Developmental level
This is often difficult to assess and many children do not wish or are unable to cooperate. However, from your observation can the child:

a) Understand cause and effect? i.e. if I do this then something happens e.g. Jack in a Box, push & go y/n
b) Stack three blocks y/n
c) Post three basic shapes into box y/n
d) Thread large beads/bobbins y/n
e) Scribble y/n
f) Copy marks on paper O y/n
g) Copy marks on paper | y/n
h) Copy marks on paper --- y/n
i) Match objects to pictures y/n
j) Recognise own picture/symbol y/n
k) Recognise printed name y/n
l) Vocalise y/n
m) Use recognisable words y/n
n) i) Use gestures to greet or leave y/n
ii) Use gestures to comment y/n
iii) Use gesture to make requests y/n
o) i) Use verbal language to greet or leave y/n
ii) Use verbal language to comment y/n
iii) Use verbal language to make requests y/n
p) Respond appropriately to instructions reinforced by gesture
q) Respond appropriately to instructions without contextual clues
r) Leave parent/carer
s) Approach other children independently
t) Sit with group for snack time
u) Manage snack/drink independently
v) Loins in turn taking game with adult
w) Join in simple circle game e.g. Ring o' roses
x) Show an awareness of toileting needs
y) Ask adult when needing help
z) Manage toilet independently (with supervision)

4. Are you concerned about the child's ability to:

a) Use the nursery environment purposefully very concerned/ concerned/not concerned
b) Follow basic nursery routines very concerned/ concerned/not concerned
c) Play happily alongside other children very concerned/ concerned/not concerned
d) Share equipment with other children very concerned/ concerned/not concerned
e) Play safely on large equipment very concerned/ concerned/not concerned
f) Concentrate on self chosen tasks very concerned/ concerned/not concerned
g) Concentrate on adult chosen tasks very concerned/ concerned/not concerned
h) Engage in symbolic/imaginative play very concerned/ concerned/not concerned

Other Concerns

5. Does the child show curiosity or self motivation?

6. Other comments

SENTASS – Dyspraxia/Physical Difficulties

School NC Year
Details of main disability/disabilities
Consequences of disability/disabilities in terms of:
a) access to the learning environment
b) access to the national curriculum
c) access to the wider curriculum
d) relationships/interactions with others in lessons
e) relationships/interactions with others in play

Under School Action Arrangements, please indicate what has been undertaken via the 4 Strands of Action SEN Toolkit.

1. **Assessment, Planning and Review**
   (Please include the pupil's IEP) e.g. Are class teacher/subject teacher and SENCO involved? How frequently have reviews been held? Are parents involved in planning and/or review?

2. **Grouping for Teaching Purposes**
   e.g. Has pupil had individual or small group tuition? Has the support been in class or on a withdrawal basis? Has the pupil attended lunchtime or homework clubs or other out of hours learning opportunities?

3. **Additional Human Resources**
   e.g. Main provision by class teacher with involvement of SENCO. Is pupil supported by LSA or adult helper, and has specialist advice been sought?

4. **Curriculum and Teaching Methods**
   e.g. How much of the pupil's work has to be differentiated to ensure curriculum access? Has the pupil needed specialist materials/programmes of work?

Are any other professionals involved?

Is the pupil absent on a regular basis?

SENTASS–Dyslexia/Specific Learning Difficulties (Key Stages 1 & 2)

School NC Year

Under School Action Arrangements, has the pupil made any progress?
Please indicate what has been undertaken via the 4 Strands of Action SEN Toolkit (section 6 COP):

1. **Assessment, Planning and Review**
   (Please include the pupil's IEPs and reading/spelling attainment)

2. **Grouping for Teaching Purposes**

3. **Additional Human Resources**

4. **Curriculum and Teaching Methods**

Information from parents should be included where relevant.

Are any other professionals involved?

Is the child school action plus for another area of difficulty e.g. EBSD?

Is the pupil absent on a regular basis?

An example of the pupil's free writing will be forwarded by post y/n

Something the pupil has copied, together with a transcript of the intended form of words will be forwarded by post y/n

Please answer yes or no to the following questions:

	Yes	No
Does the pupil appear to be brighter orally than his/her written work suggests?		
Can the pupil give sounds of randomly presented letters?		
Can the pupil write the correct letters for randomly dictated sounds?		
Can the pupil continue a rhyming sequence of regular cvc words? (e.g. hat, bat)		
Can the pupil write regular cvc words correctly?		
Can the pupil use regular consonant blends in spelling?		
Can the pupil spell regularly used words as accurately as his/her peers?		
Can the pupil use the handwriting formation taught in school?		
Is the pupil as clear in the use of b/d/p or n/u as his/her peers?		
Can the pupil structure and write a story with a beginning, middle and end?		
Can the pupil be relied upon to have appropriate equipment for PE lessons etc?		
Can the pupil carry an oral message to the teacher in the next classroom?		
Can the pupil follow instructions? – such as "Go to the art cupboard, get the red paint and put it on the table." Is the pupil aware of the time of day and sequence of events?		
Can the pupil read accurately at a level appropriate to his/her age and general ability?		
Can the pupil repeat multi-syllabic words, e.g. preliminary, institution and alphabetical?		
Has the pupil been able to maintain self esteem in spite of his/her difficulties with classwork?		

Does the pupil have any history of speech therapy or phonological difficulties?
If so, provide details of any relevant professional involvement.

Is there a family history of specific learning difficulties/dyslexic tendencies?
If so, please specify.

SENTASS–Dyslexia/Specific Learning Difficulties (Key Stage 3)

School NC Year

Under School Action Arrangements, has the pupil made any progress?
Please indicate what has been undertaken via the 4 Strands of Action SEN Toolkit (section 6 COP):

1. **Assessment, Planning and Review**
   (Please include the pupil's IEPs and reading/spelling attainment)

2. **Grouping for Teaching Purposes**

3. **Additional Human Resources**

4. Curriculum and Teaching Methods

Information from parents should be included where relevant.

Are any other professionals involved?

Is the child school action plus for another area of difficulty e.g. EBSD?

Is the pupil absent on a regular basis?

An example of the pupil's free writing will be forwarded by post y/n

Something the pupil has copied, together with a transcript of the intended form of words will be forwarded by post y/n

Please answer yes or no to the following questions:

	Yes	No
Does the pupil appear to be brighter orally than his/her written work suggests?		
Can the pupil read accurately at a level appropriate to his/her age and general ability?		
Does the pupil understand material at a level appropriate to his/her age and ability?		
Can the pupil give the sounds of randomly presented letters/consonant blends?		
Does the pupil appreciate the difference between the sounds and names of letters?		
Can the pupil write the correct letters for randomly dictated sounds – single letters and consonant blends?		
Is the pupil as clear in the use of b/d/p or n/u as his/her peers?		
Does the pupil sequence letters within words correctly? (e.g. plan and not paln)		
Can the pupil continue a rhyming sequence of regular cvc words? (e.g. hat, bat)		
Can the pupil write regular cvc words and words using regular consonant blends correctly?		
Can the pupil use regular consonant blends in spelling?		
Can the pupil spell regularly used words as accurately as his/her peers?		
Can the pupil use the handwriting formation taught in school?		
Can the pupil produce written work with age appropriate spelling?		
Does the pupil observe punctuation in reading and spelling?		
Can the pupil structure and write a story with a beginning, middle and end?		
Can the pupil be relied upon to have appropriate equipment for PE lessons etc?		
Is the pupil generally well coordinated, e.g. in P.E. and in the use of equipment in technology, design etc.?		
Can the pupil follow a sequence of instructions for procedures in science, art etc.?		
Is the pupil aware of the time of day and sequence of events?		
Can the pupil repeat multi-syllabic words, e.g. preliminary, institution and alphabetical?		
Has the pupil been able to maintain self esteem in spite of his/her difficulties with classwork?		

Does the pupil have any history of speech therapy or phonological difficulties?
If so, provide details of any relevant professional involvement.

Is there a family history of specific learning difficulties/dyslexic tendencies?
If so, please specify.

SENTASS–Communication and Learning

School NC Year

Under School Action Arrangements, has the pupil made any progress?
Please indicate what has been undertaken via the 4 Strands of Action SEN Toolkit (section 6 COP):

1. **Assessment, Planning and Review**
   (Please include the pupil's IEPs and reading/spelling attainment)

2. **Grouping for Teaching Purposes**

3. **Additional Human Resources**

4. **Curriculum and Teaching Methods**

Information from parents should be included where relevant.

Are any other professionals involved?

Is the pupil absent on a regular basis?

A copy of the observation profile will be forwarded by post y/n

A copy of the Teaching Talking screen will be forwarded by post y/n

Tick the statements in A and B which describe the pupil's behaviour:

Section A

Responds inconsistently to spoken instructions on a regular basis.

Seeks constant reassurance from teacher and/or another adult that his/her response is acceptable.

The child is frustrated by his/her difficulties in communicating.

Appears regularly to "switch off" or loose concentration in an oral teaching context.

When talking, frequently appears to struggle to find the correct words.

Regularly but inconsistently gives inappropriate responses to verbal comment, instructions or questions.

Section B

Shows more than average anxiety or embarrassment if singled out from a group.

Is socially isolated.

Says little to anyone.

Does not always do as he/she is told, but is inconsistent in response.

Rarely speaks in sentences of more than a few words.

Uses sentences which are grammatically incorrect: language which sounds "babyish".

Is particularly reluctant to ask questions of an adult or to answer an adult's questions.

Is difficult to understand. (If this is a persistent problem, then a referral should be made to speech therapy).

Able to read mechanically but unable to understand the text.

There is a history of speech, language and communication difficulties.

Whole-body movements are poorly co-ordinated.

Has poor hand control e.g. in drawing and writing.

(If the last two statements are ticked, then it may be the child has difficulties with motor organisation which will require an appropriate assessment).

Please add anything else which gives cause for concern.

Loan Equipment Service

Requisition

Client Details
Name
Address
Postcode
Telephone no
Mobile (from system details)
Date of birth
GP name GP code

Requisitioner's details
Name
Telephone no
Designation
Base
Area
Items required
Date of request
Quantity
Code
Description
Code issued
Quantity issued
Any other relevant information
Approved by (name, date)
Received by (name, date)

Special Purchase Request
Client Details
Name
Address
Postcode
Telephone no

Mobile (from system details)
Date of birth
GP name GP code

Identified difficulty
Client
Carer

Options considered/tried

Social situation/environment

Recommendation to purchase
Full item description
Supplier name
Supplier address
Supplier telephone Supplier Fax
Item size Item colour
Cost
Manufacturer's reference no
Paper copy and quote to follow y/n

Requisitioner's details
Name
Telephone no
Designation
Base
Area
Approved by (name, date)

CTLD

NHS number
Does the child have an identified learning disability? y/n
Date of identification

Speech Therapy

Understanding
The child joins in everyday routines
has difficulty following instructions
understands most of what is said

Communication
The child makes basic needs known
uses language to accompany play
asks questions, holds conversations

Fluency
The child appears to stammer (stutter)

Language
The child uses no words at all
uses single words only

uses phrases or sentences

Speech

The child	is easy to understand
	is mostly understandable, sounds immature
	is only understood by family
	is unintelligible to family

Feeding

The child	has feeding difficulties
	has dribbling problems

Occupational Therapy

Does this child have developmental or learning difficulties?

Age 4-6 (if unable to do more than 5/12 items, refer)	
Put on and take off clothing without assistance (shirt sweater socks)	A/U
Use spoon/fork to feed self without mess	A/U
Follow simple rhythm and beat with hand (6 claps)	A/U
Threads beads onto string	A/U
Build a tower of six blocks	A/U
Recognise body parts	A/U
Run without tripping	A/U
Kick a ball straight without losing balance	A/U
Jump up and down, both feet together, 10 times without losing rhythm	A/U
Walk on toes without accessory movements	A/U
Walk on heels without accessory movements	A/U
Lie on floor and raise upper body by pushing on hands	A/U

Age 7-9 (if unable to do more than 3/10 refer)	
Do buttons, belt buckle, zips and tie shoe laces	A/U
Use knife and fork together	A/U
Recognise left and right in context of an action	A/U
Use scissors to cut a straight line	A/U
Tripod hold of pen and pencil	A/U
Writes standard phrase accurately spaced and legibly	A/U
Clap a rhythm (2 long, 2 short, 3 long)	A/U
Throw and catch a medium sized ball away from body with both hands	A/U
Walk around classroom without bumping into things	A/U
Jump a sequence of movements (2 forwards, 2 back, 2 left)	A/U

Age 10+ (if unable to do more than 1 item refer)	
Complete standard phrase in handwriting*	A/U
Set out standard sum using columns	A/U
Walk heel to toe for 15 steps forwards	A/U
Hop on left foot (2) Jump 2 feet together (2) Hop on right foot (2)	A/U
Throw ball against wall, catch with both hands, without bouncing on floor, 5 times without dropping the ball	A/U

Handwriting sample has been forwarded by post y/n

Short Break Service – Shared care application form

Please specify as required:

Overnight _____ Frequency _____ Day Care _____ Frequency _____

1/1 required y/n

Support worker _____ Frequency _____

Child/young persons name: Male/Female

Is the child/young person Known by any other name? DOB

Address Age

Postcode

Telephone

Religion/Faith/Culture

Name of parent or guardian Who to contact in case of emergency (if different)

Address Specify relationship to child

Work telephone Home telephone

Is child/young person on the child protection register? y/n

Legal status of child/young person

GP name

GP address

GP telephone no

Nursery/School

Address

Teacher/key worker

Telephone no

Social worker/Care manager

Address

Telephone no

Other professional services involved:

Name Profession Base Telephone

Name	Profession	Base	Telephone
Name	Profession	Base	Telephone
Name	Profession	Base	Telephone

Family composition:

Name	Age	Occupation/School

Are there any friends/relatives who are important to the young person? Please state relationship and name

What transport is available? Can it be used to transport the child/young person?

Do you have any pets? (please specify) If not, does your child mind being with other pets?

Do you have smokers in your family? Do you have any objections to a link with carers who smoke?

Pen picture of young person.

Please give enough information regarding the child/young person to enable us to make an appropriate and successful match.

Health

Description of disability and impact on child/young person

Are there any long term health needs or other conditions?

Does the child/young person have absences or seizures? If so, how are they recognised and how long do they last? Suggestions on management.

Medication required

Any allergies?

Are there any other health needs? (e.g. spectacles hearing aids, helmet, walking aids)

Any other comments about the child/young persons health needs

Mobility

Does the child/young person use a wheelchair, special buggy, walking aids? (Please specify)

Any body braces, callipers etc? If so, when does he/she use them?

What distance can he/she walk and how much assistance, if any, is needed?

Can he/she walk unaided upstairs downstairs

Can he/she travel by public transport car

Any special needs concerning the above (e.g. position of seating, travel sickness)

Does he/she need someone to hold his/her hand while out walking?

Does he/she try to run away?

Are there any situations the child/young person find frightening or upsetting while outside?

What is there level of road sense?

Any other comments about the child/young person's mobility?

Self Care Skills

Does the child/young person need assistance with dressing/undressing? If so, how?

Does he/she need assistance with washing/shaving/menstruation (where appropriate)? Please give details.

Does the child/young person need assistance or prompting with toileting? If so, how?

Is he she incontinent during the day at night

Please indicate use and type of nappies/pads, catheters and other aids:

Any problems concerning diarrhoea or constipation? If so, how are they overcome?

Any other comments on the child/young person's self care skills/any skills you would encourage to be developed?

Communication/speech

What is the child/young person's main form of communication? Please give examples.

Sign language/BSL Makaton Gestures Noises

Sentences Writing Single words Eye contact

Any other language spoken or understood?

Special equipment (Bliss/Keyboard/touch screen) please describe.
Comprehension/understanding of child/young person

Does he/she understand:

Most of what is said	Short commands	Sign language
Tone of voice	Single words	

Does he/she have any hearing difficulty or speech difficulty?

Any comments or extra information on the child/young person's speech and understanding?

Mealtimes

Are there any special dietary needs? (e.g. gluten free/vegetarian/Halal/Kosher etc)

Any favourite food and drink?

Any preference for lunch?

Any preference for tea?

Any food or drink the child/young person dislikes or must not have?

Do we need to prepare food in a special way? (e.g. chopped, liquidised etc)

Any special equipment? (e.g. non slip map, special cup or plate?)

Does he/she normally sit with the family or eat before/afterwards?

How does he/she like to be seated? (at table, special set, on knee)

What does he/she use to eat with? (e.g. knife and fork, spoon, fingers)

Does he/she need help to eat or drink? If so, how?

Any rituals connected with food (e.g. before bed or in any particular way?)

Keeping the child/young person safe

Are there any special precautions the carer needs to take (e.g. locking cupboards, windows, doors, safeguarding electrical points, stair gates etc)

Any behaviours we should encourage in the child/young person?

How do we reward these?

Any behaviours we should discourage? If so, how?

Race, religion, culture

Are there any arrangements that need to be made for us to properly observe the child/young person's racial, religious or cultural needs? Please describe?

Please describe what we must always do.

Please describe what we must never do.

Any activities to avoid?

Any special favourites not already mentioned?

Does he/she attend a youth club? (Please specify when and where)

Does the child/young person need a structured routine? (Please give details)

Are there any situations that make the child/young person unhappy, angry or afraid? (Please give details)

How does he/she show happiness or anger?

What calms/comforts him/her most?

Special requirements

Are there any special arrangements that need to be followed in the event of an emergency?

Any other comments?

The above information will be shared with prospective carers.

Social worker Date

Team manager Date

Welfare Rights Advice

As for core form but consent details will be different. Awaiting consent text.

Acceptance/Rejection Details

Details of notifications and letters to be added.

Referral Criteria

Where available the referral criteria must be available as a help sheet from the incomplete referral form.

CAMHS Referral Criteria

Referral criteria for Newcastle Social Services to FNU Tier 3 CAMHS

- Child living in Newcastle and registered with Newcastle G.P
- Child aged 0 – 14.5 years
- Child does not have a learning disability
- Child has moderate/severe and /or longterm problems with one or more of the following : -
  - disturbance of mood and emotions
  - impulsive/inattentive/overactive behaviours
  - disruptive/antisocial/aggressive behaviours
  - physical symptoms for which medical/developmental causes have been excluded, including eating/feeding difficulties
    soiling
    sleep disturbance
  - deliberate self harm or suicidal thinking
  - problems with social interactions

- abnormal thoughts and perceptions causing distress and out of keeping with the child's sociocultural context

- assessment of child in need completed
- parents/carers are in agreement with the referral and understand the nature of concerns to be addressed

Any request for admission to an inpatient child psychiatric unit (Tier 4) must be first considered by referring the child to the Tier 3 outpatient team
Out of hours the child's G.P. or hospital paediatrician should make any emergency referral to the on-call child psychiatrist.

Specific circumstances

(1) If child is subject to care proceedings and mental health assessment is required to contribute to these : -

Additional criteria : -
(a) consideration given as to how child mental health assessment adds to assessments already completed i.e. questions still to be answered

e.g.- emotional harm suffered by child
- attachments
- parenting capacity of emotionally damaged parents (parents who have acute mental illness / substance misuse / learning difficulties / dangerous or offending behaviour should usually more appropriately be referred to adult mental health / drug & alcohol / CTLD / adult forensic services respectively)

(b) preliminary discussion with senior CAMH practitioner prior to referral

(c) local authority legal department prepare formal instructions jointly agreed with all parties identifying specific issues to be addressed and gain court permission for all papers to be released
(d) parents/carers (and child if of sufficient age and understanding) understand that the mental health assessment is independent of other assessments but is for court purposes and so not subject to health professional-patient confidentiality

Assessments for care proceedings consume disproportionate CAMHS resources and the service may need to limit the number of such referrals which can be accepted each year.

(2) If child is accommodated by the local authority and in foster care in Newcastle (or likely to return shortly to Newcastle) : -
Additional criteria : -
(a) Child's Social Worker and foster carer's Link worker jointly agree areas of concern and identify professionals/services already involved with the child i.e. education, health, social services, other

(b)Preliminary consultation with senior CAMH practitioner to establish whether
- child needs direct assessment +/- treatment (consideration needs to be given to the child's view as to whether they need help)
- foster carers need additional advice and support
- services other than CAMHS need to be approached
- combination of above

(3) If child is accommodated by the local authority and in residential care in Newcastle, refer first to CAMH LAC nurse in EAHST

(4) If child is accommodated in foster care or residential care outside of Newcastle
Additional criteria :

(a) Identification of which other professionals /services are already involved with the child

(b) If another CAMH service is involved local to where the child is living, Social worker asks them to liaise with (or refer on to if appropriate) Newcastle CAMHS
If the child is not known to the local CAMH service the Social worker should contact that service first (for Newcastle CAMHS to accept referrals of children living outside Newcastle the referral needs to be made by CAMHS local to the child's address or the PCT for that area needs to support the referral)

(c) Practicalities of attending appointments in Newcastle are considered and relevant support made available to child and carers.

Sue Wressell September 2003

.

Appendix 2 Child's record

All professionals may read all information EXCEPT Welfare Rights who may only view demographic details within Personal Details.

Which fields are mandatory?

Personal details section

Last name
First name
Dob NHS no Care First id
Gender
Current Address
Home address
Postcode
Telephone Mobile
Looked after status: start date, end date
First language & dialect
Interpreter/signer required y/n
Religion
Ethnicity
Nationality? (as on the ICS referral and information record)
Immigration status?

Additional details section

Clinical details
Primary diagnosis
Secondary diagnosis
Gestational age

Main Problems *dynamically generated from open episodes)*
Problem details

Safety or Special Precautions

Any known allergies?

Does the child suffer from absences/seizures? y/n +text

e.g. Pacemaker, Dual Sensory Loss, Brittle Bones, Insensitivity to Pain, Behavioural Management, Intervention for seizures.

Any environmental sensitivities? (lighting, noise, crowds, colours etc.)

Is a moving and handling assessment required? Yes/ No

Any other precautions relevant to child or family? Please state

Status
Mobility – does the child use a wheelchair/buggy y/n +text

use crutches/callipers/rollator +text
walk with assistance y/n/ +text
walk unaided a limited distance indoors y/n +text
walk unaided a limited distance outdoors y/n + text
use public transport y/n +text

Hand function

For a child aged over 2 years - can the child	Fasten large buttons on the front of a garment.?
For a child aged over 3 years – can the chid	use a fork?
For a child aged over 5 years – can the child	fasten buttons?
	fasten a zip?
	use a knife and fork?

Does the child need help with personal care/toileting? y/n +text
Does the child suffer from communication impairment? y/n +text
Does the child suffer from a visual impairment? y/n +text
Does the child suffer from a hearing impairment? y/n +text
What is the child's mood/conduct with unfamiliar adults? text

Category
Autism, Mobility, Hand Function, Personal Care, Incontinence, Communication, Learning, Hearing, Vision, Behaviour, Consciousness

CoP Status

None	School action	School action plus	Statement
			Review date

Child Protection Information
For child & siblings
Registration start
Registration end
Category
SSTeam
Key worker

Relationships section

Main carers

Last name		Last name	
First name		First name	
Address		Address	
Postcode		Postcode	
Telephone no	Mobile no	Telephone no	Mobile no
Relationship		Relationship	
Parental responsibility		Parental responsibility	
First language		First language	
Interpreter/signer required y/n		Interpreter/signer required y/n	
Religion		Religion	
Ethnicity		Ethnicity	

Parents

Last name		Last name	
First name		First name	
Address		Address	
Postcode		Postcode	
Telephone no	Mobile no	Telephone no	Mobile no
Relationship		Relationship	
Parental responsibility		Parental responsibility	
First language		First language	
Interpreter/signer required y/n		Interpreter/signer required y/n	

Religion	Religion
Ethnicity	Ethnicity

Siblings

For each:	
Last name	
First name	
Dob	Care First id
Gender	
Current Address	
Home address	
Postcode	

Other household members

For each:	
Last name	
First name	
Dob	Care First id
Gender	
Current Address	
Home address	
Postcode	
Relationship to child	

Significant Others

For each:	
Last name	
First name	
Dob	Care First id
Gender	
Current Address	
Home address	
Postcode	
Relationship to child	

Key Agencies

GP Details

Name	GPcode
Surgery Address	
Postcode	
Telephone	

Health Visitor Details

Name
Address
Postcode
Telephone

Nursery/School Details

Name
Address
Postcode
Telephone

Current Involvement

(Derived from open episodes)
Name
Agency
Base
Telephone
Mobile
Links to Associated referral/assessment/activity
Assessment co-ordinator indicator
Staus – indicator of where child is in the system for the service – referral accepted, assessment started, assessment complete, receiving therapy, discharged.

Referrals/Episodes

Chronological list of referrals
Date referred, Referrer, Referrer agency, Referred to agency, date accepted, date discharged.
Current open episode indicator

Assessments

Chronological list of assessments
Date started, Date completed, Assessor, Assessors agency,
Filter available for display

Plan

Chronological list of plans
Date created, Date reviewed **what else here?

Activities

Chronological list of activities.
Date of contact
IP/OP
Venue (coded see appendix 4)
Time in contact (mins)
Travel time (mins)
Contact type (Code & reason see appendix 4)
Activity type (Code see appendix 4)
Discharge code (see appendix 4)

Reviews

Chronological list of reviews and actions
Date of review, Review lead, Review actions

Diary Entries

(child view)
Date
Time
Place
Purpose
Required attendees

Links

Links to web sites for Welfare Rights and Disability North.

Appendix 3

Minor headings should be displayed as help text to be available to the user when completing the form.

Joint Health, Social Care and Educational Assessment

Date Joint Assessment Commenced **Date Completed**

Contributors to Assessment			
Agency/Role	**Name**	**Agency/Role**	**Name**

Questionnaire, scales or other instruments used in assessment ☐ Yes ☐ No

Instrument Used Date Used

Health Status

Nature of Developmental Problem, Main Health Concern or Related Disability
Diagnosis if known
Investigations to date.
Is health state stable or changeable?

Other Known Health Conditions
Past Operations or Hospital Admissions
Epilepsy
Sensory/Visual
Sensory/Hearing
Genetic/ Syndromes
Other (please specify)

2months-4months:Diptheria,Tetanus,Whooping Cough, Polio, Hib, Meningoccocal C

12months-15months:Measles, Mumps, Rubella

At 3years should have had: Diptheria, Tetanus, Whooping Cough, Polio,Hib, Meningococcal C, Measles, Mumps, Rubella

At 15years should have had: BGC

Current Medication
Current medication and dose

Immunisation Status
Are immunisations up to date?

Physical Health
Stamina, General Fitness, Ill health
Breathing –oxygen, tracheotomy, ventilator
Skin Condition
Continence –bowel/ bladder
Weight and Growth pattern (height and weight centiles)
Resting and Sleep pattern
Mobility/Movement

Mental Health
Has a medical diagnosis of a mental health condition been made?
Has there been a referral to Child and Adolescent Mental Health Services? Yes/No

Aids, appliances or equipment
What aids, appliances or equipment are used in which settings? (Including communication aids)
Is use occasional or frequent?

Physical State and Functioning
Ability in lying, sitting, standing, changing position
Mobility – rolling, crawling, walking, transfers
Motor Control
Motor ability –indoors, outdoors, stairs, use of public transport,
Balance and co-ordination
Postural support and seating
Use of wheelchair, trike
Motor planning –organisation, body and spatial awareness

Self Care, Functional and Independence Skills

Are Self Care Skills limited due to health status e.g. pain, weakness, mobility?
Hand-eye co-ordination
Upper limb and hand function
Dressing
Manipulation- use of pencil, scissors, construction tasks, computer keyboard
Use of toilet (including continence management)
Hygiene and washing
Age appropriate use of community facilities (shops, telephone, leisure centre) Any limitations because of health status?

Eating and Drinking Skills
Method of feeding – oral/non oral
Range and consistencies in diet
Oral feeding abilities
Swallowing
Self feeding
Dribbling

Cognitive Skills, Perception, Speech and Language Skills

Play skills
Concentration
Attention span
Organisation and sequencing
Memory
Imaginative thinking
Reasoning and problem solving skills

Sensory skills and Perception
Vision and visual perception
Sensory modulation
Awareness of joint and body position
Impact of sensory/perceptual loss on function

Speech, Language Skills
Language used at home
Hearing
Attention
Social interaction
Understanding of language
Expressive language – how does he/she express him/herself?
Speech

Use of gestures and/or signing
Fluency
Voice quality

Education Status

Pre School child has Educational Input (SENTASS, Nursery, Play School etc)
Child/ Young Person has Statement of Special Educational Need
Child/Young Person has an Individual Educational Plan

Areas of Learning and Experience
Childs main areas of strengths
Childs main areas of difficulty
Teaching approaches and strategies
Specialist materials used
Rate of Progress and levels of attainment
Attendance record
Attitude to learning
Response to play and learning experiences

Emotional and Behavioural Development

Age appropriate/inappropriate behaviour
Behaviour in different settings, home, school, playground, community settings
Impulse control
Self awareness
Self esteem
Peer relationships
Relationships with adults
Relationship between behaviour and other Special Educational Needs
What strategies are in place to manage behaviour?

State in what context information has been gathered. Are views impressionisting or has a formal assessment been undertaken?

Family Social and Environmental Factors

Do any cultural values need to be considered in relation to identifying or meeting child's or family needs?
Do any religious values need to be considered in relation to identifying or meeting child's or family needs?
Level of clinical care provided by family
Continuity of care
What kind of help is available from friends relations and local community?
Are any parents/carers groups supporting the family?
Impact of child's/ young person's special needs on siblings
Do parents/sibling get short breaks from their caring role?
Has parent/carer any health needs that need to be considered?

Accommodation

Is accommodation privately owned/ council / housing association or other
What type of accommodation–single storey building, two storey building high rise building, terraced house, semi detached house etc.
Is the accommodation sub let or temporary?
Has accommodation any features which limit access
Is a specialist environmental assessment required Yes/No

Benefits

Is family in receipt of benefits?
Would parents like a benefits check from Welfare Rights?

Social Services Initial Assessment

Must use ICS Initial assessment record.

Social Services Core Assessment

Must use ICS Core assessment record.

Appendix 4 Plans & Reviews

Child Plan

(See page 8 of the ICS initial assessment)

Column headings
Identified child developmental needs and strengths and difficulties in each domain
How will these needs be responded to?
Frequency and length of service
Person/agency responsible
Date service will commence/commenced
Date Service completed
Planned outcomes

Row (domain) headings
Child's developmental needs
Parenting capacity
Family/environmental factors

Child review

Copy of above + contents

Column heading
Actual Outcomes

Section headings
Actions
Date of next review

Appendix 5 Report Details

Reports required:

Children by diagnosis
Children by problem
Children by disability category
No of children with open episodes
First seen within date range
Assessment not completed within set time interval
No of home visits/activities by child/service/professional/child not seen
No of children seen by service within date range
Children by consultation/activity frequency
No of referrals to service
Referrals to service that do not result in service
Re-referrals (how do we know this?)
Waiting times: time intervals between acceptance, tray 1, tray 2, assessment, discharge.
Record access by non-involved professionals

Appendix 6 Code lists

Venue

Venue	Code
Day services - other	DSO
Further education	FED
Family/friends home	FFH
GP surgery	GPS
Health centre	HC
Sanderson Centre	SAN
Independent/voluntary day service	IVD
Northgate hospital	NG
Other hospital	OH
Out of area hospital	OA
Out of area – other setting	OO
Other	OR
Patient's home	PH
Prudhoe hospital	PR
Probation service	PS
Social services ATC	SSA
Social services – day care	SSD
Social services - office	SSO
Social services - residential	SSR
School – mainstream	SC
School – special	SS
N & P Trust home	TH

Contact type

Contact type	Code
Direct face to face contacts with either patient or a proxy of the patient	D
Group face to face contacts with either patient and or proxies	G
Family face to face contacts where the patient may or may not be present and the family are acting as proxy	F
Direct contact with a parent or patient where the parent is not acting as a proxy	P
Direct face to face contact with somebody other than a parent of a patient where he/she is not acting as a proxy	O
Indirect work where there is no face to face contact	I
First contact	FC

Contact type reason

Reason	Code
AAC – high tech	AAH
AAC – low tech	AAL
AAC – signing	AAS
Ageing	OLD
Anger management	AG
Behaviour management	BM
Bereavement	BE
Care management	CM
Challenging behaviour	CB
Child protection	CP

Child related difficulties	CH
Complementary therapy	CT
Continence	CO
Counselling	CU
Crisis intervention	CI
Develop daily living skills	DL
Diabetes	DI
Dysphagia	DY
Eating/drinking	ED
Epilepsy	EY
Expressive language	EL
Facilitating health care	FH
Family support	FM
Forensic	FO
Mental health problems	MN
Non verbal communication	NVC
Offence related problems	OF
Oromotor	OM
Other	OT
Parenting assessment	PA
Physical disability/health promotion	PD
Physical health	PH
Prelinguistic	PL
Receptive language	RG
Relationships	RL
Self advocacy	SA
Self harm	SH
Sensory development	SN
Sexual health	SX
Skills development	SK
Social skills training	SS
Speech/phonology	SPP
Transitions	X

Activity

Activity	Code
Acute treatment	AT
Assessment	AS
Cancelled by team	UTA
Case conference/review	CW
Consultancy/advice	CA
Daily living skills	DLS
Did not attend	DN
Health promotion	HPO
Hospital OP clinic	OP
Hydrotherapy	HP
Intervention	IV
Monitor/maintenance FU/team meeting	MM
Moving and handling	MV
Orthotics advice/clinic	OA
Other	OT
Postural management	PM
Rebound	RE
Report writing and preparation	RW
Runner equipment	RUE

Seating	SE
Staff/carer training	TR
Teaching and training	TT
Telephone work	TE

Discharge

Discharge reason	code
Assessment completed	1
Failed to attend	4
Failed to respond to treatment	13
Intervention completed	14
Moved out of area	5
Patient died	10
Refused further treatment	15
Inappropriate referral	11