# Document 2 – Initial Scoping and Information Sharing Template

## Proforma for Rapid Review

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| 1. **CHILD AND FAMILY DETAILS** | | | | | | | | | | |
| **Name of child(ren):** |  | | | | | | **Date of Birth:** | | |  |
| **Child’s ethnicity** |  | | | | | | **Religion** | | |  |
| **Sex at birth (and gender identity if different)** |  | | | | | | **Disability** | | |  |
| **Associated Addresses:** |  | | | | | | | | | |
| **Family details:** | **Name** | | | **D.O.B** | | | | **Address** | | |
| **Related Adults:** |  | | |  | | | |  | | |
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| **Related Children:** |  | | |  | | | |  | | |
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| **Report prepared by:** | **Name** | |  | | | **Role** | | |  | |
| 1. **YOUR AGENCY INVOLVEMENT** | | | | | | | | | | |
| **Professional roles with child/family** |  | | | | | | | | | |
| **Name of involved professional:** |  | | | | | | | | | |
| **Date involvement started:** |  | | | | | | | | | |
| **Reason for involvement (if applicable)** |  | | | | | | | | | |
| **Summary of involvement.**  **What were the key events for your agency, and what was the impact for this child?** |  | | | | | | | | | |
| **Please comment on the voice of the child(ren) in describing their lived experience** |  | | | | | | | | | |
| 1. **INTERAGENCY WORKING** | | | | | | | | | | |
| **Which other agencies were you in direct contact with in working with this family, and was there information missing from these in your records that would have helped form a more robust assessment of need and risk?** | | | | | | | | | | |
| Agency | | State if you were in contact with this agency about this family | | | State if your notes are missing information from this agency that would have helped form a more robust assessment of need and risk | | | | | |
| GP | |  | | |  | | | | | |
| Midwifery | |  | | |  | | | | | |
| Health Visiting Service | |  | | |  | | | | | |
| School Nursing Service | |  | | |  | | | | | |
| Children & Young People Mental Health Service (CAMHS) | |  | | |  | | | | | |
| Perinatal Mental Health Community Service | |  | | |  | | | | | |
| Adult Mental Health Services | |  | | |  | | | | | |
| SWAST (ambulance) | |  | | |  | | | | | |
| A&E/Minor Injuries Unit | |  | | |  | | | | | |
| Domestic Abuse Services | |  | | |  | | | | | |
| Substance Misuse Services | |  | | |  | | | | | |
| Adult Social Care | |  | | |  | | | | | |
| Children’s Social Care | |  | | |  | | | | | |
| Early Help | |  | | |  | | | | | |
| Youth Offending Service | |  | | |  | | | | | |
| LADO | |  | | |  | | | | | |
| Police | |  | | |  | | | | | |
| Fire & Rescue Service | |  | | |  | | | | | |
| Probation | |  | | |  | | | | | |
| CAFCASS | |  | | |  | | | | | |
| Education/Childcare provider | |  | | |  | | | | | |
| Housing | |  | | |  | | | | | |
| Hospital Trust (please name) | |  | | |  | | | | | |
| Other Local Authority (please name) | |  | | |  | | | | | |
| Other agency e.g. voluntary (please name) | |  | | |  | | | | | |
| Please expand on any missing information here: | |  | | | | | | | | |
| 1. **ANALYSIS OF INVOLVEMENT** | | | | | | | | | | |
| **What has worked well?** | |  | | | | | | | | |
| **What are the learning points within your agency?** | |  | | | | | | | | |
| **What are the learning points across agencies?** | |  | | | | | | | | |

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| ***Please suggest single and multiagency actions. Actions should be SMART. The Rapid Review Panel will create a single action plan derived from all of the suggested actions. Not all suggested actions will be included.*** | | | | |
|  | **Action** | **Lead** | **Deadline** | **Progress** |
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| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |