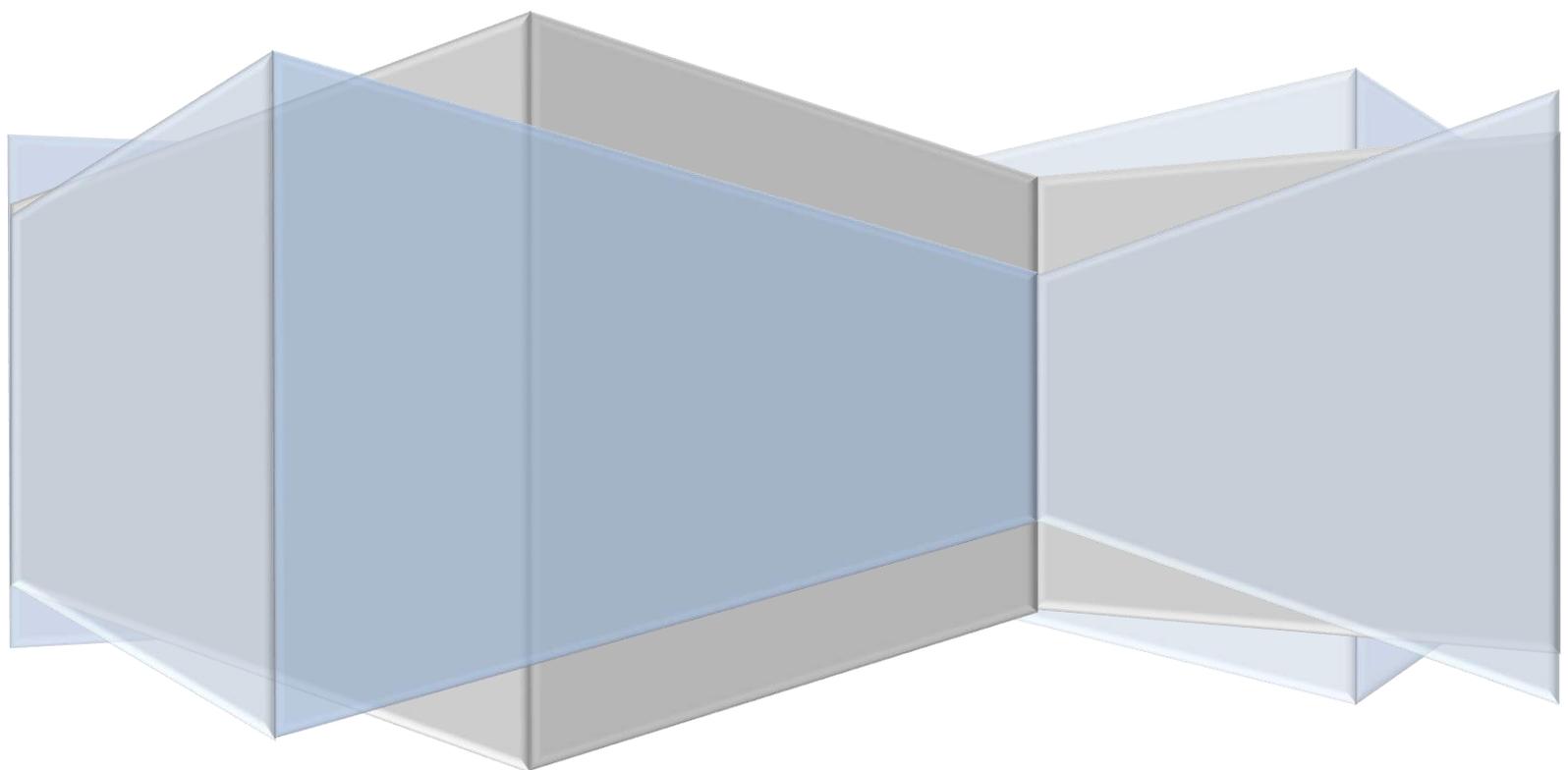


Development & Behaviour Pathway

What to do if you are worried about the development or behaviour of a child or young person in Bournemouth, Dorset and Poole.

June 2018



Development and Behaviour Pathway

Welcome to the Development and Behaviour Pathway for children, young people and families in Bournemouth, Dorset and Poole. **The pathway has been developed to help clarify the steps that should be taken when someone is worried about a child or young person's development or behaviour.**

It has been developed in partnership with parents and carers, with input from professionals working in health, education and social care and is based upon findings from local and national research as well as NICE guidelines.

A project group has been working together to develop this pathway and will continue to meet to make the changes that are required to make this pathway work in agencies and organisations across Bournemouth, Dorset and Poole.

Thank you to all those professionals, parents and carers who have given their valuable time to inform the development of this pathway. All those involved have demonstrated a real and genuine desire and commitment to improving outcomes for children, young people and their families and have given up significant amounts of their time, shared thoughts and experiences and looked for solutions all the way through the process.

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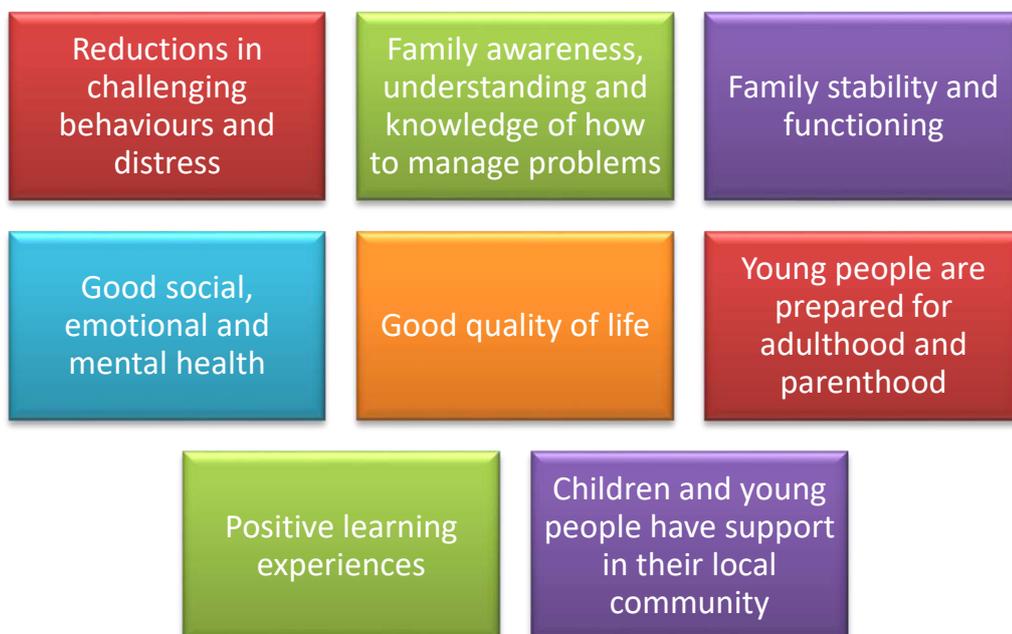
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1. Introduction

- 1.1. This pathway has been developed to support children and young people where there are concerns about their development and/or behaviours. These issues can arise for a number of reasons including social, emotional and medical, or a combination of these. Families, young people and service providers tell us that often concerns can be medicalised and that support and referrals are made too late, or to the wrong agency, which can result in delay, confusion, frustration, duplication and waste.
- 1.2. Feedback from families, clinicians and practitioners suggests that referrals to specialist services are made without adequate early support in place, as there is a perception that a 'diagnosis' is required to be able to access support. In Bournemouth, Dorset and Poole there are some support options that have historically required a diagnosis; however, this pathway aims to remove barriers and to ensure that early support is required.
- 1.3. It has been designed with input from a wide range of stakeholders from a range of different agencies. There is a strong commitment from all to improve outcomes for children, young people and families from all agencies and a recognition that prevention and early intervention can help to prevent the escalation of concerns. The desired outcomes are outlined below:



2. Principles

2.1. These principles will underpin the way we will work to ensure that there is appropriate multi-disciplinary assessment and support.

Good communication

- Strengthen and support inclusion of children, young people and families in decision making.
- Between teams and services.
- Plain English.
- Identification of a key worker at an early stage as a single point of contact.

Appropriate identification of problems

- Getting it right first time.
- Consideration of differential diagnosis.

The right intervention and/or support at the right time

- Appropriate sources of support for all, with or without diagnosis.
- Easy and quick access.
- Early help and support is available.
- Role of education professionals is clear and understood.

Multi-professional pathways – NICE compliance

- Professionals working together to reduce referrals passing between teams.
- Multi-professional involvement in assessment and diagnosis.
- Reduce duplication.

Consistency of approach

- Review processes – implement and act.
- Look at family experience of processes – share and act.
- Identification of a key worker at an early stage.

Holistic and timely assessments

- Involvement of other key professionals.
- Consideration of a range of factors.

3. Stages of the Pathway

3.1. This pathway has been designed in order to reflect the child, young person and family journey of managing concerns about development and behaviour. The graphic below sets out the key stages of the pathway. Each stage of the pathway is described in more detail in the subsequent pages.



Stage 1: Identification of issues, requests for help and sources of support

About Stage 1

This stage of the pathway seeks to ensure that:

- early intervention is put in place (at home/school/other settings) and monitored before consideration of any referral to specialist services
- any underlying medical conditions are ruled out by universal health services e.g. hearing/vision; and
- needs and concerns are discussed with the family, and child/young person themselves where appropriate.

The emphasis at this stage is on **prevention, de-escalation and providing the right support, at the right time and in the right place**. We want to ensure that when parents and families seek help they are able to find high quality information that meets their needs.

Families have identified a number of triggers for the identification of issues:

- parental or family worries as a result of comparison with other children or siblings
- pre-school or school raise concerns
- other professional concerns
- family report difficulties in managing behaviours; and
- routine checks at 10 months or 2 ½ years (the ASQs).

Professionals involved with families at this stage are well placed to help provide information, advice and guidance. The families we worked with through the project told us about the ways in which they seek help when they identify issues with their child's development or behaviour. These are described below.

Seeking help to understand and manage behaviours

Family feedback identifies the key sources of support that they use when they or another professional identifies concerns:

Pre-school

- Health Visitor*
- Nursery Nurses*
- GP
- SALT
- Children's Centres
- Social Workers

School age

- Local authority family support/early help professionals*
- Education/school professionals
- School Nurse*
- Special Educational Needs Coordinator (SENCO)*
- Social workers
- GP
- School Doctor/Paediatrician

Any Age

- Self-help
- Internet search
- Friends/family

The role of professionals at this stage

- a. Provide parent/carer and or young person information about the pathway and discuss needs and concerns.
- b. Seek consent to share information with other agencies if appropriate.

- c. Agree who will act as the lead professional/key worker. **The lead professional/key worker can be from any organisation and should be someone that is trusted by the family.** This person should support the family to access help and advice (*identifies potential professionals that could undertake this role).
- d. Undertake an assessment that identifies (as a minimum): family background and circumstances; description of parental concerns; observations; description of professional/setting concerns.
- e. Consider Safeguarding; understand other professional involvement and/or assessments already undertaken.
- f. Signpost/refer to early help and support or put early help and support intervention in place and monitor progress
- g. Ensure that underlying medical conditions are ruled out

If there is developmental regression or sudden unexplained changes in behaviour, then an immediate referral should be made to the GP to consider medical conditions which may need different interventions.

If there are concerns about emotional/mental health, e.g. suicidal intent, serious self-harm or eating disorders contact CAMHS directly to discuss. CAMHS referral criteria should be reviewed for other children where the primary concern is about mental health.

If needs or concerns persist then move to STAGE 2: On-going Support and Referral for Behaviour and Developmental Assessment

Stage 2: Ongoing support and referral for Behaviour and Developmental Assessment

About Stage 2

This stage of the pathway seeks to ensure that early support is continued and that the concerns identified at Stage 1 are clarified, collated and reviewed by the professionals involved and that the process of the referral is appropriate and managed efficiently.

Actions required before referral are outlined within the 'Pan-Dorset Development and Behaviour Referral Pack and Guidance' (Appendix 2).

Referrals need to give as full a picture of the child's difficulties as possible and should, in the majority of cases, come from health visitors or community nursery nurses for pre-schoolers, and the school SENDCO for older children. Referrals for pre-school children may be accepted from the Early Years Education Support Team, after liaison with the health visitor, and from the GP for older children, but in exceptional cases only.

Who should be referred?

- Children who present with behavioural and developmental difficulties where there is concern there may be an underlying neurodevelopmental condition and a diagnostic assessment is required.
- The difficulties should be causing an impact on the child's functioning, and should have been present for a period of time.
- Children and young people aged 0–16 years, who have a Dorset GP and who live in Bournemouth, Poole or east Dorset should be referred to the CDC at Poole Hospital NHS Foundation Trust.
- Children aged 16-18 should be referred to CAMHS (or children aged 0-15 where there is a mental health concern).
- Children and young people aged 0-18, who have a Dorset GP and who live in west or north Dorset should be referred to the Children's Centre at Dorset County Hospital.

The role of the referring professional(s) at this stage:

- a. Ensure that early support continues; this is vital.
- b. Understand the signs and symptoms of neurodevelopmental conditions that may indicate referral is needed.
- c. Draw together the information already collected to help clinicians decide on the most appropriate pathway; request new/further information if necessary.
- d. Complete referral form FULLY (included in Appendices 1 and 2 of the Referral Guidance).
- e. Support parents/carers to understand the process.
- f. Seek consent from families to share information with professional partners.

The role of receiving organisation at this stage:

- a. Offer information/advice ('Advice and guidance') to referring professionals on the most appropriate pathway.
- b. Decide on the most appropriate assessment, by the appropriate professional, if indicated.
- c. Provide information to parents/carers on the process.
- d. Signpost family to parent workshops (if not already completed).
- e. If referral is not accepted, provide rationale and advice to referring professional.

Incomplete referrals add delay or risk being returned to the referrer. It is therefore important that as much information as possible is provided at this stage.

Early practical support should be offered to family at this stage - diagnosis or clarification of need is not required to provide support.

Move to STAGE 3: The Assessment

Stage 3: The Assessment

About Stage 3

This stage of the pathway is where an assessment is undertaken by a clinician (usually a paediatrician or psychiatrist) in order to understand and clarify the needs of the child or young person. How this happens will depend on the age of the child, the nature of the concerns and the team undertaking the assessment. Pre-school and school age children will follow different pathways, and paediatricians will work in different ways to psychiatrists.

Neurodevelopmental conditions often co-exist and overlap, and it may not be immediately obvious that a particular diagnosis or diagnostic pathway is appropriate. The clinician will take a full history and perform an appropriate examination and the necessity (or not) of further assessment for a specific condition will be made. Details of some of the conditions which may be diagnosed are given in Appendix 2. As examples, autism diagnoses are made by a multi-disciplinary team which should include a clinician and speech and language therapist as a minimum; ADHD is likely to be diagnosed by a clinician with supporting information from school; developmental co-ordination disorders after assessment by physio and/or occupational therapists; attachment disorders by psychologists or psychiatrists. Liaison between different professionals may be needed and review after intervention or the passage of time may be appropriate. Good communication between families and the professionals involved, as well as between different professionals, is vital. All professionals in Dorset aim to follow appropriate guidance around diagnostic assessments, guided by NICE and other authorities and organisations. DSM-5 and ICD-10 criteria exist for many neurodevelopmental conditions, and will be the generally accepted standards for making particular diagnoses.

On-going support should be offered to the family through this stage, along with information on the process. A case co-ordinator (in many cases this will be the referrer) should be identified for every child or young person who is to have an autism diagnostic assessment, in order to act as a single point of contact for the parents or carers and, if appropriate, the child or young person being assessed. They will keep parents or carers and, if appropriate, the child or young person, up-to-date about the likely time and sequence of assessments; arrange information and support for parents, carers, children and young people AND gather information relevant to the autism diagnostic assessment.

Move to STAGE 4: The Outcome of the Assessment

Stage 4: Outcome of the assessment

About Stage 4

This stage is important in helping to ensure consistency in the management of outcomes for children, young people and their parents and carers. It is intended to help the family to understand next steps and where they can access support. It is desirable that the outcome of the assessment is shared with relevant agencies and so consent should be sought from the family to share this. No matter what the outcome of the assessment is, families, children and young people will require support to manage the issues that have been identified.

Initial feedback

The relevant clinician will meet with the parents/carers, young person and, where appropriate, child to share the outcome of the assessment, explain next steps and if relevant provide new diagnosis information. Ideally this will be a face-to-face meeting. Families should be consulted about the format of this meeting and explicitly asked if they would like to bring anyone to the feedback meeting. Clinicians should be prepared to answer questions but understand that for some families the situation may be overwhelming and ability to absorb information at this time may be limited. Therefore, the number of professionals involved in this feedback meeting should be kept to a minimum.

Information provision

Information about sources of support should be provided and new diagnosis information provided where relevant. The 'Local Offer' should be used as the main source of support and NICE have created public information leaflets about specific conditions. The NHS Choices website is a valuable resource.

Contact details for appropriate key professionals should be provided to enable parents/carers to seek support.

Information sharing

A written report outlining the outcomes of the assessment should be prepared and shared with the family, GP and key worker where appropriate as well as other appropriate professionals (where consent has been received). Any relevant referrals to other services should be made. The report should describe presenting needs and make recommendations for on-going support (where appropriate).

Move to STAGE 5: On-going support and review

Stage 5: Ongoing support and review

About Stage 5

This stage of the pathway is to ensure that on-going support is maintained for the children, young people and parents/carers. The aim is to offer high quality, evidence based, integrated services for children, young people and their families based upon need. Access to support services should not be dependent upon receipt of a specific diagnosis, but rather be based on the presenting needs of the child.

Role of the clinician

The clinician should identify any medical needs and offer a follow-up appointment where appropriate, as routine follow-up is not required for all cases. Clinicians should provide interventions and support in line with NICE guidance.

Role of the key worker

The key worker should arrange a multi-agency meeting in order to bring together key professionals to discuss the child/young person's needs and should consider:

- Revisiting key worker role to identify most appropriate person
- Clarifying the graduated offer of support in the educational setting and understand if an Education, Health and Care (EHC) Plan is required
- Agreeing an action plan reflecting the young person's and families presenting needs
- Disseminating the action plan to key professionals and working with the family (including education and children's services); and
- Act as a single point of contact.

Supporting children, young people and families

The following types of support should be available to children, young people and families depending on needs:

- Information provision
- Peer support opportunities
- Parent workshops (psycho-education)
- Specific targeted parent programmes
- Graduated offer in educational setting leading to EHC Plan where appropriate
- Early help assessment and support
- Medical support as required
- Educational psychology support as required
- Leisure activities; and
- Short breaks.

Where/when appropriate move to STAGE 6: Transition Planning

Stage 6: Transition planning

About Stage 6

This stage is to ensure that those young people that will need on-going help and support into adulthood have good support to ensure that there is effective transition through to adult services that is timely. Transition planning should commence when the young person is in year 9 or 10, or by the age of 14 years.

The role of the key worker

The key worker role should be revisited to ensure that the identified worker is the most appropriate one to undertake this role. This should be in partnership with children, young people and their families.

The key worker should:

- Co-ordinate a multi-agency meeting/discussion to develop and coordinate an action plan
- Work with key professionals to deliver the action plan
- Use a person centred approach to planning
- Consider the use of personalised budgets
- Consider plans for independence including further education, employment, training, housing
- Consider links with and use of other services e.g. sexual health, drug and alcohol, youth offending services
- Identify involvement of others e.g. children and adult's social care
- Request medical report from relevant clinician to inform planning and share with adult services; and
- If it hasn't already been completed and is required, then request a cognitive assessment (required for Fair Access to Care Services Criteria).

The role of clinicians

Clinicians should ensure that the care of young people between paediatric services/Child and Adolescent Mental Health Services and adult services is planned and managed according to the best practice guidance identified in the Department of Health's paper: [Transition: Getting it right for young people](#).

Appendix 1 – Glossary of Terms

ADHD	Attention Deficit Hyperactivity Disorder
ASQ	Ages and Stages Questionnaire
CAMHS	Child and Adolescent Mental Health Services
CDC	Child Development Centre
SALT	Speech and Language Therapy
SENDSCO	Special Educational Needs and Disabilities Co-ordinator

Appendix 2 – Pan-Dorset Paediatric Behaviour and Development Referral Pack and Guidance



Pan-Dorset
Paediatric Behaviour

Click on the icon to access