Pan-Dorset (Bournemouth, Dorset and Poole) Development and Behaviour Referral Pack and Guidance for Professionals

1. Introduction

1.1. This referral pack has been designed to provide information and advice to professionals from health, education and social care, who have concerns about the development and behaviour of children and young people under their care and are thinking about a referral to paediatric services. It contains practical advice and referral forms and should be used in conjunction with the Development and Behaviour Pathway developed locally by clinicians, professionals, parents and carers and the voluntary sector. There are some minor differences in how services are delivered by health trusts across Dorset, but referral criteria and pathways have been produced jointly, with stakeholder involvement from the outset. There is a strong commitment to improve outcomes for children, young people and families from all agencies across education, health and social care.

1.2. This document uses the term "development and behaviour" as shorthand for a variety of neuro-developmental conditions, such as ADHD, autism spectrum disorders, or developmental co-ordination disorders, or other broader developmental difficulties, which may result in a wide range of behaviours that are concerning.

2. Current Services

2.1. Currently, Poole Hospital NHS Foundation Trust provides acute and community paediatric services across Bournemouth, Poole and east Dorset, with a central hub in the Child Development Centre at Poole Hospital and clinic bases in various settings. Dorset County Hospital provides the same services for north and west Dorset, again with a central hub in the Children's Centre at the hospital and other clinics across the county. There is joint working with Dorset Healthcare (DHC), which provides speech and language therapy (SALT), Child and Adolescent Mental Health Services (CAMHS) and learning disability services. Paediatric occupational therapy services are provided by both Poole and Dorchester Hospitals. The three local authorities: Dorset, Bournemouth and Poole provide educational psychology and learning support services to schools. There is a wide range of early years support for pre-school children, including portage and additional input at nursery if appropriate.

2.2. The new CAMHS referral criteria should be consulted too, as they may provide a more appropriate service (see Appendix 6) to the child or young person and their family.

3. Background

3.1. In order for children to grow and develop to their full potential, they need to be surrounded by an environment (family, home, nursery, school) that provides rich opportunities for them to develop, communicate and learn. Most children will progress as expected, but some may find it harder and experience specific difficulties which may need additional input, sometimes from universal services and sometimes from more specialist services. Children are clearly all individuals and there will be differences between them which may not be best understood using a diagnostic framework. It is important to understand that a child's difficulties require recognition and support, **not necessarily a specific diagnosis**. Support may involve school, or nursery and child minders, as well as the family in the home setting. Integrated community children's services are a vital part of the assessment and intervention processes. Good communication between services is essential.

3.2. The majority of children presenting with behavioural and/or developmental concerns at home and possibly at nursery or school can, and should, be supported by universal services, such as health visiting (HV), school nursing (SN), nurseries and schools. Professionals who know the child should be able to provide advice, support and reassurance (where appropriate) without immediate referral to specialist services. However, for some children, particularly pre-school children, initial concerns may be of significance and referral onwards should not be delayed. It should, however, be accompanied by specific advice and an offer of further support whilst the child and family are waiting.

3.3. Local services have worked together to design an agreed referral pathway, with referral forms which trigger the collection of appropriate information, as well as advice on early intervention strategies. The new CAMHS and Speech and Language Therapy Referral Pathways (Appendices 6 and 7) sit alongside the Paediatric Community/Neurodevelopmental Pathways.

3.4. School entry is a natural time of transition and universal services provided for children change at this time. Pre-schoolers are predominantly supported by health visitors, community nursery nurses and early year's special educational needs and disability co-ordinators (SENDCOs). School age children are supported by school SENDCOs and school nurses. These professionals are well placed to make referrals and co-ordinate all the necessary information in support of this**. It is important that schools should not indicate to families that a formal diagnosis is needed to access educational support or additional funding.**

3.5. Whilst all children have access to their GP in relation to health issues, if the primary concern is about development and behaviour, then a short GP consultation slot will not enable full consideration of all relevant issues. GPs may be asked to provide additional information for the referral, if required. Referrals received by the paediatric department will be triaged by a consultant neurodevelopmental paediatrician.

3.6. Referrals may be accepted from GPs or other professionals who know the child and family in exceptional circumstances, recognising that symptoms of neurodevelopmental conditions may

not be evident in all settings and some children may be educated at home. However, it will still be necessary for information to be gathered from previous or current schools (if available) to support the referral. Reports from other professionals who know the child are likely to be very helpful and should accompany any referral.

3.7. For children who have moved into the area with an already recognised condition, as much information as possible should be sent on to the consultant neurodevelopmental paediatrician, with appropriate information sharing to ensure support is put in place at school or nursery as necessary.

4. Who should I refer?

4.1 Children who present with behavioural and developmental difficulties, where there is concern there may be an underlying neurodevelopmental condition requiring a diagnostic assessment. Further information on the conditions which can be assessed by the neurodevelopmental paediatricians can be found in Appendix 4.

4.2 Difficulties should be causing an impact on the child's functioning and should have been present and **persistent** for a period of time in different settings, although presentation may vary. There should be ongoing concern, even after early intervention/support.

4.3 Children and young people aged 0–16 years, who have a Dorset GP and live in Bournemouth, Poole or east Dorset, should be referred to the CDC at Poole Hospital NHS Foundation Trust. **Currently, children aged 16–18 with a mental health concern should be referred to CAMHS.**

4.4 Children and young people aged 0–18 years, who have a Dorset GP and who live in west or north Dorset, Weymouth or Portland, should be referred to the Paediatric Department, Children's Centre, Dorset County Hospital, unless there is a mental health concern.

Of note, further work is being undertaken to align age criteria across the county.

5. When NOT to use this pathway:

5.1. If any of the following concerns are also present, then the referrer should seek medical attention sooner, usually via the GP, rather than this pathway:

- Concerns about seizures and possible epilepsy
- Concerns about developmental regression, or loss of skills
- Concerns about physical growth
- Concerns about physical health, including headaches
- Concerns about hearing or vision, and
- Children with mental health difficulties may meet criteria for referral to CAMHS (Appendix 6).

General health concerns are not the remit of this pathway.

6. Before Referral

The following interventions and actions are expected before any onward referral. Please consider whether referral is appropriate, using the information in this pack, and follow the actions as detailed below.

6.1. Pre-school children with concerns about development and behaviour at home and/or at nursery

6.1.1. The health visitor or nursery nurse would be expected to listen to concerns from parents or carers and make an assessment of the child's needs, which would usually include an objective assessment with the appropriate 'Ages and Stages Questionnaire' (ASQ) for the child's age. The health visitor should use professional judgement at this stage to decide whether it is appropriate to offer early intervention, support with ASQ materials, Children Centre input, Early Help, parenting support, and review before considering referral. Liaison with the nursery, pre-school setting or child minders would be expected and a report requested from them. This is helpful, even if nursery do not have concerns, to build up a picture of the child's strengths and difficulties. Copies of nursery early years' assessments should be requested. Referral for a speech and language therapy assessment may be appropriate (see Appendix 7), as may a referral for an audiological assessment, though there is no need for this to be routine if the child has passed the Newborn Hearing Screening Programme (NHSP) and there are **NO** current concerns about hearing. The health visitor can refer on to the local portage service; they can notify the appropriate education authority (with a Health to Education Notification (HEN)/EA2 form) if it seems likely that the child will need a very high level of additional support at school.

6.1.2. If the nursery is concerned about a child's developmental progress, they should follow the processes of the SEND Code of Practice and, if necessary, seek support from their SENDCO. The health visitor can refer on to the local portage service; they can notify the appropriate education authority (with a Health to Education Notification (HEN)/EA2 form) if it seems likely that the child will need a very high level of additional support at school.

6.1.3. If concerns are significant at the first presentation, or persist after support, then the Pre-School Behaviour/Development Referral Form (Appendix 1) should be completed **FULLY** and sent to the appropriate community paediatrician in the east (Poole Hospital) or to the community paediatric team at Dorset County Hospital. Any referrals not fully completed may be returned for further information. (See Section 7).

6.2. School age children where there are concerns about learning, behaviour and social development at home and/or at school

6.2.1. Special Educational Needs and Disability (SEND) fall into four broad categories. Any, or all, can impact on learning, behaviour and social development. The four areas are:

- Communication and interaction
- Cognition and learning
- Social, emotional and mental health, and
- Sensory and/or physical needs.

6.2.2. Schools should follow the SEND Code of Practice:

- Assessment and identification of the child's needs
- Ensure the child has access to quality first teaching, and that a graduated approach/ response is implemented to support the child's needs
- Relevant and purposeful action and reasonable adjustments should be made and, where necessary, drawn together in an SEN support plan, and
- Review of the support should take place regularly.

6.2.3. Schools should:

- Consider whether the child's difficulties may be due to an underlying learning problem and seek advice from relevant specialists, for example, educational psychologist, SENSS, or LSS if there are significant concerns regarding cognitive ability, or specific learning difficulties, such as dyslexia
- School should ensure parents/carers have been offered an evidence based parenting/behaviour management course (e.g. Triple P, Incredible Years/Webster Stratton)
- Consider the whole context of the child's daily life and note the potential impact of family disruption, social deprivation, parental mental health difficulties and traumatic life events on their presenting behaviour
- Consider whether the child's difficulties may be due to an underlying problem with core speech and language skills and, if so, make a referral to the Speech and Language Therapy Service, according to their service referral criteria (see Appendix 7)
- Provide early support/intervention for identified needs whilst assessment continues. Support should be 'needs led' and does **NOT** require a specific medical diagnosis to have been made
- Ask the school nurse to check hearing and signpost parents/carers for vision testing at a local optician/optometrist where relevant, and
- Advise parents to take their child to the GP if there are concerns regarding physical health.

6.2.4. Support for children with identified difficulties with social communication:

- Schools should implement strategies known to be good practice in supporting social communication and interaction difficulties. These include visual approaches, structured work systems and support to develop social and emotional skills such as Social Thinking, input from an emotional literacy support assistant (ELSA) and Social Use of Language Programme etc.

- Such approaches should be implemented, monitored and evaluated in order to assess the child's response to interventions known to support children with social communication needs, and
- The Autism Education Trust produces a set of "Autism Standards" which outline good practice. Schools should aim to be meeting these standards.

7. Making Referrals

7.1. If concerns regarding the possibility of an underlying neurodevelopmental condition persist, following early support and intervention, referral to the community paediatrician should be made on Pre-school Community Paediatric Referral Form (Appendix 1, included in this pack), providing **ALL** requested information. For pre-school children, referrals would generally be expected to come from health visitors or community nursery nurses (under supervision of named health visitor), but speech and language therapists or early years SENDCOs may wish to refer directly.

7.2. For school age children, referrals should be made by the SENDCO. In exceptional cases, referrals may be accepted from GPs.

7.3. For all children, the referral form should be completed **FULLY**. Any referrals not fully completed may be returned for further information. It is essential that all available reports and assessments are included with the form. Referrals will be reviewed by a consultant neurodevelopmental paediatrician.

7.4. Ensure parental consent to share information is agreed and documented as part of the referral process. For older children and adolescents, it is good practice to let them know when a referral is made and the reasons why.

8. Support during the time of the Assessment

8.1. Schools will need to ensure they are following a graduated response to addressing the child's needs. The identification of a child's needs through school will enable appropriate educational strategies to be implemented. These, along with recommendations from external assessments, will be incorporated into the child's SEN support plan.

8.2. If there are concerns regarding social communication skills, schools should provide support through strategies such as ELSA input, Social Use of Language Programme (SULP), buddy systems, 'Circle of Friends' etc. Schools should implement positive behaviour support strategies that are known to be helpful in ASD and other neurodevelopmental conditions such as ADHD. Whilst assessment continues, support should be 'needs led' and does **NOT** require a specific medical diagnosis to have been made.

9. Other concerns

9.1. Physical skills/co-ordination

- This pathway should **NOT** be followed if there are concerns about an acute neurological abnormality (loss of motor skills, changes in personality or associated ill-health). School or health visitors should advise parents/carers to take their child to the GP.
- Information is available on the Poole Hospital NHS Foundation Trust website www.poole.nhs.uk (search 'handouts for parents') covering common co-ordination and motor skill difficulties, which may be helpful to both parents and professionals.
- Co-ordination difficulties rarely exist in isolation and can be associated with concerns about behaviour and learning. The advice given in Section 6 above should be followed.
- The child must have had the opportunity to participate in programmes that develop their physical skills e.g. Learn to Move, Move to Learn, Storycise. If progress has not been made following regular input over two school terms, the school can refer directly to Children's Therapy Services at Poole Hospital or Dorset County Hospital for the child to be seen by either an occupational therapist or physiotherapist.

9.2. Sensory issues

- Sensory issues may exist on their own, or can be associated with a variety of neurodevelopmental difficulties. There may be a manifestation of high anxiety levels often associated with autism spectrum disorders but are **NOT** diagnostic of ASD or only seen in individuals with an ASD.
- The ASD Occupational Therapy service at Poole Hospital has information regarding sensory needs on the hospital website www.poole.nhs.uk (search 'sensory integration') which schools can access. The paediatric therapists cannot see children and young people for sensory assessments unless a formal ASD diagnosis has been made.
- The paediatric therapists at Dorset County Hospital will see children and young people as part of an autism assessment to meet National Institute for Health and Care Excellence (NICE) guidelines, but only those referred directly by the paediatricians in the diagnostic team. They can offer sensory assessments, post-diagnosis, for those individuals who do not have learning needs and whose independence and function is severely impacted by sensory behaviours.
- Schools can implement programmes to support sensory integration needs e.g. sensory circuits.
- Schools can request sensory integration assessments from external agencies e.g. SENSS.

9.3. Audiology

- Services in the east of the county are provided by DHC from Shelley Road, Bournemouth. Referrals for children in whom there are concerns about hearing should be addressed to East Dorset Audiology Service, 11 Shelley Road, Bournemouth BH1 4JQ.
- In the west, Dorset County Hospital provides audiology services. Referrals should be addressed to Audiology Department, Dorset County Hospital, Williams Avenue, Dorchester, Dorset DT1 2JY.

9.4. Mental Health

- Across the county there are six core CAMHS teams and two Intellectual Disabilities CAMHS teams. These teams offer specialist assessment and treatments for children and young people with a wide range of mental health difficulties (please refer to Appendix 6 for further details).
- CAMHS are able to offer a specialist service to children aged 0–18 years who are experiencing mental health difficulties. Parent and wider family support is offered as part of the treatment plan where appropriate.
- When reviewing referrals sent to CAMHS, the presenting difficulties will be considered in relation to the **IMPACT**, **DURATION** and **CONTEXT**. There is an expectation for support to have been put in place for the child or young person and their family/carer prior to a referral to CAMHS, unless there is significant risk or the symptoms are severe. Where the mental health difficulties persist or worsen, a referral to CAMHS is appropriate.
- If the primary concern relates to a mental health difficulty for the child or young person that is impactful, persistent and/or worsening despite support in place, it would be appropriate to initiate a referral to CAMHS.

10. Data Protection

The new Data Protection Act 2018 came into force on 25 May 2018. In relation to the pathway, the following processes will be in place relating to data, communications and accountability:

- All referrals to the pathway must have the consent of the parent (this is outlined on the referral form)
- It must be made explicit to the family that part of the assessment process will require sharing of personal information across health, education and social care settings. Required permissions must be sought and all parties must be made aware. Restricted information will be clearly identifiable
- Only information that is relevant to the assessment process will be obtained and it will be made clear throughout the assessment pathway about how the information will be used
- Depending on the referral route, the data obtained throughout the assessment process will be securely stored on the relevant data systems. Parents/carers will be made aware of where the data is stored. Only clinicians with a specific need to access the information will have access, and
- Any breaches to the security of data will be taken seriously and investigated fully. There is a Data Protection Officer (DPO) in place for each trust (DHUFT, DCH and PGH) to ensure compliance with the DPA 2018.

At the time when personal data are obtained the child and/or parents/carers must be provided with all of the following information:

- The identity and contact details of the person collecting the information
- The contact details of the Data Protection Officer in the organisation
- How the data will be stored in the organisation
- The purpose for collection of the data and how it will be used

- The recipient, or categories of recipients, of the data
- How the child and/or parents/carers can request that their information be removed from records.

11. Further Information

- Dorset County Council schools can access specialist support and advice from the SENSS team based at Learning & Inclusion Services, Monkton Park, Winterbourne, Dorchester, Dorset DT2 9PS. Tel: 01305 228300. http://www.dorsetnexus.org.uk/Services/817

- For specific advice on behaviour and structuring change, further information can be found via Autism Wessex based at Parley Lane, Christchurch, Dorset BH23 6BP. Tel: 01202 483360. Email: enquiries@autismwessex.org.uk. https://www.autismwessex.org.uk/ You do not need a diagnosis to access this information.

- For specific ideas about structuring change, contact the Autism Education Trust based at National Autistic Society, 393 City Road, London EC1V 1NG. Tel: 020 7903 3650. Email: info@autismeducationtrust.org.uk. https://www.autismeducationtrust.org.uk/

Appendix 1 – Pre-School Community Paediatric Referral Form

Pre-School Community Paediatric Referral Form

All sections should be completed with as much detail as possible

If you do not have the relevant information, please discuss with the Child's HV or CNN.

Please PRINT this form and send to the appropriate paediatrician

In this version of the form, the sections will expand to accommodate the text you enter

<table>
<tr>
<td rowspan="3">Full Name and Details:

Name: Click here to enter text.

Date of Birth: Click to enter a date.

Address: Click here to enter text.

NHS Number (if known):
Click here to enter text.

Gender: Click here to enter text.

Parent/Carer Name(s):
Click here to enter text.

Other Members of the Household:
Click here to enter text.

Relationship: Click here to enter text.

Contact Number: Click here to enter text.</td>
<td>Language at Home:
Click here to enter text.

Special requirements:
(e.g. interpreter, sensory impairment)
Click here to enter text.</td>
</tr>
<tr>
<td>Education Setting /Pre-School/Childminder:
Click here to enter text.</td>
</tr>
<tr>
<td>Reason(s) for referral: (What is your clinical question?)
Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Medical Background:
(Pregnancy and birth history; significant past medical history. Hearing and vision testing if relevant. Active referrals)
Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Family and social background: (including employment, relevant health issues, social care, housing etc.)
Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Clinical Query:
(What is the clinical question? What is the background to this? What are your findings on observation/examination?)
Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Interventions and Strategies: (what has been done / offered / to be done, to support the child/family)
Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Expectation of outcome:
Click here to enter text.</td>
</tr>
</table>

Consent: **Please Note: Consent should be from a parent/carer with parental responsibility for the child.** For this referral: ☐Yes ☐No For relevant information to be shared with the appropriate professionals: ☐Yes ☐No	
Supporting information attached: (please include recent ASQs, SLT reports, nursery assessments. Please request a written report from nursery/pre-school, particularly if they have raised concerns) Click here to enter text.	
Other agencies/professionals involved (please indicate the key worker, if exists): Click here to enter text.	
Any other information or comments: Click here to enter text.	
Referrer Details: Name: Click here to enter text. Designation: Click here to enter text. Address: Click here to enter text. Contact Number: Click here to enter text. Role with the child and family: Click here to enter text.	
Referrer Name and Signature:	**Date:** Click here to enter a date.

Appendix 2 – School Age Community Paediatric Referral Form

School Age Community Paediatric Referral Form

All sections should be completed with as much detail as possible

If you do not have the relevant information, please discuss with the School SENDCO and parent(s)/carer(s). This form will need to be completed and PRINTED and sent to the appropriate paediatrician.

In this version of the form, the sections will expand to accommodate the text you enter

<table>
<tr>
<td rowspan="2">Full Name and Details:

Name: Click here to enter text.

Date of Birth: Click to enter a date.

Address: Click here to enter text.

NHS Number (if known):
Click here to enter text.

Gender: Click here to enter text.

Parent/Carer Name(s):
Click here to enter text.

Other Members of the Household:
Click here to enter text.

Relationship: Click here to enter text.

Contact Number: Click here to enter text.</td>
<td>Language at Home:
Click here to enter text.

Special requirements:
(e.g. interpreter, sensory impairment)
Click here to enter text.</td>
</tr>
<tr>
<td>Education Setting /School and School Year:
Click here to enter text.

Reason(s) for referral: (background, strengths/difficulties, impact on child/family/school, etc.)

Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Known Medical Conditions/Existing diagnoses:
(include outcomes/formulation of existing assessments if known, e.g. cognitive, mental health, social care assessments, etc.)
Click here to enter text.

Hearing Check: ☐ Yes ☐ No Date: ……..
Vision Check: ☐ Yes ☐ No Date: ……..</td>
</tr>
<tr>
<td colspan="2">Family and Social Background: (including employment, relevant health issues, social care, housing etc.)
Click here to enter text.</td>
</tr>
<tr>
<td colspan="2">Expectation of Outcome:
Click here to enter text.</td>
</tr>
</table>

Consent: Please indicate below that appropriate consent has been obtained (including consent for this referral and relevant information to be shared and a copy kept within the patient record) from **either** the Young Person aged 13+ or from the parent/carer with parental responsibility.

In accordance with the Data Protection Act 2018, Young People 13+ "have the right to make decisions for themselves unless it is shown that they are unable to make them."

Consent of Young Person 13+

For this referral: ☐Yes ☐No

For relevant information to be shared with the appropriate professionals: ☐Yes ☐No

For children under the age of 13, consent should be from the parent/carer. Please note: this should be a person who has parental responsibility.

Consent of Parent/Carer with parental responsibility

For this referral: ☐Yes ☐No

For information to be shared with the appropriate professionals: ☐Yes ☐No

Supporting Information: (please attach all relevant reports and provide an interpretation of these for the clinician)

Learning Level/Academic Progress: *Tick which boxes apply and please give specific information*

Individual learning/SEN plan: ☐ Yes ☐ No

Educational Psychologist: ☐ Yes ☐ No

SENISS/SENSS: ☐ Yes ☐ No

SALT: ☐ Yes ☐ No

Behaviour Support Services: ☐ Yes ☐ No

CAMHS: ☐ Yes ☐ No

Social Care: ☐ Yes ☐ No

Special School Outreach: ☐ Yes ☐ No

Standardised Spelling Level …….

Standardised Reading Level ……

Standardised Maths Level ……

Other (e.g. EHC plan): Click here to enter text.

Intervention/Support:

Learn to Move/Move to Learn Programme: ☐ Yes ☐ No

Completion of evidence based behaviour management/parenting programme: (please state name of the programme) Click here to enter text.

Other: Click here to enter text.

Are there any concerns regarding the child's emotional wellbeing due to external life events, family or social difficulties? ☐ Yes ☐ No

If yes, please provide as much detail as possible: Click here to enter text.

Supporting information attached: (please include reports from educational and therapy assessments)
Click here to enter text.

Any other information or comments:
Click here to enter text.

Referrer Details:

Name: Click here to enter text.

Designation: Click here to enter text.

Address: Click here to enter text.

Contact Number: Click or tap here to enter text.

Role with the child and family: Click here to enter text.

Referrer Name and Signature:	**Date:** Click here to enter a date.

Appendix 3 - Glossary

ADHD	Attention Deficit Hyperactivity Disorder
ASD or ASC	Autism Spectrum Disorder or Condition
ASQ	Ages and Stages Questionnaire
CAMHS	Child and Adolescent Mental Health Services
CDC	Child Development Centre
CNN	Community Nursery Nurses
CYP	Children and Young People, or Child and Young Person
DHC	Dorset Healthcare
DCH	Dorset County Hospital
ELSA	Emotional Literacy Support Assistant
EP	Educational Psychologist
EYFS	Early Years Foundation Stage
HEN	Health to Education Notification
HV	Health Visiting
LSS	Learning Support Services
NHSP	Newborn Hearing Screening Programme
Oromotor dyspraxia	Is a form of dyspraxia. It is also called verbal apraxia or apraxia of speech. It can be difficult to coordinate muscle movements needed to pronounce words.
SALT	Speech and Language Therapy
SEAL	Social and Emotional Aspects of Learning
SENDCO	Special Educational Needs and Disability Co-ordinator
SENISS	Special Educational Needs Inclusion Support Service
SN	School Nursing
SoGS	Schedule of Growing Skills
SULP	Social Use of Language Programme

Appendix 4 – Helpful information to support understanding around neurodevelopmental conditions

A large spectrum of neurodevelopmental conditions is recognised in children, often with significant overlap between individual diagnoses. Frequently, children may present with difficulties which **DO NOT** meet criteria for a specific diagnosis, but who would benefit from support at home and/or at school to help promote positive learning and development and prevent long-term sequelae (e.g. low self-esteem or challenging behaviour). Most children presenting with concerns about learning or behaviour are healthy, but there are some important medical conditions which should be considered. Therefore, assessment by a paediatrician may be necessary. This paediatrician should also be able to make an assessment of many, but not all, neurodevelopmental conditions.

Examples of conditions which can and cannot be diagnosed by the Community/Neurodevelopmental Paediatric teams at Poole and Dorset County Hospitals are provided below. Further information is available on the NHS Choices website https://www.nhs.uk/Conditions/Pages/hub.aspx

1. *ADHD: Attention Deficit Hyperactivity Disorder*

   This is a condition characterised by impulsivity, inattention, distractibility and hyperactivity, which must be present in more than one setting and been obvious before the age of 7 years. Most paediatricians will not diagnose ADHD/Hyperactivity in pre-school children. The first line of intervention is support for parents, with an evidence based parenting programme. Parents should be referred for this – a diagnosis is not necessary. Information from school is essential as part of the assessment for ADHD/Hyperactivity. Concerns should initially be discussed with the teacher and SENDCO. Objective rating scales will be used to provide more information. Medical treatment is an option for some children.

2. *ASD*: *Autism Spectrum Disorder*

   This is not as common as the many other causes of disordered behaviour in children – the spectrum is wide. Difficulties with interaction, communication, restricted/repetitive behaviours and interests are all part of Autism. NICE guidance recommends that diagnosis is made by a multi-disciplinary team, which should include: a paediatrician, or psychiatrist and a speech and language therapist. Autism may be recognised in a very young child, or may not become apparent until after some time in school.

3. *Attachment Needs and Trauma*

   Children who have suffered significant trauma, or have had disrupted attachments in their early life, can show difficulties in adjusting their behaviour in social situations. It can affect their learning and progress in school, as well as their social interaction skills and ability to integrate information through their senses. These children will be best seen in CAMHS, rather than paediatrics.

4. *DCD: Developmental Co-ordination Disorder*

   This was often described with the term 'dyspraxia', though the two are not strictly synonymous. It describes children who have motor skills at the bottom of the expected range – usually below the 5th percentile. Children are generally clumsy, with poor motor skills but no neurological abnormality. Gross or fine motor skills may be affected, or some children have an 'oromotor dyspraxia'. Children with Developmental Co-ordination Disorder can often have difficulties across areas of functioning, including with academic progress and social interaction. They usually have normal intellectual abilities, but their motor co-ordination difficulties may impact on their academic progress, social integration and emotional development.

5. *DLD: Developmental Language Disorder*

   This condition is characterised by moderate to severe language difficulties, in turn having a moderate to severe functional impact. It does not respond well to universal approaches and needs targeted and specialist input. A child with DLD will have ongoing significant language needs, despite early universal intervention. DLD presents in pre-school children, but is usually not diagnosed until a child is in school. A speech and language therapist would make this diagnosis. It can co-exist with other neurodevelopmental difficulties such as ADHD or Dyslexia. However, if there is a specific diagnosis associated with a language disorder for example, an ASD, Down Syndrome or a hearing impairment, the child's difficulties would be described as a 'language disorder associated with X'.

6. *Dyslexia/Dyscalculia*

   These are specific learning difficulties, affecting literacy and numeracy respectively. They often overlap with the neurodevelopmental conditions described here, but they are **NOT diagnosed by paediatricians**. Concerns about these conditions should be discussed with the school.

7. *LD: Learning Disability, can be mild, moderate (MLD) or severe (SLD)*

   In the UK, this term describes an individual with an IQ of less than 70, with some significant implications for access to services, including CAMHS and adult support. The paediatric service is not commissioned or provisioned to measure the child's IQ. Younger children with learning difficulties tend, initially, to be described as having 'global developmental delay' or 'early developmental impairment', with LD being used when it is clear there will not be significant catch-up. Psychologists can make formal assessments of IQ, but as this score is not always the most useful measure, they tend to provide different information. However, it can be essential in deciding whether or not a child meets diagnostic criteria for an ASD, or what support services they may be eligible for in child/adulthood.

8. *ODD: Oppositional Defiant Disorder and Conduct Disorder*

   These are behavioural conditions which are defined in the DSM-5 and ICD-10. They often co-exist with neurodevelopmental conditions listed here and are also associated with emotional distress, but would not be seen as primary paediatric conditions. Support for parenting and behaviour management would be the first line of intervention.

9. *PDA: Pathological Demand Avoidance*

   This is a controversial diagnosis that is neither in the American nor European classification of diagnoses. In the UK, it is generally considered to be a manifestation of Autism rather than a separate diagnosis. Dorset does not have the tools or experience to diagnose or refute this and will not be in the position to be offering any assessment regarding the question of PDA.

10. *SPD: Sensory Processing Disorder*

    Sensory Processing 'Disorder' is **NOT** currently recognised as a specific diagnostic entity. Many children with an ASD will have sensory processing difficulties, but they are not required for an ASD diagnosis and can be seen in children without Autism. The Poole Hospital paediatric and occupational therapy services are not commissioned to offer specific assessment or intervention for children with sensory processing difficulties that are not part of a diagnosed neurodevelopmental disorder. The Poole Hospital website provides information for families with concerns about sensory processing difficulties.

    The paediatric therapists at Dorset County Hospital will see children and young people as part of an autism assessment to meet NICE guidelines, but only those referred directly by the paediatricians in the diagnostic team. They can offer sensory assessments, post-diagnosis, for those individuals who do not have learning needs, where their independence and function is severely impacted by sensory behaviours.

    Dorset County Council schools can access specialist support and advice from the SENSS team based at Inclusion Services, Monkton Park; tel: 01305 228300. For specific advice on behaviour and structuring change, contact Autism Wessex; tel: 01202 483360 or enquiries@autismwessex.org.uk. For ideas about structuring change, contact the Autism Education Trust based at National Autistic Society, 393 City Road, London EC1V 1NG. Tel: 020 7903 3650. Email: info@autismeducationtrust.org.uk, https://www.autismeducationtrust.org.uk/

11. *Auditory Processing Disorder*

    This is not diagnosed by the paediatricians at Poole Hospital, Dorset County Hospital or the local Audiology Service.

12. *Sleep Disturbance*

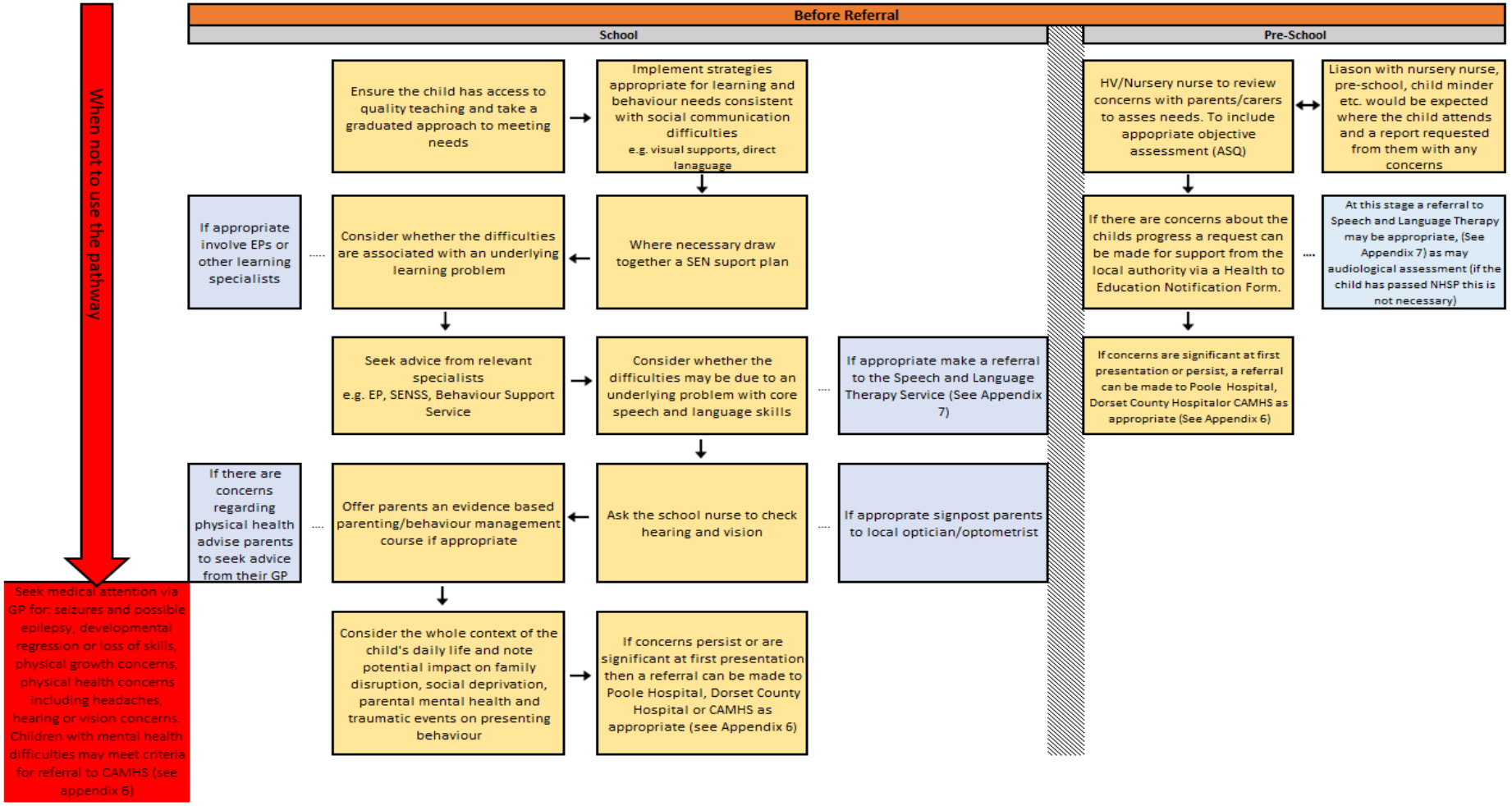
    Sleep disturbances are common in children, often as part of a broader concern about behaviour. Services which support parents to manage sleep difficulties with a behaviour approach are available through the health visiting team, or school nursing service. Services which support evidence based practice in the management of children with challenging behaviour (including sleep disturbance) are available through the Action for Children (Incredible Years Parenting) and Early Help services within each local authority. The paediatric team at Poole Hospital cannot offer assessment of children with sleep difficulties that are not part of a broader neurodevelopmental disorder. Melatonin (and other medications to address sleep difficulties in otherwise neuro-typical children) is not advised as first line intervention for sleep disturbance. The Dorset Prescribing Forum does not support provision of melatonin prescriptions for children presenting to the Paediatric Service with a sleep disturbance.

13. *Tourette's Syndrome*

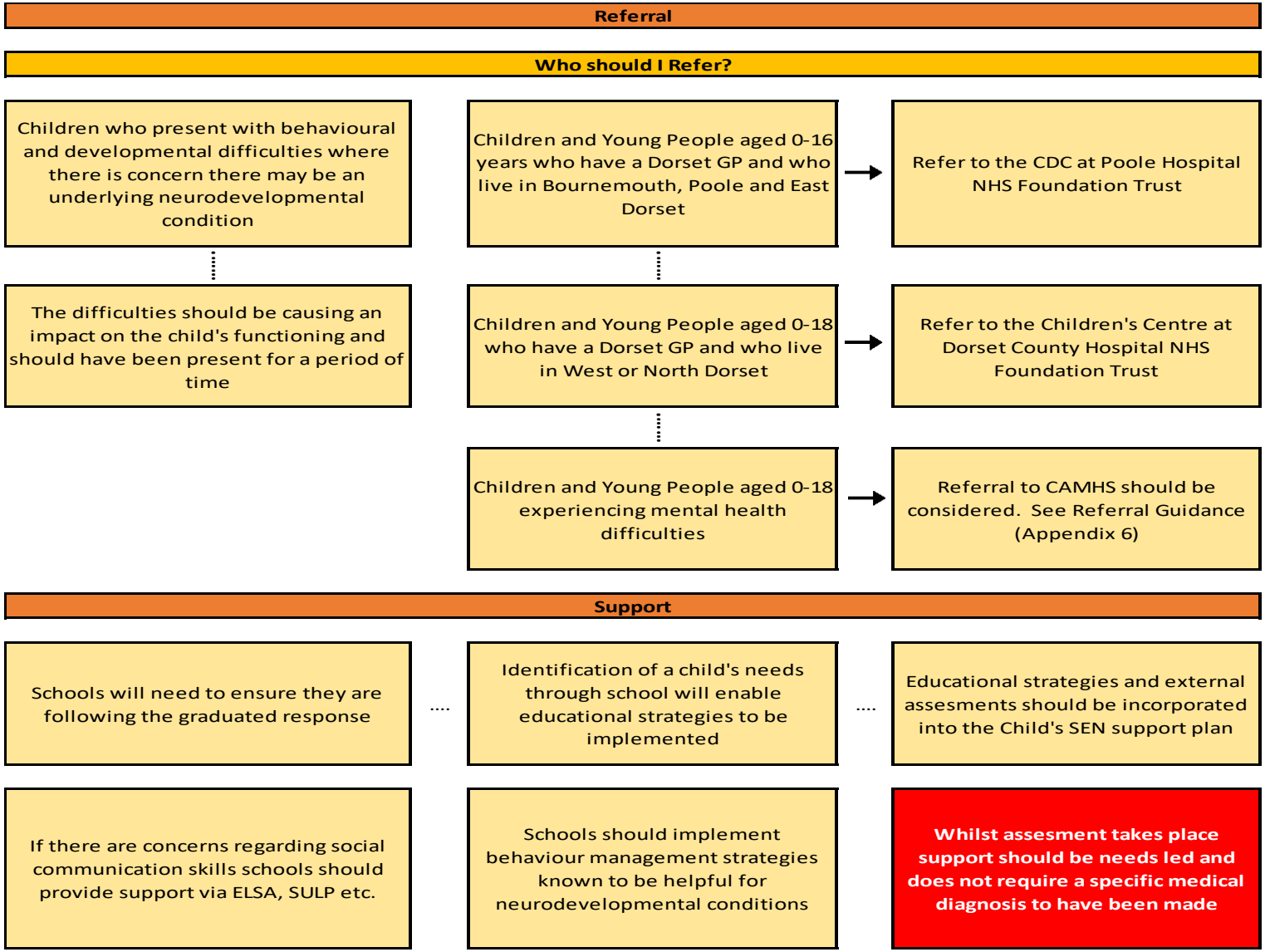
This is defined as the presence of phonic and motor tics, for more than 12 months in adults (sometimes a shorter time in children). The Great Ormond Street Hospital website has a good information sheet on this https://www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/tourette-syndrome, as does the Tourette's Action website https://www.tourettes-action.org.uk/.

Appendix 5 – Referral into Pathway

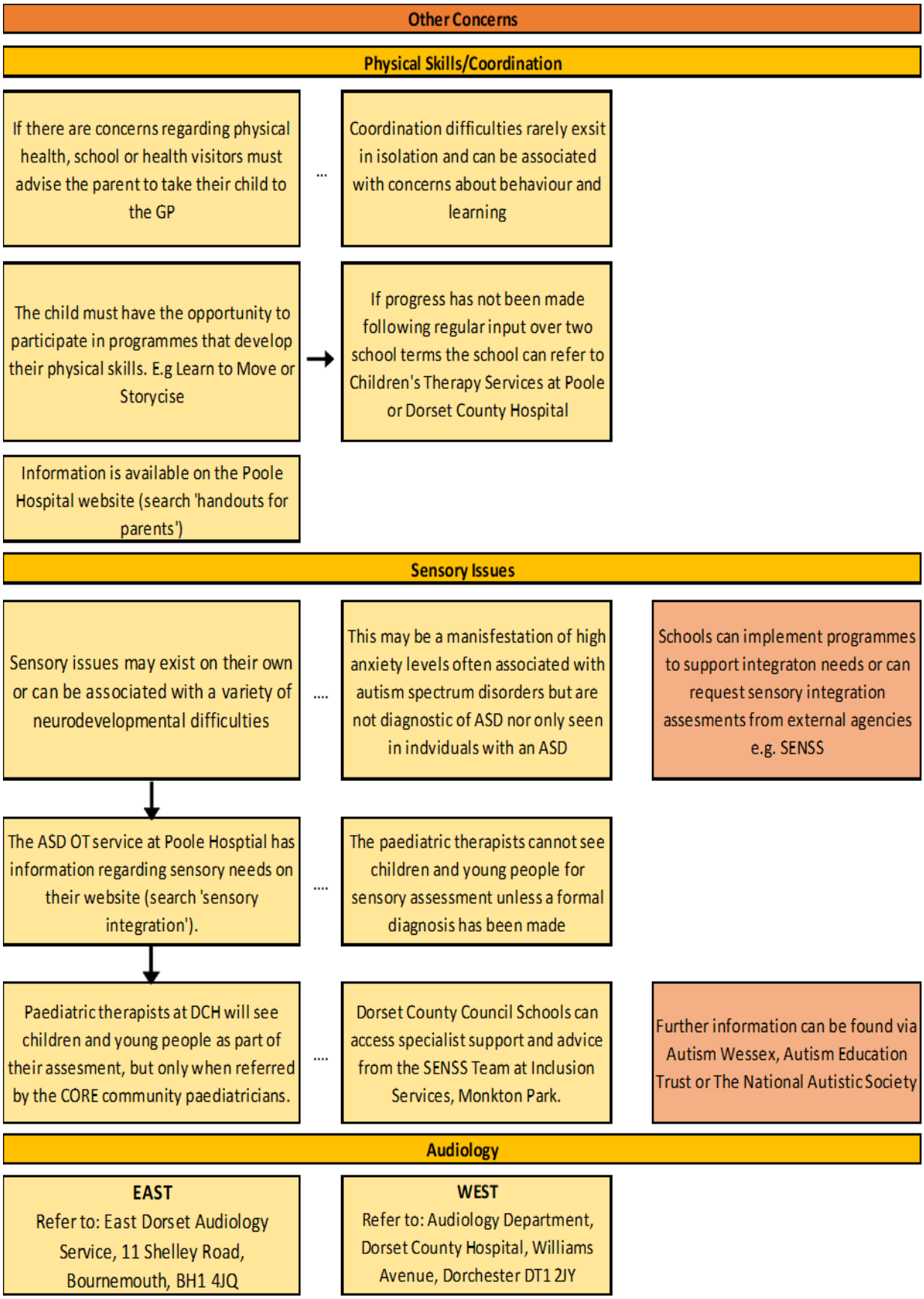
Before Referral



Referral & Support



Other Concerns – Physical Skills/Co-ordination, Sensory Issues & Audiology



Appendix 6 – CAMHS Referral Criteria and Pathway

Core Child and Adolescent Mental Health Services (C-CAMHS) Referral Support and Guidance

Appendix 7 – Paediatric Speech and Language Therapy Service Referral Pathways and Models of Care

1. Referral Pathway

- For the assessment of speech, language and social communication characteristics of importance to the diagnosis of Autistic Spectrum Disorders.
- As part of the multi-agency Pan Dorset Paediatric Neurodevelopmental and Behaviour Assessment Pathway.

1.1. Acceptance criteria (all referrals)

- Children and young people aged 0–18 years who are registered with a Dorset GP practice.
- Referrals from non-health agencies and organisations require signed parental consent.

1.2 Additional access criteria for this specific referral pathway

- For children and young people on the Pan-Dorset Paediatric Neurodevelopmental and Behaviour Assessment Pathway requiring multi-agency assessment for Autism Spectrum Disorders, in accordance with diagnostic criteria for Autism (DSM-5).

1.3 Additional exclusion criteria for this specific referral pathway

- Where the service user has been seen for ASD assessment within the last 12 months.

1.4 Referral routes and criteria

Parent /Carer	•Direct referrals are not accepted. •If the child is already under the care of the speech and language therapy service, discuss concerns with the therapist. •0-5 years (pre-school): discuss concerns with the health visitor who will assess needs and liaise with other early years agencies (i.e. nursery) and consider whether to refer for specialist speech and language assessment in accordance with the Pan-Dorset Paediatric Neurodevelopmental and Behaviour Assessment Pathway. •School age: discuss concerns with the school who will assess needs and liaise with other agencies (i.e. educational psychologist) and consider whether to refer for specialist speech and language assessment in accordance with the Pan-Dorset Paediatric Neurodevelopmental and Behaviour Assessment Pathway. For children not in school, parents to discuss concerns with the GP.
Paediatrician or CAMHS Clinician	•Referrals will be accepted if additional speech, language and communication information is required in order to make a differential diagnosis. •Referrals **will not** normally be accepted if a specialist assessment has already taken place following referral via HV or school and a report with relevant information has already been provided. •Referrals **will not** normally be accepted where behaviour is the **only** presenting difficulty. •Refer to service by electronic or e-referral or by completion of service specific referral form. A letter is acceptable if accompanied by copies of developmental history/background and other relevant clinical reports and letters. •Send by post or via secure email.
Health Visitor / GP	•Refer to Table 1 'Signs and Symptoms in Preschool Children' in this document. If criteria is met, refer to service for specialist assessment by electronic or e-referral or by completion of service specific referral form.
School	•Refer to Table 2 'Signs and Symptoms in Primary School Age Children' or Table 3 'Signs and Symptoms in Secondary School Age Children'. Refer to service for specialist assessment using specific referral form.

2. Recognition: ASD signs and symptoms in relation to speech, language and communication

The signs and symptoms in Tables 1–3 are language, social and communication skills and behaviours, focusing on features consistent with the criteria for the diagnosis of Autistic Spectrum Disorders (DSM-5). **They are not intended to be used alone**, but to help professionals who are considering the possibility of Autism to recognise when it is appropriate to involve and refer to the speech and language therapy service for specialist assessment of the child or young person's difficulties with speech, language and communication. The report detailing the outcome of the speech and language assessment (which will include any observed indicators of Autism) is to be included in any onward referral to paediatrics or CAMHS, in accordance with the Pan Dorset Paediatric Neurodevelopmental and Behaviour Assessment Pathway.

2.1 Pre-School Age Children

Table 1 - Signs and symptoms of speech, language and communication difficulties which may be possible indicators of Autism in pre-school children (or equivalent mental age)

Spoken Language
Language delay (in babble or words, for example, less than ten words by the age of 2 years).
Regression in or loss of use of speech.
Spoken language (if present) may include unusual: ○ non-speech like vocalisations ○ odd or flat intonation ○ frequent repetition of set words and phrases ('echolalia'), and ○ reference to self by name or 'you' or 'she/he' beyond 3 years.
Reduced and/or infrequent use of language for communication, for example, use of single words although able to speak in sentences.
Responding to Others
Absent or delayed response to name being called, despite normal hearing.
Not following verbal instructions to an age appropriate level.
Other signs and symptoms IN ADDITION to the above
Eye contact, pointing and other gestures
Reduced or absent use of gestures and facial expressions to communicate, although may place adult's hand on objects.
Reduced and poorly integrated gestures, facial expressions, body orientation, eye contact (looking at people's eyes when speaking) and speech used in social communication.
Reduced or absent joint attention shown by lack of: ○ following a point (looking where the other person points to – may look at hand).

2.2 Primary School Age Children

Table 2 - Signs and symptoms of Autism in primary school children (aged 5–11 years or equivalent mental age)

Spoken Language
Spoken language may be unusual in several ways: ○ very limited use ○ monotonous tone ○ repetitive speech, frequent use of stereotyped (learnt) phrases, content dominated by excessive information on topics of own interest ○ talking 'at' others rather than sharing a two-way conversation, and ○ responses to others can seem rude or inappropriate.
Responding to Others
Reduced or delayed response to name being called, despite normal hearing.
Subtle difficulties in understanding other's intentions; may take things literally and misunderstand sarcasm or metaphor.
Not following verbal instructions to an age appropriate level.
Other signs and symptoms <u>IN ADDITION</u> to the above
Interacting with others
Unable to adapt style of communication to social situations, for example may be overly formal or inappropriately familiar.
Eye contact, pointing and other gestures
Reduced or absent joint attention shown by lack of: ○ gaze switching ○ following a point (looking where the other person points to – may look at hand) ○ using pointing at or showing objects to share interest.

2.3 Secondary Age Children & Young People

Table 3 – Signs and symptoms of possible Autism in secondary school children (older than 11 years or equivalent mental age).

Spoken Language
Spoken language may be unusual in several ways: ○ very limited use ○ monotonous tone ○ repetitive speech, frequent use of stereotyped (learnt) phrases, content dominated by excessive information on topics of own interest ○ talking 'at' others rather than sharing a two-way conversation, and ○ responses to others can seem rude or inappropriate.
Interacting with others
Unable to adapt style of communication to social situations, for example may be overly formal or inappropriately familiar.
Not following verbal instructions to age appropriate level.
Subtle difficulties in understanding other's intentions; may take things literally and misunderstand sarcasm or metaphor.

3. Models of care for the assessment of speech, language and social communication characteristics of importance to the diagnosis of Autistic Spectrum Disorders (as part of the Multi-Agency Pan-Dorset Neurodevelopmental and Behaviour Assessment Pathway for Children and Young People)

Speech and language therapists are an integral part of the local multi-agency diagnostic teams for Autism Spectrum Disorders. Autism/Autistic Spectrum Disorder (ASD) is a neurodevelopmental condition, qualitatively identified by the presence of behavioural impairments: impaired social interaction, communication and social imagination.

4. Aims and objectives of the speech and language assessment of social communication characteristics of importance to the diagnosis of Autistic Spectrum Disorders

The speech and language therapist will aim to assess language, social and communication skills and behaviours, focusing on features consistent with the criteria for diagnosis of Autism (DSM-5). This will be achieved through formal assessment of core and higher level language skills and interaction with and observation of the service user. Consideration will also be given to parent's or carer's concerns, if appropriate, the service user's concerns and the service user's experiences of home life, education and social care. The assessment will also seek to identify any sensory differences and possible differential diagnosis/co-existing conditions.

A written report of findings will be provided, including recommendations to facilitate the development of communication. This may also involve advice around consideration of the environmental needs, need for routine and dislike of change, hypersensitivity to noise or textures, dislike of close proximity to others, need for rituals and other behaviours that impact on their everyday life. These needs also have implications for learning and learning environments.

5. Management of social communication characteristics relating to ASD

The management of ASD involves multi-disciplinary and multi-agency teams. Provision of care for children with ASD is across health, social services, education and the voluntary and independent sectors. There are a variety of different approaches that can improve language and communication skills in individuals with ASD. Consideration needs to be given to who delivers the intervention, for example, parents and teachers can usefully both be involved. Introducing interventions as part of a child's daily routine can also be effective.

Following the assessment, the speech and language therapist will provide a written report. This will include: observations, results of formal assessment, background information and an opinion as to whether the diagnostic criteria for Autism (DSM-5) has been met in respect of the areas relevant to speech, language and communication. Where appropriate, written advice, strategies and recommendations will be provided to parents and carers. These can be shared with schools and pre-schools.

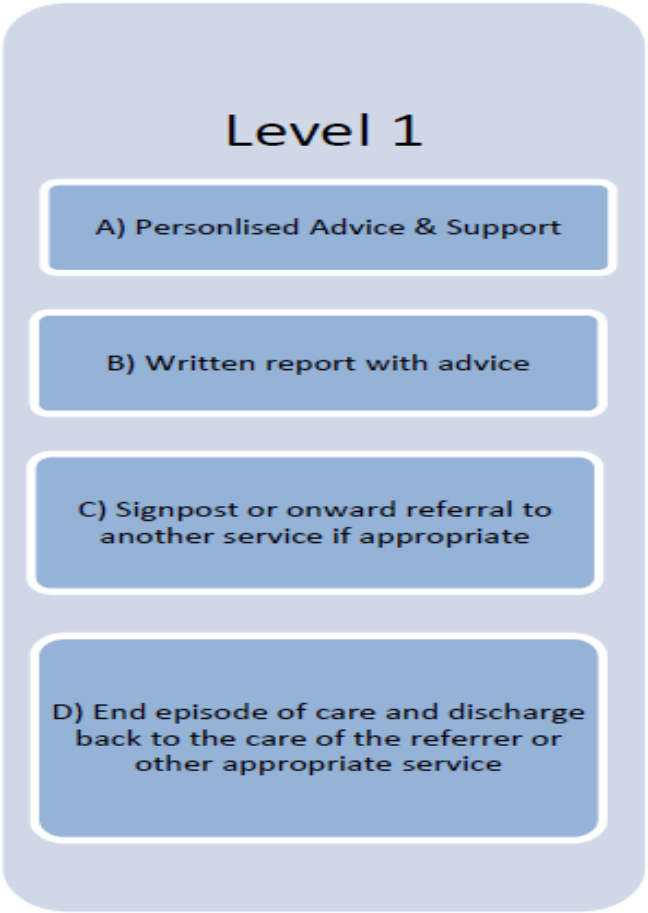
Strategies will:

- be adjusted to the child or young person's developmental level;
- aim to increase the parents', carers', teachers' or peers' understanding of, and sensitivity and responsiveness to, the child or young person's patterns of communication and interaction;
- include techniques to expand the child or young person's communication, interactive play and social routines;
- include age appropriate play-based strategies to increase joint attention, engagement and reciprocal communication in the child or young person.

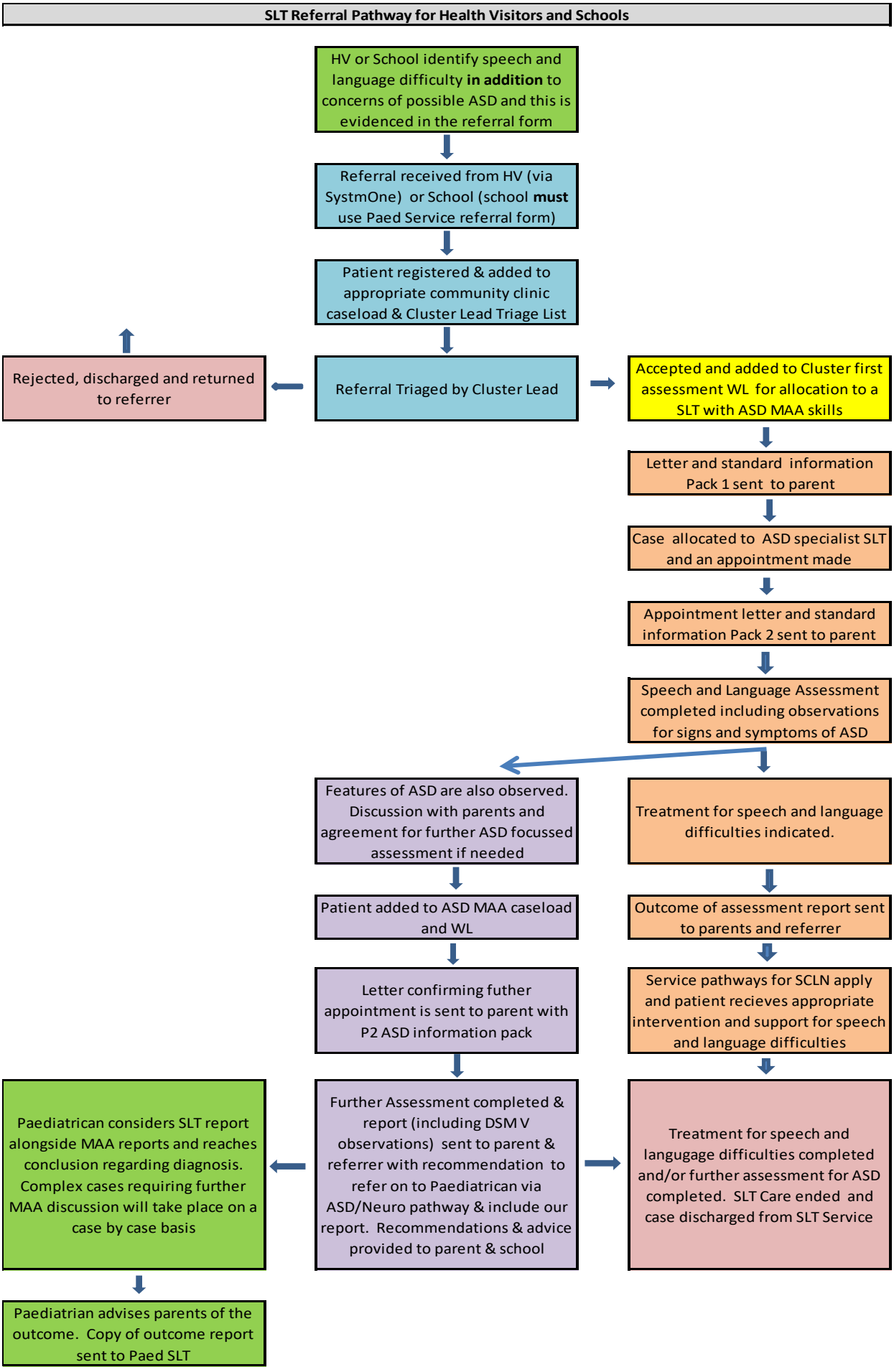
The overall outcome of the multi-agency assessment is fed back by the paediatrician or CAMHS clinician to the parents/carers/young person and the other agencies. They will also provide information about Autism and its management and the local support available.

6. Delivery Models for assessment of speech, language and social communication characteristics of importance to the diagnosis of Autistic Spectrum Disorders (as part of the agreed Multi-Agency Pan-Dorset Paediatric Neurodevelopmental and Behaviour Assessment Pathway)

Provision for this pathway will be at Level 1 (see below). The assessment appointment for this pathway will be with a qualified specialist SLT in an appropriate community setting. If speech and language difficulties are identified, the service user will be transferred to the appropriate community service pathway for further support. Where no further speech and language therapy intervention is indicated, the service user will be discharged to the care of the referrer.



7. SLT Referral Pathway for health visitors and schools



8. Referral Pathway for paediatrician or CAMHS clinician