NOTTINGHAMSHIRE
CHILDREN'S TRUST

NOTTINGHAMSHIRE COUNTY MULTI-AGENCY PATHWAY TO SUPPORT CHILDREN AND YOUNG PEOPLE WITH CONCERNING BEHAVIOURS

TOOLKIT

www.nottinghamshire.gov.uk/concerningbehaviourspathway

1. Prevention, recognition and clarification of need/concerns and early interventions

2. Early support and possible assessment

3. Assessment

4. Outcome of assessment

5. Ongoing support for child and family

6. Transition to adulthood

Glossary of Terms

CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CC	Children’s Centre
CCG	Clinical Commissioning Group
CYP	Child/Young Person
EI	Early Interventions
EHAF	Early Help Assessment Form
EHC	Education Health and Care Plan
EHU	Early Help Unit
EP	Educational Psychologist
EPS	Educational Psychology Service
FACS	Fair Access to Care Services
GP	General Practitioner
HV	Health Visitor
KW	Key Worker
MAM	Multi-Agency Meeting
MAT	Multi-Agency Team
MDT	Multi-Disciplinary Team
NICE	National Institute for Health and Clinical Excellence
NUH	Nottingham University Hospital Trust
OT	Occupational Therapist
PHCT	Primary Health Care Team
PSED	Personal, Social and Educational Development Team
SCS	Social Care Staff
SEN	Special Educational Need
SEND	Special Education Needs/Disability
SENCO	Special Educational Needs Coordinator
SFHT	Sherwood Forest Hospital Trust
SLT	Speech and Language Therapist
SN	School Nurse
SPA	Single Point of Access (Nottinghamshire Health Partnerships)
TAC	Team Around the Child
TS	Targeted Support
YOS	Youth Offending Service

Introduction

Welcome to Nottinghamshire County's multi-agency pathway to support children and young people with "concerning behaviour". Concerning Behaviour or put more simply 'behaviour that is concerning' can arise for many different reasons which could be social, emotional or medical – or indeed, a combination of all - or any of these factors. Families, young people and service providers tell us that too often concerns can be medicalised and that support and referrals are made too late or to the wrong agency which results in delay, confusion, frustration, duplication and waste. Frequently, referrals to specialist services are made without early support being put in place first due to a popular myth that a 'diagnosis' is required in order to access support (see toolkit resources for an information sheet on diagnosis and support).

This pathway has been developed in partnership between a broad range of agencies to ensure that the reasons for concerning behaviour are fully explored and that ***the right support is available at the right time and at the right place.*** It aims to prevent preconceived ideas about a child's problem being made, and dispel emphasis on diagnosis rather than support. In particular, it aims to focus on prevention and early intervention approaches – avoiding escalation of concerning behaviours and or crisis management where possible. It ensures appropriate and timely multi-disciplinary assessment and support, and ensures ongoing care planning and support for children and young people and their family/carers - including transition to adulthood - to improve outcomes. It coordinates involvement between different agencies and promotes partnership with parents and children/ young people.

Early intervention is defined as "intervening early and as soon as possible to tackle problems emerging for children, young people and their families, or with a population most at risk of developing problems". Early intervention is a process and may occur at any point in a child or young person's life. In Nottinghamshire, the ambition is for early intervention and prevention services to be in place at the earliest opportunity, ensuring that children, young people and their families receive the most appropriate support to meet their needs, in order to ensure better outcomes and the cost effective delivery of services (Pathway to Provision).

The pathway is informed by NICE guidance and has been endorsed by Nottinghamshire Childrens Trust Board and NHS Nottinghamshire County's CCGs - thus demonstrating commitment from all partner agencies. The pathway supports children and young people aged 0-19 years, and up to 25 years where an Education and Health Care plan (EHC) is in place.

The County's pathway and this toolkit mirror and reflect nearby approaches in Bassetlaw and Nottingham City. By adopting similar approaches each area is making a commitment to promote cohesion and consistency for service users and workers whilst retaining a unique local focus.

The pathway has 6 stages. This Toolkit provides guidance and resources for professionals, workers and families to facilitate implementation. It is underpinned by the following integrated strategies, guidance and principles which should be applied throughout;

- Early intervention
- Nottinghamshire safeguarding policies and procedures
- Nottinghamshire County pathway to provision

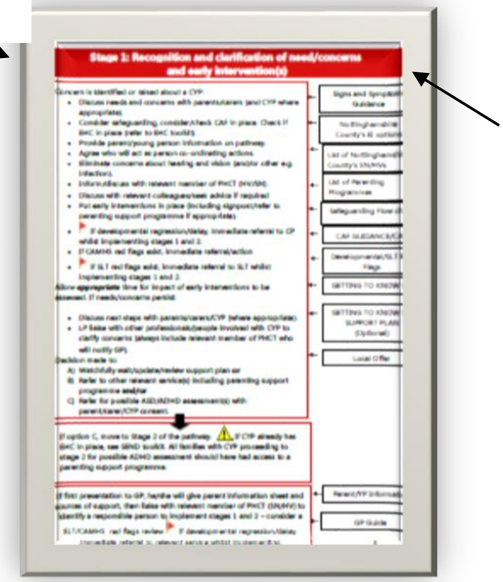
- A primary health care referral approach
- Multi-agency working
- Findings from the SEND pathfinder and the new EHC plan pathway.

The toolkit is supported by an on-line webpage hosted via Nottinghamshire County Council. This can be accessed at www.nottinghamshire.gov.uk/concerningbehaviourspathway

How to use the Toolkit

The toolkit takes you through the six stages of the pathway, step by step. Each stage starts with an algorithm in which the coloured boxes on the left hand side give details of the actions that need to be taken, whilst the black boxes on the right refer to specific tools and resources available to workers and families.

Text in the coloured left hand boxes detail actions to be taken.



Stage 1: Recognition and clarification of need/concerns and early intervention(s)

The black boxes on the right denote tools and resources available at the webpage.

Each stage is accompanied by detailed written guidance. Areas of particular importance where you may need to take specific issues (caution) into account or take specific actions (red flag) are identified by the following symbols:

⚠ **Caution**

🚩 **Red Flag**

A separate, quick reference guide for General Practitioners is also available at www.nottinghamshire.gov.uk/concerningbehaviourspathway

Understanding roles and responsibilities within the Pathway

There is a clear expectation in Nottinghamshire County that an individual identifying concerns about a child's behaviour will discuss these with the family (and child where appropriate). Similarly, families who have concerns are encouraged to speak to someone who is involved with their child on a day to day basis (e.g. nursery nurse, teacher). Together, they will agree who will be the **key worker** (KW) to explore concerns and implement stages 1 and 2 of the pathway. The key worker should be someone who has direct and regular contact with the child/young person and family/carers and who is most relevant to their needs at any given stage in the pathway. It is a flexible role and may/should transfer to a different person at different stages of the pathway or the child's journey. However **it must always** be agreed, clearly documented and shared with the CYP and parents/carers who this person is.

If a formal request for support from the Early Help Unit is made using the Early Help Assessment Form (EHAF – formerly CAF Form), a Lead Professional will be identified to coordinate activities in line with Pathway to Provision.

Data collection

Agencies involved in the pathway will, over time, be required to collect and report baseline and ongoing data (including incidence/prevalence) to commissioners to help monitor activity and aid evaluation for each stage of the pathway they are involved in. This will be developed with individual agencies through strategic commissioning routes.

Stage 1: Recognition and clarification of need/concerns and early intervention(s)

Concern is identified or raised about a CYP:
Provide parent/young person information on pathway and discuss needs and concerns with parents/carers (and CYP where appropriate).
Agree who will act as key worker co-ordinating actions.
Consider safeguarding, check if CAF/EHAF in place/consider. Check if EHC plan in place (refer to EHC toolkit).
Eliminate concerns about hearing and vision (and/or other e.g. infection).
Explore the concerning behaviours using the mind map available in the toolkit if necessary.
Discuss with relevant colleagues/seek advice if required.
Inform/discuss with relevant member of PHCT (HV/SN).
Put early interventions in place (including Springboard, signpost/refer to parenting support programme and/or SLT if appropriate) (see the local offer and useful resources/links).

🚩 If developmental regression/delay, immediate referral to GP whilst implementing stages 1 and 2. If increased concerns about emotional health e.g. suicidal intent/self-harm contact CAMHS directly to discuss any increased concerns regarding a child whilst implementing stage and 2 of the pathway.
Allow ***appropriate*** time for impact of early interventions to be assessed.
If needs/concerns persist:
Discuss next steps with parents/carers/CYP (where appropriate).
KW to liaise with other professionals/people involved with CYP to clarify concerns using Getting to Know Me form or EHAF (always include relevant member of PHCT who will notify GP).
Decision made to:
Watchfully wait/update/review support plan **or**
Refer to other relevant service(s) including Early Help Unit parenting support programme (see Local Offer) **and/or**
Refer, if indicated for possible ASD/ADHD assessment(s) with parent/carer/CYP consent.

Safeguarding Flow chart

Notes on Educational Provision

EHAF GUIDANCE/CAF

ASD/ADHD Guidance

Nottinghamshire County's SN/HVs

Early Interventions ideas/Local Offer

Information for Families

EHC Toolkit

Statement on diagnosis and funding

↓

If option C, move to Stage 2 of the pathway. ⚠ If CYP already has EHC plan in place, see EHC toolkit. All families with CYP proceeding to stage 2 for possible ADHD assessment should have had access to a parenting support programme (See Local Offer).

EHAF GUIDANCE/CAF

If first presentation to GP, he/she will give parent information sheet and link to sources of support/Local Offer, then liaise with relevant member of PHCT (SN/HV) to identify a key worker to implement stages 1 and 2. If red flags 🚩 immediate referral to relevant service whilst implementing stages 1 and 2.

GP Guide

About Stage 1:
Stage 1 of the pathway ensures;

- any underlying factors such as hearing/vision and or medical conditions are ruled out
- needs and concerns are discussed with the family/carers and CYP (as appropriate)
- early interventions are put in place (at home and at school/other settings) and monitored before referral to any specialist services (unless red flags are evident).

The emphasis is on prevention, de-escalation and providing the right support, at the right time and in the right place. There are a broad range of options for support at this early stage – helping organisations, workers and families increase skills and confidence in supporting young people. **The Local Offer details services/support and agencies available.** http://nottinghamshire.sendlocaloffer.org.uk/. **Similarly the concerning behaviour pathway webpage has information on a range of options available in the county.** www.nottinghamshire.gov.uk/concerningbehaviourspathway. **The Early Help Unit is a valuable source of signposting and information.**

The key worker should check if the EHAF/CAF is in place and, if not, whether this should be initiated (see CAF/EHAF guidance on the webpage for more information).

Remember, at Stage 1 children may present for a range of reasons. Information gathering and clarification of concerns will ensure appropriate support and interventions are put in place. Review of the impact these have will help to clarify whether further referral/assessment is appropriate. **Referral for assessment for ASD/ADHD should only be made to specialist services where there is a medical or emotional health need and/or it is in the interests of the CYP – not merely for diagnosis.** Many children with concerning behaviours and/or additional needs may well be best supported in their everyday environments, or by referral to the Early Help Unit.

The monitoring period will need to be determined on an individual basis. Each case should be looked at individually on its own merits as one size will not fit all in this early stage. Some children will move rapidly through the early stages of the pathway. Others may respond well to early interventions and support and will not need to continue beyond Stage 1 or 2.

It is important to note that the needs of adults in a household and the social and environmental factors which may be impacting on the CYP's behaviour/ development should be considered when planning early interventions.

If stage 1 is initiated outside of primary care settings, the GP may also wish to review the CYP at the point when early interventions are initiated.

If red flags are evident, the GP should always be contacted to consider an immediate referral to the relevant service (with family consent) whilst stages 1 and 2 are initiated.

Red flags for referral to community paediatric services include developmental delay, developmental regression, sudden, unexplained changes in behaviour.

Children expressing suicidal intent, self-harm or signs of eating disorder should also be referred directly to CAMHs whilst stages 1 and 2 are initiated.

If, despite implementation and monitoring of early intervention strategies, a CYP continues to experience moderate difficulties the key worker should coordinate actions through Stage 1 and 2 of the pathway. This involves gathering information and recording on the **Getting To Know Me form** (or EHAF/CAF if in place/desired) and may include liaison with Health Visitors, early years staff (Children's Centres and Education), child care providers, Social Care Staff , Special Educational Needs Coordinators (SENCOs), teachers, School Nurses, youth workers and GPs (and others) as appropriate. The key worker should review this information with the family and decide on the most appropriate course of action/support in conjunction with relevant professionals (e.g. HV/SN).

Should assessment for ASD/ADHD be considered necessary, a request for referral should be made accompanied by the Getting to Know Me Form (or EHAF if in place). The GP will review this information and decide on the most appropriate course of action.

Should referral for ASD/ADHD assessment **not** be considered necessary/in the interests of the child, but moderate difficulties remain, consider with family consent, making a request for support to The Early Help Unit using the EHAF.

If the key worker is not a member of the PHCT, they should always liaise with the most appropriate member, such as the Health Visitor or School Nurse in order to ensure that the GP is aware/involved at this stage.

If initial presentation is to the GP, s/he will liaise with the appropriate health professional (Health Visitor/School Nurse) to request support in identifying a key worker to initiate stages 1 and 2 (see webpage for a current contact list). If a CYP displays red flags, immediate referral to the relevant service should be made whilst ensuring early interventions are implemented and concerns clarified in line with the pathway. To help Primary Care in this action, information for parents and a quick primary care guide is available to download on the webpage.
www.nottinghamshire.gov.uk/concerningbehaviourspathway

The key worker should be the most appropriate person working with the CYP. For pre-school children this is likely to be: Early years staff (Children's Centre and Education). For the school aged CYP this is likely to be the person who identifies the concern, for example the teacher, SENCO, member of Social Care staff or youth worker. If other agencies are not involved in early years, this could be undertaken by the Health Visitor.

This multi-agency approach will ensure that early interventions are implemented and support is in place, and, that any referrals are timely and appropriate. It ensures the GP has medical, educational, social and safeguarding history to inform his or her decision whether to refer a CYP to relevant service. Where SystmOne is used please consider use 'share' to facilitate multi-agency working.

Consent to move through the pathway and share information should be gained from parents/carers and/or young person where appropriate.

PLEASE NOTE: A diagnosis is not required in itself to access either support in education or an EHC plan and may not be in the long term interests of the CYP.

"You need a diagnosis to be able to get support in schools" is a phrase often heard – it is also cited as a reason why parents/carers may push for diagnosis – which is not always in the long term interest of a child. It is, although commonly cited, not true – a myth.

Families and professionals have asked for clarification about what support children can get in school. We have listened to this request, and, as a consequence, developed this short statement to provide clarity.

"If a child has a medical diagnosis, a school needs to take this into account when it plans provision to meet the child's educational needs. Educational law however, specifies that schools have a responsibility to identity and make provision for a child's educational needs whether or not they have a medical diagnosis".

If a child is experiencing difficulty in their educational setting, families can expect the following;

The classroom teacher would talk to parents/family and in partnership agree strategies which need to be put into place. The classroom teacher may discuss this with the school Special Educational Needs Coordinator (SENCO), or, with your consent, other experts for advice. These ideas are usually recorded on an Individual Education Plan (IEP) and reviewed, typically on a termly basis, or, more frequently if needed. Families can reasonably accept that the school would work in partnership with them, and be clear with them about what they are doing to support a child, and what success would look like.

If difficulties continue, then the school may ask for additional advice and guidance - usually through the Family of Schools Springboard meeting. This is where a group of professionals from both within schools and from the Local Authority meet to agree how best to support children. These meetings not only find help to find ways forward with particular children, but also support the longer term development of schools' practice with children with SEND.

As a result of recent changes to SEN funding introduced at a national level, there is greater consistency and clarity about what it is reasonable to expect of schools. In the first instance, every state funded mainstream school is expected to put in place up to £6,000 of targeted support per year for a child with special educational needs (with or without a diagnosis). This is on top of whatever is made available to all pupils at the school.

If, despite this level of funding, more needs to be done to help a child in school, then the school can approach it's Family of Schools to request additional money (again, with or without a diagnosis). This is known as Additional Family Needs funding (AFN). Currently, in most Families of Schools this additional money can, depending on need, provide up to £8,000 worth of support per child on top of the £6,000 the school would already be contributing.

For a small number of children in the county, even more support is needed. In these cases where the school and AFN funding hasn't provided enough help, the school applies directly to the Local Authority's High Level Needs panel (HLN). This panel moderates requests for funding across the whole of the county. Whilst some of these children may have a statement, and/or a diagnosis, neither of these is needed for the school to apply for HLN funding; the HLN panel makes it's decision by matching the child's needs against commonly agreed descriptors.

Schools are asked to present their case for extra funding with reference to descriptors set out in a document called "Arrangements for accessing top-up funding for pupils with special educational needs and disabilities in Nottinghamshire mainstream schools", rather than the decision being reliant on a diagnosis. This document is available at www.nottinghamshire.gov.uk/concerningbehaviourspathway
The HLN panel is single panel across the county and consists of school representatives (SENCOs, Family SENCos, head teachers) as well as LA specialist staff and health representatives. Their collective decision draws on the information provided by the school, their own expertise, and case precedents. For children where AFN or HLN funding is being sought, schools are required to produce what is called a 'Provision Map' which describes in detail how the school proposes to use the funding.

Increasingly, schools have freedom to use any additional funding in a range of ways and not simply by the provision of additional teaching assistant (TA) support. Best practice would suggest that any individual pupil interventions (such as TA support) are most effective when implemented within context of a whole school approach. See below for some useful links. Where schools need advice on the elements of such a provision map, or how best to support a child then they can access this help from LA support services, namely the Schools and Families Specialist Support Service (SFSS), and Educational Psychologist service - either directly, or preferably, through the Family of Schools Springboard meeting.

Some childrens needs are so complex that specialist placement is required to meet the child's educational needs. Currently, a child requires a statement/EHC plan to be able to access this provision. Statements will be replaced by Education, Health Care Plans in 2014, which also do not need a diagnosis. Again, this is based on an understanding of a child's needs, and a diagnosis is not required. Wherever possible, and where a parent wants it, funding and provision is made available to support children in mainstream educational settings.

The above applies to all state funded mainstream schools including academies.

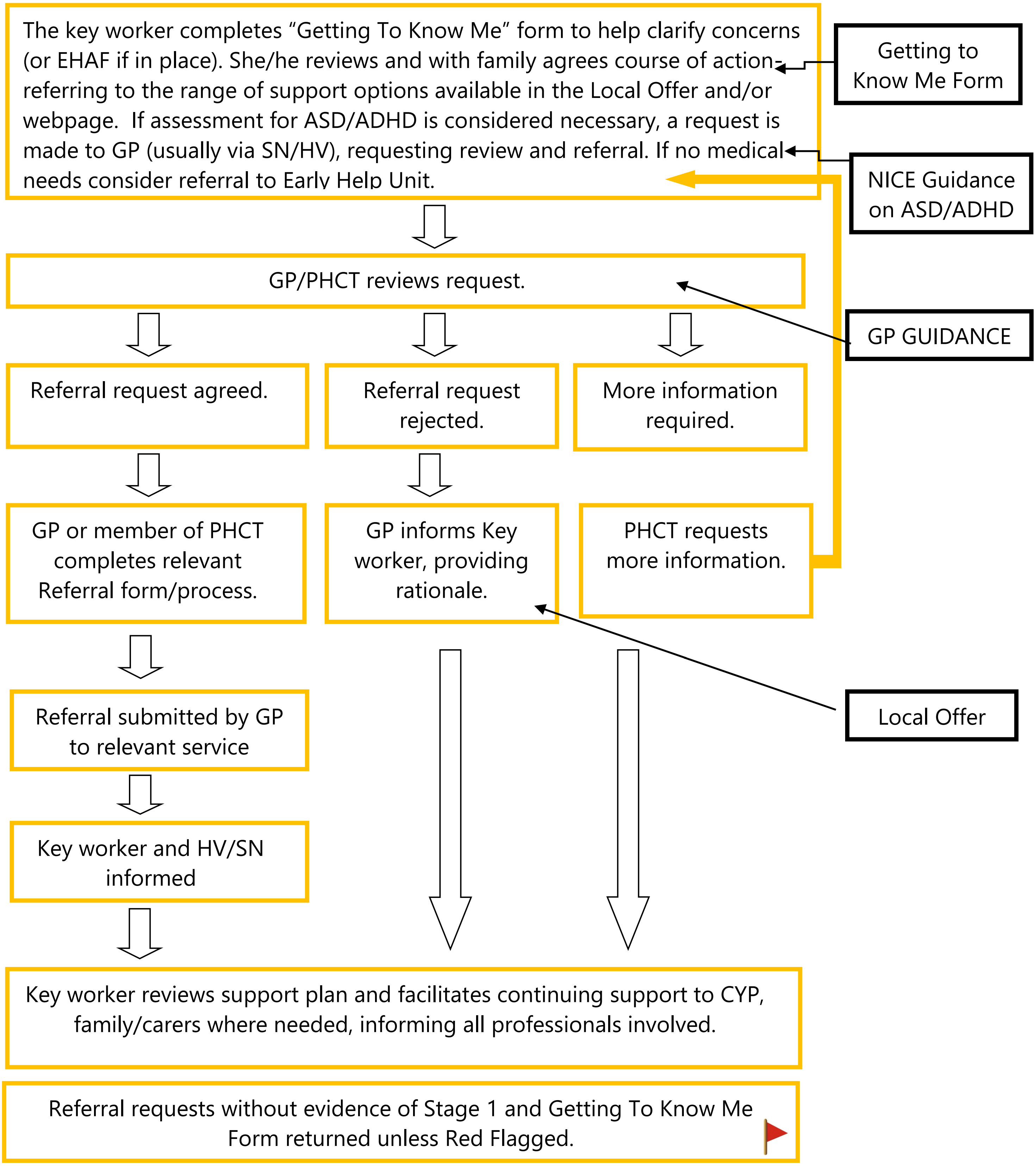
Standard Approaches to Education Provision

All schools have got a responsibility to provide good quality teaching for all students. It is a reasonable expectation that all teachers will 'flex' or adapt their teaching around those pupils for whom universal quality teaching for all is insufficient for good learning to take place. Most reasonable adjustments will take place in the classroom and broader school setting, facilitated or led by the classroom teacher and school team. In a small number of cases, a classroom teacher may work with the schools SENCO (Special Educational Needs Coordinator) to determine if any additional strategies can be made to support a child's learning - sharing these approaches with the child and family.

Just as the classroom teacher may look to their SENCO to support their thinking about how best to support a child, the SENCO is able to, and may develop their thinking by discussing how best to support a particular child at a 'Family of Schools Springboard meeting'. These meetings are a source of expert advice. They include not only other SENCOs but specialist support services such as Educational Pyschology and Specialist Teachers. All of this would be a standard precursor to implementing stage 2 of the Nottinghamshire County Multi-Agency Pathway.

Education providers are encouraged to apply the pathway principles when supporting children and young people in these early stages. In particular, to think holistically about a child and family outside of the school setting. For further information see the pathway toolkit and resources at www.nottinghamshire.gov.uk/concerningbehaviourspathway

Stage 2: Ongoing support and referral



The key worker completes “Getting To Know Me” form to help clarify concerns (or EHAF if in place). She/he reviews and with family agrees course of action- referring to the range of support options available in the Local Offer and/or webpage. If assessment for ASD/ADHD is considered necessary, a request is made to GP (usually via SN/HV), requesting review and referral. If no medical needs consider referral to Early Help Unit.

Getting to Know Me Form

NICE Guidance on ASD/ADHD

GP/PHCT reviews request.

GP GUIDANCE

Referral request agreed.

Referral request rejected.

More information required.

GP or member of PHCT completes relevant Referral form/process.

GP informs Key worker, providing rationale.

PHCT requests more information.

Local Offer

Referral submitted by GP to relevant service

Key worker and HV/SN informed

Key worker reviews support plan and facilitates continuing support to CYP, family/carers where needed, informing all professionals involved.

Referral requests without evidence of Stage 1 and Getting To Know Me Form returned unless Red Flagged. 🚩

About Stage 2:
Stage 2 ensures that early support is continued and that the concerns identified at Stage 1 are clarified, collated and reviewed by the PHCT/GP, and that the process of referral is appropriate and managed efficiently.

The key worker should review the information gathered with the family and other appropriate professionals and decide on next steps.

All referrals for ASD/ADHD will be authorised by the GP. The GP/PHCT will review the Getting to Know Me Form - referring to guidance on ADHD/ASD signs and symptoms and the Local Offer.

If the information provided is not indicative of ASD/ADHD, but concerns issues related to challenging behaviour, referral should be considered to a relevant services – notably The Early Help Unit using the EHAF (see the Local Offer). If more information is required, the PHCT/GP will discuss with parents/carers and request the relevant information from the key worker. Once received, they will review the request again. Support to the CYP should be maintained throughout this process.

If the decision is not to refer, or to continue to watchfully wait, the GP will discuss with parents/carers and inform the key worker plus HV/SN, requesting appropriate support to the CYP is maintained throughout this process.

At stage 2, check if a EHAF is in place and, if not, whether one should completed (see EHAF guidance on the ADHD/ASD pathway webpage). Where SystmOne is used please consider use 'share' to facilitate multi-agency working.

Consent to move through the pathway should be gained from parents/carers.

IMPORTANT NOTE: Incomplete referrals for possible ADHD/ASD assessment will be returned to the PHCT - although if red flags are evident, the referral will be processed whilst further information is gathered.

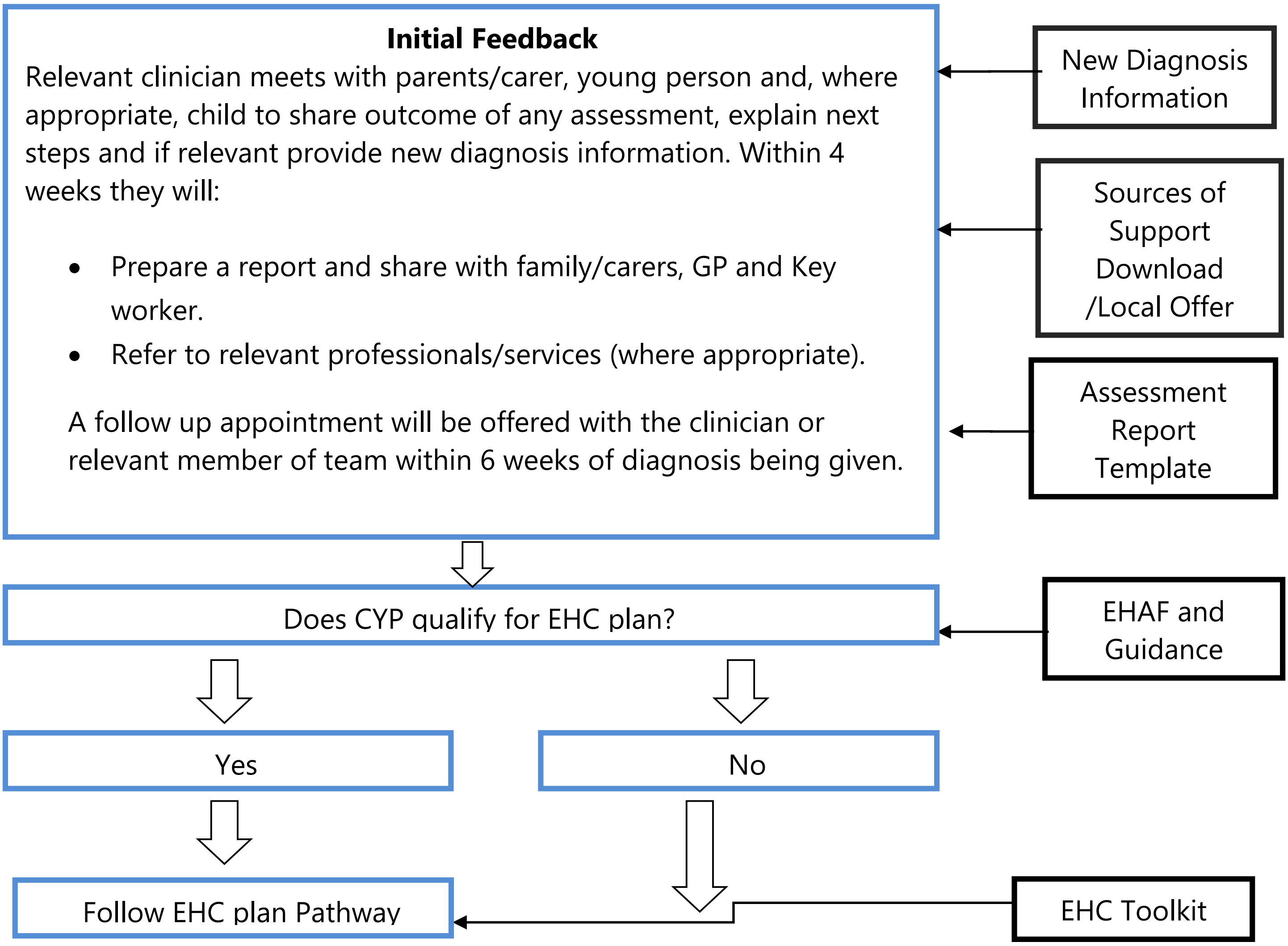
Stage 3: ASD/ADHD Assessment

All Assessments for ASD will be conducted by the Community Paediatric Service. Assessment for possible ADHD should be conducted by the clinically appropriate service (Community Paediatrics or CAMHS). CAMHs should be considered as a route when the main concern is mental health/emotional health and or well-being. Referral routes for ADHD are currently under review and Primary Care will be notified of any updates.

⚠ **IMPORTANT NOTE:** Ongoing support for the child/young person/family/carer **must** be maintained throughout the assessment process facilitated by the key professionals involved with the child.

🚩 **If the referral is incomplete, but a child presents with red flags, the service will process the referral whilst requesting that the KW clarify concerns in line with Stages 1 and 2.**

Stage 4: Outcome of assessment



Initial Feedback

Relevant clinician meets with parents/carer, young person and, where appropriate, child to share outcome of any assessment, explain next steps and if relevant provide new diagnosis information. Within 4 weeks they will:

- Prepare a report and share with family/carers, GP and Key worker.
- Refer to relevant professionals/services (where appropriate).

A follow up appointment will be offered with the clinician or relevant member of team within 6 weeks of diagnosis being given.

New Diagnosis Information

Sources of Support Download /Local Offer

Assessment Report Template

Does CYP qualify for EHC plan?

EHAF and Guidance

Yes

No

Follow EHC plan Pathway

EHC Toolkit

Key worker arranges a MAM (to occur within 6 weeks of notification of assessment outcome) including parents/carers, CYP and key professionals involved with the CYP. The MAM will:

- Agree an action plan with family and professionals.
- Consider a EHAF if not in place.
- Revisit the key worker role to ensure it is the most appropriate person.
- The key worker disseminates the action plan to the MAM and GP and will facilitate delivery in partnership with agencies and child/young person/family.

If diagnosis occurs after the age of 14, commence Transition Planning (see Stage 6).

About Stage 4:
Stage 4 of the pathway will ensure consistency in the management of outcomes for children/young people, families and carers. It will help the family to access next steps, ensure that the outcome of the assessment is shared with relevant agencies and support the family in accessing multi-agency support where needed.

The professional coordinating the assessment process will discuss the outcome of the assessment with the parent/carer and, if appropriate, the child/young person at a face to face meeting (unless otherwise requested), sharing the diagnosis and providing a new diagnosis information where relevant, and explaining next steps.

If a diagnosis is made, they will, within an overall timescale of 4 weeks from this appointment;

- Make any relevant referrals;
- Prepare a written report to share with the family/carers/young person, GP and key worker.

And within six weeks:

- Offer a follow up appointment if clinically indicated.

If the CYP meets the criteria for an EHC plan, follow the EHC toolkit and pathway. If not, the key worker will arrange a Multi Agency Meeting (MAM) within 6 weeks of receipt of the report to include parents/carers and key professionals who are involved with the child and young person. At the MAM an action plan will be drawn up, reflecting the assessment recommendations and presenting needs. The action plan should capture the voice of the child and family and their ongoing support needs. A EHAF should be completed if not already in place. At the MAM, the key worker role should be revisited to ensure that this is undertaken by the most appropriate person. Action following the MAM meeting will be disseminated by the key worker.

Stage 5: Ongoing Support for Child and Family

Key worker co-ordinates multi-agency support including signposting and referrals based on CYPs changing needs. Transition to be considered at all times. EHAF instigated with family consent. The Local Offer and pathway webpage offer information on a range of sources of support.

EHAF
Support Plan
and
Guidance

The (EHAF)/CAF/support plan will be reviewed by the key worker with the parents/carers and CYP annually or more often if needs change. The key worker role will be reviewed at the same time to ensure it is the most appropriate/relevant person (this role may evolve to lead professional if EHAF implemented). GP will be informed of any significant changes.

GP should be notified if new medical needs present. GP will refer to relevant services to address medical needs.

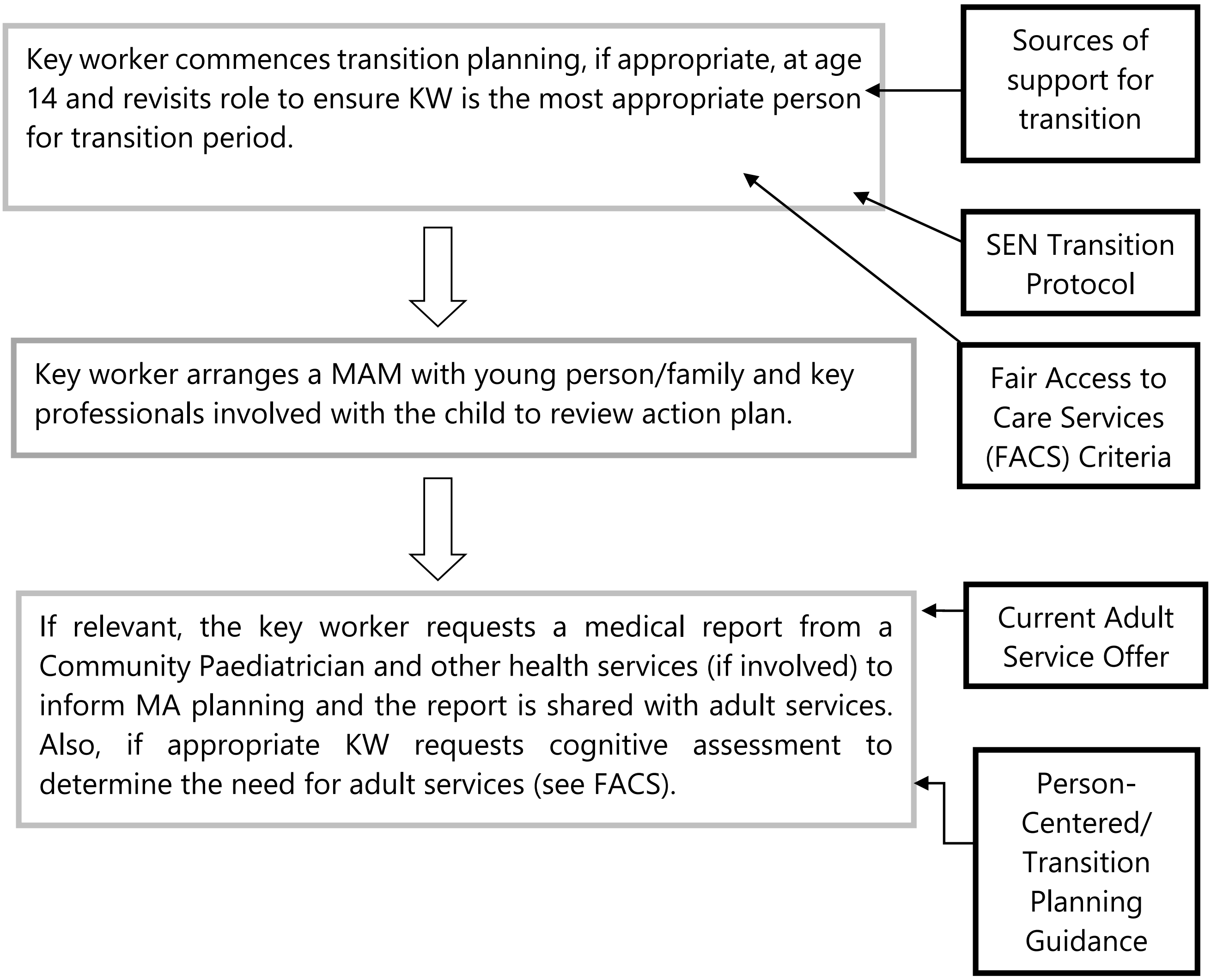
About Stage 5:
Stage 5 of the pathway will ensure ongoing support is maintained for the CYP and their family/carers, including signposting and referral to additional or specialist services to meet changing needs. The GP will be informed of any significant changes or if new medical needs present. GP will refer to relevant services to address medical needs. The potential impact of a co-morbidity or pain will be considered at all stages.

Stage 5 will be delivered by universal and targeted services with access to specialist services and the Community Voluntary Service (CVS) as required. It may consist of a range of support services detailed in the Local Offer and or on the concerning behaviours webpage.

The key worker will be the single point of contact for parents/carer and professionals, and coordinate this process with input from a range of providers/services as relevant/appropriate. The aim is to provide timely, high quality, evidence based, integrated services for the CYP and their families. The key worker will also work collaboratively with colleagues from education and childrens social care to enable the best possible outcomes and achievements for the CYP. Positive engagement approaches should be considered for families who may not find engagement easy. Specialist family parenting support should be available, such as parenting workshops. Schools should access targeted support services to meet the specific needs of the CYP, including Educational Psychology and ADHD/ASD specialist support if appropriate. Children and young people should have access to a range and choice of leisure activities/short breaks where appropriate.

The PHCT and Community Paediatric Service will be involved in Stage 5 where clinically appropriate. Community Paediatricians will make follow up arrangements dependent upon medical needs. Routine follow-up is not required for all cases.

Stage 6: Transition to adulthood



Key worker commences transition planning, if appropriate, at age 14 and revisits role to ensure KW is the most appropriate person for transition period.

Key worker arranges a MAM with young person/family and key professionals involved with the child to review action plan.

If relevant, the key worker requests a medical report from a Community Paediatrician and other health services (if involved) to inform MA planning and the report is shared with adult services. Also, if appropriate KW requests cognitive assessment to determine the need for adult services (see FACS).

Stage 6: Transition to Adulthood

Stage 6 of the pathway will ensure transition to adulthood and adult services, where required, is timely and effective. Transition planning should commence in year 9/10, by the age of 14, following the SEN Transition Protocol.

The key worker role should be revisited to ensure she or he is the most appropriate person for the transition period. A MAM will review the action plan with the young person to identify ongoing needs throughout the transition.

For information on transition and adult services see stage 6 on the concerning behaviours pathway webpage
www.nottinghamshire.gov.uk/concerningbehaviourspathway

Care of young people in transition between paediatric services/child and adolescent mental health services (CAMHs) and adult services should be planned and managed according to the best practice guidance described in the Department of Health's 'Transition: getting it right for young people'.

If a clinician is involved at this stage, they will prepare a medical report to share with the young person, parent/carers, key worker, GP and relevant adult services if appropriate.

If Social Care are involved, the" Looked After Child or Children in Need Plan" will include recommendation for ongoing support and be shared with the young person, parent/carers, key worker, GP and relevant adult services.

The key worker should:

- Use a person-centered approach to planning.
- Consider individual budgets and the Personalisation Agenda.
- Check that the young person is engaged with other support services, for example; Contraception and Sexual Health, Drug and Alcohol Services, Youth Offending Service (YOS), and engage appropriately.
- Consider work placements.

For additional information and/or resources on transition see the webpage
www.nottinghamshire.gov.uk/concerningbehaviourspathway

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