

Children's Therapy Service Referral pack

Introduction

Solent NHS Trust is the NHS provider of therapy services (Speech & Language Therapy, Occupational Therapy, Physiotherapy) for children and young people, 0 – 19 years in Hampshire, Southampton and Portsmouth.

This referral pack provides information to referrers on the context in which the Children's Therapy Service operates the criteria and guidelines for referral, the referral procedure and how to contact the service for further information and advice.

Context

In order for children to grow and develop to their full potential all children need to be surrounded by an environment (family, home, early years staff, schools) that provides rich opportunities for them to learn, communicate and develop physically.

Whilst most children given these opportunities will develop as expected, many children will find it harder, with some experiencing a delay in their development, whilst others will present with more complex difficulties that will significantly affect their ability to make friends, learn and manage on a day to day basis.

The therapy service aims to work with parents, health and education professionals in supporting the development of all children. We try to ensure that parents have access to information about how to support their child to develop, what to expect and whether to be concerned. We provide training and advice to health visitors, early years workers and school to ensure that they have the knowledge and skills to provide rich opportunities for development. We provide resources, leaflets, therapy ideas, training and screening checklists to enable health and education staff to support children with mild to moderate difficulties wherever possible and as a result anticipate that many children will be supported by those people who know the child best and spend time with the child on a daily basis.

There are, however, some children who either do not respond to this early intervention or who need more specialist support. These are the children who may need to see a qualified therapist who will be able to assess the child and identify their needs, discuss and agree with parent and health/ education professionals how best to meet those needs and monitor response to intervention to inform further planned input.

The following guidelines explain which children may need this specialist support and how to access it.

Who should I refer?

- Children and young people aged 0 – 19 years who have a Hampshire, Southampton or Portsmouth GP or who attend a Hampshire, Southampton or Portsmouth school.
- Children who present with a complex or disordered (uneven) profile of development
- Children whose needs cannot be met by those who work closely with them

Speech & Language Therapy

Children and young people who present with speech, language, communication and / or eating and drinking difficulties as outlined in the Early Years Developmental Checklist and Schools Therapy Pack.

This includes difficulties with:

- Understanding spoken language
- Using spoken language
- Developing speech sounds
- Social communication
- Stammering
- Voice e.g. husky or hoarse (referral to ENT is required prior to referral)
- Eating and drinking (This refers to the process of eating, drinking and swallowing rather than in children choosing to eat a restricted diet). Please complete the Feeding Questionnaire and attach it to the referral form.

Children with mild / moderate speech and language difficulties will be supported by the HCC Early Communication Support Service in Hampshire.

Please refer to Appendix 1 for more specific guidance.

Occupational Therapy

Children and young people who present with difficulties with postural-motor, perceptual-motor or motor planning function which affects their ability to develop and perform gross and fine motor skills, pre-writing and handwriting skills and activities of daily living **or** with underlying motor difficulties which result in:

- difficulties with seating and positioning
- undertaking activities of daily living such as
 - dressing
 - eating
 - handwriting
 - school activities
 - self care and independence

Children who present with primary emotional and behavioural difficulties not related to any underlying motor dysfunction should not be referred. Please refer to Appendix 2 for more specific guidance.

Physiotherapy

Children and young people who present with any condition which impairs their physical development and therefore may affect functional physical potential.

This includes:

- Moderate – severe delays with gross motor skills
- Difficulties with mobility e.g. moving around the floor, moving between sitting and standing, walking, running (dependent on the age of the child)
- Difficulty with maintaining symmetrical postures
- Poor balance in sitting or standing
- Abnormal walking pattern
- Abnormal movement patterns
- Reduced muscle power
- Limited range of movement patterns / poor quality of movements

Please refer to Appendix 3 for more specific guidance.

How do I refer?

The Children's Therapy Service will receive referrals from anyone, including parents.

Referrals should ideally be made on the Children's Therapy Service referral form to ensure that all the information required to process the referral is provided. Referrals will also be accepted in writing and over the telephone. Referrals may be made to one therapy service or all three therapy services on the same form by ticking the appropriate boxes.

The child's parents or guardian must consent to the referral.

Please attach supporting evidence to the referral form where appropriate e.g. Feeding Questionnaire, Early Years Developmental Checklist, Child Monitoring Tool (KOT or ECaT).

All school referrals must be accompanied with forms and supporting information from the Schools' Therapy Pack.

All referrals should be sent to:

Children's Therapy Service

Better Care Centre

William Macleod Way

Southampton

SO16 4XE

Email: SNHS.SolentChildrensTherapyService@nhs.net

Tel: 0300 300 2019

Parents may also attend any of the drop-in clinics advertised without a referral.

For further advice on when to refer, please contact the Children's Therapy Service telephone advice line on 0300 300 2019

What will happen next?

Once received the referral will be processed within five working days to:

- check that all required information has been provided and parental / guardian consent obtained. If further information is required the referral will be put on hold pending receipt of further details.
- determine the level of complexity of the referral and need for an integrated assessment
- allocate the referral to the appropriate therapist or team.

Once processed, the parents / carers will be contacted to arrange an appointment for the child to be seen at the most appropriate location e.g. clinic, early years setting, school or home.

The child will be prioritised according to need and seen within 12 weeks of acceptance of the referral.

At the initial appointment the child and parents / carers will be seen by a qualified therapist who will

- ascertain from the parents/carers (and others where appropriate e.g. early years setting, school) the child's presenting difficulties and their own particular concerns
- undertake an initial assessment to identify the child's level of functioning
- agree with parents / carers an appropriate course of action
- with the consent of parents / carers, communicate that course of action to the referrer and other interested parties e.g. health visitor, GP, early years setting, school, consultant.

What happens if the child does not attend the initial appointment?

All children who do not attend the initial appointment are managed under the 'Was Not Brought Protocol' which considers whether there are any safeguarding issues that should be raised. Parents / carers are contacted to ascertain the reason why the child was not brought to the appointment and to arrange another appointment. If the family cannot be contacted they are sent a letter asking them to make contact within two weeks. If there is no response the child is referred back to the referrer for further action.

Children's Therapy Service Referral Form

(Please return the completed form to: Children's Therapy Service, Better Care Centre, William Macleod Way, Southampton, SO16 4XE.

Email: SNHS.SolentChildrensTherapyService@nhs.net

Service referred to:	
Speech & Language Therapy	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Physiotherapy	<input type="checkbox"/>

Client details:		NHS No:
First Name	Surname	Date of birth:
	Previous names:	Male <input type="checkbox"/> / Female <input type="checkbox"/>
Address:		
Postcode:		
Name of parent/guardian		
First name	Surname	
Daytime tel:	Home tel:	Mobile tel:
Ethnicity:		
Languages spoken at home:	Interpreter/Signer required: Yes <input type="checkbox"/> / No <input type="checkbox"/>	
	Language:	
GP name:	Health Visitor/School Nurse Name:	
Surgery:	Base address:	
Tel:	Tel:	
Preschool / School name:	Days/Times attended:	
Address:	Tel:	
Postcode:		
Transport difficulties: Yes <input type="checkbox"/> / No <input type="checkbox"/>	Details:	
Referral information <i>(Please attach appropriate supporting evidence from Early Years Developmental Checklist, Schools pack, Feeding Questionnaire or Child Monitoring tool as well as any audiology or recent paediatrician reports)</i>		
Diagnosis (if known):	Stated: Yes <input type="checkbox"/> / No <input type="checkbox"/>	

		Statement designation:
Are there any Safeguarding issues?		
Is the child a Looked After Child? Yes <input type="checkbox"/> / No <input type="checkbox"/>		
Social services involvement: Yes <input type="checkbox"/> / No <input type="checkbox"/> Social worker's name: Contact number:		
Are there any concerns about; hearing? Yes <input type="checkbox"/> / No <input type="checkbox"/> vision? Yes <input type="checkbox"/> / No <input type="checkbox"/>		Has hearing been tested? Yes <input type="checkbox"/> / No <input type="checkbox"/> Date:
Reasons for referral:		
What is the functional impact? Give details:		
What support has already been provided?		
Please attach supporting information <input type="checkbox"/>		
Has it made a difference? Yes <input type="checkbox"/> / No <input type="checkbox"/>		
Other professionals/services currently involved (e.g. Paediatrician, Portage, Audiology, Educational Psychologist. Please provide names where known)		

Referrer details:		Date of referral:
Name of referrer (please print name):		
Profession (e.g. Hospital/GP/HV/Preschool):		
Would you like a copy of the appointment date? Yes <input type="checkbox"/> / No <input type="checkbox"/>		
Address:		
Tel:		Signature:

Parent guardian informed		
This referral has been discussed with me, and I agree to take my child to the clinic for assessment and ongoing therapy intervention as required, which may take place in school, clinic or nursery setting.		
I understand that if I do not attend the assessment, my child will be discharged and no further appointments will be offered. I am aware that for training purposes, a student may be present.		
Name of parent/guardian (PRINT NAME):	Signature: If unsigned, verbal consent given: <input type="checkbox"/>	Date:

Referral and background information

Please complete as fully as possible at referral stage, to avoid the family having to repeat family history

Developmental and medical history information

Were there any complications in pregnancy or birth?

General health/Childhood illnesses

Are the child's immunisations up to date? Yes / No

Does the child have any allergies? Yes / No If 'yes' please state:

Is there any family history of medical diagnoses? (e.g. autism, specific learning difficulties, developmental delay)? Please give details:

Current treatment/Medication:

Has the child had any of the following (please circle)?:	Frequent colds	Frequent ear infections	Frequent chest infections	Tonsillitis	Asthma
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Has the child had any visits to hospital?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
If 'Yes' please give details:	

Hearing/Vision	
Does anyone in the family have a hearing impairment/loss/deafness?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Has the child had middle ear infections/glue ear?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Does anyone in the family have visual impairment?	Yes <input type="checkbox"/> / No <input type="checkbox"/>

Feeding	
Can the child eat foods that need chewing e.g. meat, sandwiches, raw fruit or vegetables?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Did the child have any problems weaning/taking lumps?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
Do they use a bottle, beaker, inverted lid or open cup to drink?	
Has the child ever had fluid or food escape through their nose?	Yes <input type="checkbox"/> / No <input type="checkbox"/>

Motor skills			
Does the child <i>(please also indicate from what age)</i> :			
Roll	Age:	Crawl	Age:
Sit	Age:	Walk	Age:
Run	Age:		
Do you have any concerns about their movements?		Yes <input type="checkbox"/> / No <input type="checkbox"/>	
Does the child complain of pain?		Yes <input type="checkbox"/> / No <input type="checkbox"/>	

Personal care		
Is the child toilet trained?	Yes <input type="checkbox"/> / No <input type="checkbox"/>	If 'yes', at what age?:
Can the child dress themselves?	Yes <input type="checkbox"/> / No <input type="checkbox"/>	If 'yes', how do they help?:

Emotional				
What time does the child...	Go to sleep:		Wake up:	
Does the child stay in their own bed?	Yes <input type="checkbox"/> / No <input type="checkbox"/>			
Do they use a: <i>(please circle any that apply)</i>	Dummy	Bottle	Security blanket	Other comforter

Play and attention	
What types of games/toys/activities does the child enjoy?	
Does the child like to play with others (adults or children)?	Yes <input type="checkbox"/> / No <input type="checkbox"/>

Roughly how many hours of TV/DVD/Computer time a day does the child watch?	
How would you describe the child's attention span for:	
- Activities of their own choice:	
- Activities that the parent chooses:	

Speech and Language						
Is there a family history of speech and language difficulties? e.g. late talking, unclear talking, stammering (please give details of who and what)?						
If the family uses more than one language at home, when is each language spoken and to whom?						
Did the child babble as a baby?				Yes <input type="checkbox"/> / No <input type="checkbox"/>		
At what age did the child:	Say their 1st word:		Begin to put 2 words together:		Talk in sentences:	
Does the child dribble excessively for their age?				Yes <input type="checkbox"/> / No <input type="checkbox"/>		
Does the child have any problems with their teeth?				Yes <input type="checkbox"/> / No <input type="checkbox"/>		
Does the child have any problems with their lip or tongue movements?				Yes <input type="checkbox"/> / No <input type="checkbox"/>		

Therapist use only	
Signature:	Date:
Location:	
The therapist(s) will talk through anything you are unsure of or have any concerns about.	

We constantly aim to improve our services and we value your feedback. Please tick box if you would be happy for us to contact you in the future <input type="checkbox"/>
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Feeding Questionnaire

Please complete and attach to the Children's Therapy Service Referral Form	
Child's name:	NHS number:
Date of birth:	Age:
Name of referrer:	
Contact number:	
Area of concern and reason for referral:	
Any recent changes in the child's ability to eat/drink? (e.g. increased gagging/coughing, not managing more complex food texture or not coping with usual textures or drinks, concern about deterioration of skills)	
Any recent signs of aspiration/choking? (Please describe i.e. coughing, gurgly voice, red face, feeling of food stuck/feeling of choking/rattly breathing sound only when eating or just after eating)	
General health (including any chest infections, respiratory difficulties e.g. asthma possible developmental problems, medical diagnosis)	
Any signs/diagnosis of reflux and/or vomiting? Yes <input type="checkbox"/> / No <input type="checkbox"/>	
Is the child's weight stable? Have they lost or gained weight significantly in the last 2-4 months?	
Current feeding regime, including alternative feeding intake and quantity	

Drinking: bottle / cup	Type of teat:
Quantity and type of fluids consumed:	
Describe seating used at meal times:	
Length of time taken to consume each different meal:	
Describe any signs of pain / discomfort:	
Any sensory issues/challenging behaviour during meals:	
Level of parental concern:	
Information regarding strategies already attempted, advice already provided and their effectiveness:	

GP details
GP/Consultant name:
GP/Consultant contact details:
NB: GP/Consultant must be informed of referral in order for it to be accepted

Guidance on referring children for Speech & Language Therapy

Early communication skills

Appropriate referrals can be made to the Service if there are significant concerns regarding social interaction i.e. a child is disinterested in others and is not showing signs of attempting to communicate by pointing, making eye contact, using facial expressions or vocalising.

Language

Parents should be reassured that children vary greatly when learning language in the early years. There is a wide range of what is considered to be 'normal' in the pre-school years. Typically understanding of spoken language develops in advance of use of spoken language however delays can be present in one area or another or both.

When considering a child's ability to understand spoken language it is important to consider contextual clues that we as adults often give (e.g. looking towards an object, pointing and whether the request is part of a daily routine). It is helpful to establish how much the child understands without these additional contextual clues.

When considering the child's use of spoken language we consider vocabulary, sentence structure, clarity of speech and how language is used e.g. to ask for things, tell things etc.

Children in an education setting (pre-school/school) are usually able to benefit from the skills of the setting workforce who provide a communication friendly environment and encourage positive carer-child interaction. Schools and pre-schools have access to training packages from our service to support them in meeting the language and communication needs of their pupils throughout the school day. Children not yet in an education setting are able to access similar support through children's centres and toddler groups.

Appropriate referrals can be made to the service if there are significant concerns such as delayed and limited understanding of spoken language, no babbling/vocalisations/speech, and language difficulties which significantly impact on the child's ability to access the national curriculum.

English as an Additional Language (EAL)

In general, acquiring two languages within a bilingual family should not have any significant impact on a child's ability to develop communication skills. Typically developing children may show a mild delay in both languages initially, but demonstrate interest and enthusiasm for communication, catching up quickly and managing bilingualism without concern.

When English is not a first language, it is expected that there will be a 6-month delay in a child's understanding and use of English in comparison with their skills in their first language. Therefore, a child of chronological age 2 years 6 months, who has an English language age of 2 years, is considered to be age-appropriate.

A child who is age-appropriate in their first language, but more than 6 months delayed in English is not appropriate for referral as this is indicative of difficulties in learning a second language, rather than acquiring language in general. These children should be referred to EMAS.

A pre-school child who is delayed in both/all languages is appropriate for referral to this Service in order to determine the extent of delay, whether it is a disorder and to give appropriate advice.

Children who present with a delay in either language at school-age are not appropriate referrals, as Education staff should be able to support them from within their own resources. Schools should access support from the Specialist Teacher Advisory Service.

When making a referral for a bilingual child, please also consider factors that may be impacting on language development – for example, whether the child has had the opportunity to engage in interactive play with both adults and peers, and whether it is considered appropriate within their home environment to make eye-contact with adults. Also consider the length of time the child and parents have been in the UK, and the environments in which the child is exposed to English in comparison with their first language.

It is often worth encouraging families to attend local playgroups initially, particularly at Children's Centres where there are often play workers who can support the family in developing communication through their home language. Supporting play and communication development in the child's first language often results in a noticeable change to language skills.

Speech

Children make many speech sound errors as they learn to talk. Most of these are a typical part of development until the age of around 3 years, with some errors naturally persisting until the age of around 5 or 6.

Children who have experienced a delay in developing language skills are likely to show a correlating delay in their use of sounds.

In general, children should only be referred for assessment of speech sounds before the age of 3 years if there are significant concerns regarding physical or structural difficulties in sound production (e.g. hearing impairment, muscle weakness, cleft palate/nasality or difficulties with co-ordination).

Children should be referred at the age of 3+ years if they are not using the sounds p, b, t, d, k, g, s, f and all vowels (ah, ee, oo etc.) clearly within single words

Referrals may also be appropriate if a child is not intelligible (i.e. the message is not understood) in longer utterances within context. Reduced intelligibility may indicate difficulties in either speech sound production (clarity) or in expressive language, whereby children produce strings of nonsensical sounds (jargon) as a substitute for unknown vocabulary. Children presenting with jargon can be referred prior to 3 years of age, however, if it appears a child's difficulty is with clarity they should be monitored as outlined.

Non-significant variations

Children will not be seen for regional variations (e.g. thumb → fum) or mild delays that do not affect intelligibility (e.g. immature production of 'r' e.g. red → wed). These children can be supported within their everyday environments by parents, carers and educational staff and do not require access to specialist services.

Interdental 's' sounds i.e. lisping (e.g. see → thee) should not be referred until the child's secondary dentition is complete.

Selective mutism

Selective mutism is an emotional disorder of childhood in which children speak fluently in some situations but remain silent in others. In other words they can speak normally and they want to speak normally but they often don't speak. They may behave in a completely normal way when they are in an environment in which they feel relaxed and comfortable i.e. at home with family.

Selective mutism often occurs at times of 'transition' i.e. starting pre-school or school. A period of 'settling in' and some general strategies may help to support them to talk during this time. If after 3 – 6 months the child is still not talking advice should be sought from a Speech & Language Therapist (SLT).

For a diagnosis of selective mutism to be made the condition has to:

- Interfere with the child's social and learning development
- Have lasted for longer than one month after the first month at nursery / school
- Not be due to having English as an additional Language
- Not be better explained by a communication disorder or any known condition

The SLT has a role in assessing the child and co-ordinating / supporting the pre-school or school in implementing a structured programme, which to be successful, needs to be

carried out by someone with whom the child has a good relationship with and who they see daily in the environment in which they are not speaking.

Children should also be referred to CAMHS (Child & Adolescent Mental Health Service) and families signposted to support groups e.g. SMIRA (Selective Mutism Information and Research Association)

Fluency (Stammering)

Children often experience a period of normal non-fluency while acquiring language. The demands of remembering and finding new words amongst a rapidly increasing 'dictionary' place sudden pressure on the child's language processing system, meaning that they stop-start, repeat and change the words they use. This can last a few weeks or even months until they have mastered their new skills. They may also hesitate or get stuck while trying to access the information required to produce a word, all of which may result in an apparent 'stammer' while they are learning to manage their new skills effectively.

Children who show self-awareness, become very frustrated or who are displaying secondary features such as grimacing, blinking, wringing their hands, tapping their feet or head-banging are likely to be experiencing dysfluency and should be referred to the Service, as should children who have a significant family history of stammering or who have been stammering for a period of more than 6 months. These factors suggest the stammer is more likely to persist without additional support.

The term 'dysfluency' refers to a number of disorders of fluency, all of which are classified by their interruption to the smooth flow and timing of speech; the terms stammering or stuttering can be used interchangeably and mean the same thing.

Feeding

Feeding assessment aims to determine whether the difficulties reported and observed have a structural (mechanical or neurological) cause. If a structural cause is identified, the child will be seen as part of the Therapy caseload for ongoing assessment and management strategies until it is considered that the child's needs are stabilised and can therefore continue to be managed by adults in their environment.

Indicators of structural feeding difficulties include:

Failure to thrive, difficulty in developing a sucking action, coughing/choking, recurrent chest infections, physical difficulty in chewing more difficult textures, nasal escape or regurgitation.

All children who are suspected to have difficulty in structural feeding should be referred to the Service for assessment. If you wish to refer a child for structural feeding difficulties completion of the additional feeding questionnaire is required.

Indicators of behavioural feeding difficulties include:

Gagging on specific textures, rigidity surrounding times of eating, temperature of food, utensils used, and textures accepted etc., and with the exception of fussy eating, the child is otherwise following a normal developmental pattern.

Children who have only behavioural feeding difficulties should not be referred. If they are they will be given advice and signposted to appropriate support from Health Visitors, School Nurses and if appropriate Portage Workers and Taste & Talk groups.

Please see Early Years Developmental Checklist or School's Therapy Pack for more detailed advice on when to refer.

Guidance on referring children for Occupational Therapy

The emphasis of Occupational Therapy is on overcoming functional difficulties that occur in daily life and may present at home or in school.

Referral is indicated for children who have an uneven pattern of development with obvious deficits in the following functions:-

Postural – motor function

- Abnormal tone –e.g.
 - Postural tone is too high and there is resistance to passive movements. Arms / legs / body may adopt fixed postures or there is a limited range and poor control of movements.
 - Postural tone is too low and child has difficulty controlling their body e.g. in sitting / standing (compared to milestones)
 - Asymmetrical movement –e.g.
 - Part of body is used less, may be poorly controlled or weaker.
 - Certain postures or movement patterns are frequently used.
 - Functional motor difficulty e.g.
 - Child has difficulty with sitting, standing, walking or running compared to other milestones.
 - Their quality of movement may be affected e.g. child can walk but falls easily.
 - Unusual movement patterns
 - Diagnosis of Cerebral Palsy / Evolving Motor Disorder
 - Deterioration in functional ability

Gross and fine motor skills

- Balance
- Ball skills
- Bilateral coordination
- Hand strength
- Dexterity
- Handwriting and scissor skills
- Deterioration in skills

Activities of daily living

- Dressing
- Eating and drinking
- Bathing
- Using the WC

Motor planning function

- Sequencing movements
- Spatial awareness

- Limitation of postures or sequences of movements

Visual perception

- Visual motor integration
- Letter formation

Sensory processing affecting function **

- Over/under awareness of sensory information
- Difficulties modulating responses to sensory information

***These referrals are only accepted in Winchester, Eastleigh North, Andover and Aldershot.*

Other

- Oncology or other life limiting conditions where there is a need for equipment and/or therapy to improve quality of life.
- Hospital discharges - Children not known to the community therapy service before admission to hospital and whose needs are short term (less than 6 months) are not appropriate referrals to the Children's Therapy Service. Their needs should be met by the acute therapy services in liaison with other agencies.

For pre-school children please see 'Early Years Developmental Checklist'

For school-age children please refer to the School Therapy Pack or website for developmental checklists, supporting advice and process for referral.

Guidance on referring children for Physiotherapy

Neurological concerns

- All children with a new diagnosis of Cerebral Palsy, who have a motor impairment impacting on movement and function
- Babies/children presenting with any of the following;
 - Abnormal tone – postural tone is too high and there is resistance to passive movements. Arms / legs / body may adopt fixed postures or there is a limited range and poor control of movements. Postural tone is too low and child has difficulty controlling their body e.g. in sitting / standing (compared to milestones)
 - Asymmetrical movement – part of body is used less, may be poorly controlled or weaker. Certain postures or movement patterns are frequently used.
 - Functional motor difficulty e.g. child has difficulty with sitting, standing, walking or running compared to milestones. Their quality of movement maybe affected e.g. child can walk but falls easily.
 - Acquired brain injury which has had an impact on child's motor skills – this may include altered tone, reduced coordination, muscle power and /or sensation.
 - Unusual movement patterns
 - Diagnosis of CP/ Evolving motor disorder
- Re-referral with new/functional problems and post surgery
- Children with a known diagnosis of CP who have moved into the area and have functional difficulties.

Neuromuscular concerns

Neuromuscular conditions involving a progressive loss of functional motor skills. Physiotherapy can be very beneficial in terms of promoting independent skills, reducing deterioration and promoting health and well being. Input is given depending on the child's needs at that time. Treatment and frequency will vary according to the age and stage of the child.

Children should be referred for community physiotherapy if they present with the following.

- All children with a new diagnosis of neuromuscular disease
- Concerns over lack of progress in the baby / child's motor skills development where gross motor development appears to have stopped for more than 6 months.
- Loss of motor skills. Previously acquired skills are more effortful or show less coordination, e.g. tripping and falling
- Re-referral with new/functional problems / post surgery

- Children with known diagnosis of neuromuscular disease and who have moved into the Solent area

Children / young people presenting with an increase in respiratory difficulties / frequency of chest infections may need an increase in physiotherapy input.

Premature infants

Babies with one or more of the following risk factors should be referred to the physiotherapy team to monitor the infant's development in the first 12-18 months.

- Very low birth weight of less than 1000g
- Neurological insult
 - Hypoxic ischemic encephalopathy (HIE) (II or III)
 - Intraventricular haemorrhage (III or IV)
 - Periventricular leukomalacia
 - Severe neonatal seizures
- Congenital syndromes, neuromuscular disease, musculoskeletal deformities.
- Babies going home on oxygen therapy

Babies at risk are usually highlighted and referred onto physiotherapy by the Neonatal team.

The neonatal teams (provided by the acute service) should follow up babies at risk during the first 6 months of life. If there are going to be ongoing therapy needs, a referral to the community integrated therapy service should be made (this is usually becoming apparent by 6-9 months). These young infants should be referred to the community team to enable a holistic child and family package (s) of care to be implemented, e.g. home equipment, liaison and home visits with other services i.e. portage, health visiting.

Babies whose development falls within the expected norms for prematurity do not need a referral to community therapy, with follow up developmental checks being carried out by the neonatal team (provided by the acute provider). For babies born at Queen Alexandra Hospital, Cosham, the Solent neonatal community in-reach team provide this early monitoring and intervention service.

Developmental concerns

- Children, who have no neurological or genetic involvement and have normal patterns of movement, should be referred to community physiotherapy if they are demonstrating a gross motor delay of 3-6 months or more (for children under 2 years) or delay of 9-12 months or more (for children aged 2- 5years). See guide below
- Bottom shuffling is not an indication of abnormal movement patterns. Many children who bottom shuffle instead of crawling to move around the floor, start walking at a later age.
- Children presenting with specific syndromes and demonstrate gross motor delay should be referred for **community** physiotherapy. Some babies who have been on

the NICU unit may receive follow up from the neonatal team until the age of 6 months. At this time infants should be referred to the community team to enable a holistic community package of care to be implemented, e.g. home equipment, liaison and home visits with other services i.e. portage, health visiting.

- An information leaflet produced by the Children’s Physiotherapy Team is available which can provide general advice for parents regarding activities to promote gross motor skills. See website for details.

Activity	Age child usually reaches milestone	Refer to physiotherapy
Independent floor sitting	9 months	12 months
Independent rolling	6 months	12 months
Cruising	12 months	18 months
Independent walking	14 months (children who bottom shuffle are usually delayed in walking)	22 months
Jumping	3 years - 2 feet together from bottom step	4 years
Climbing stairs	3 years – up and down holding hand rail, 2 feet per step	4 years
Riding tricycle	3 years – able to use pedals, steer round wide corners	4 years

Idiopathic toe walkers

- Children who habitually walk on their toes should be referred for community physiotherapy if they are over the age of 3 years.
- Children under the age of 3 years should be referred to community physiotherapy if there is asymmetry or if it is not possible to achieve 90° passively.
- Altered postural tone – consider if toe walking is due to an underlying neurological condition, in which case refer - child may follow alternative pathway if underlying cause has neurological origin.

Intoeing

Some children’s feet turn in when they walk and this is very common in young children. It is one of the most common normal variants in children.

Referral to community physiotherapy is only needed if:

- Significant asymmetry is present
- Pain is present
- Child has tight hamstring muscles.
- Child has metatarsus adductus
- Child is still intoeing after 6 years of age

Hypermobility

Joint hypermobility is defined as an excess in joint range of movement.

Children should be referred to community physiotherapy hypermobility if they have

- Delayed gross motor skills - if child is demonstrating a gross motor delay of 3-6 months or more (for children under 2 years) or delay of 9-12 months or more (for children aged 2- 5years).
- Functional difficulties – e.g. unable to walk distances compared to norms.
- Pain

Musculoskeletal problems

Children presenting with musculoskeletal problems should be referred to the acute provider.

- Flat feet – no physiotherapy intervention is needed. Refer to podiatry if the child has foot pain.
- Foot pain – Children under 10 years refer to the Children’s Podiatry Service for Fareham, Gosport and East Hampshire localities. Children over 10 years can be referred to the adult Podiatry service. Children in other areas should be referred to the acute Physiotherapy service.
- **Baby musculo-skeletal problems.** Babies presenting with talipes, torticollis, Brachial plexus injury or plagiocephaly should be referred to the acute provider until the age of 6-9 months. If the infant has **ongoing** needs beyond the age of 9 months, a referral to the community physiotherapy service should be made to enable a holistic community package of care to be implemented, e.g. home equipment, liaison and home visits with other community services i.e. portage, health visiting.

Juvenile Idiopathic Arthritis

Children who have difficulties which affect their function at home and / or school and require advice on the long term management of their condition should be referred for community physiotherapy. Hydrotherapy should be provided by acute services.

Chronic Fatigue Syndrome (CFS)

Physiotherapy and occupational therapy can offer advice on graded exercise, relaxation, pacing and home / school equipment. However, our clinical experience has demonstrated that without the support of the Clinical Psychology Service for the child and family, this intervention is likely to be much less effective.