

**The Hampshire Joint Strategic Needs
Assessment (JSNA)**

Summary document

**Children with Special Educational Needs and
Disabilities (SEND)**

2016/17

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Who is included in Hampshire's population of children with SEND?

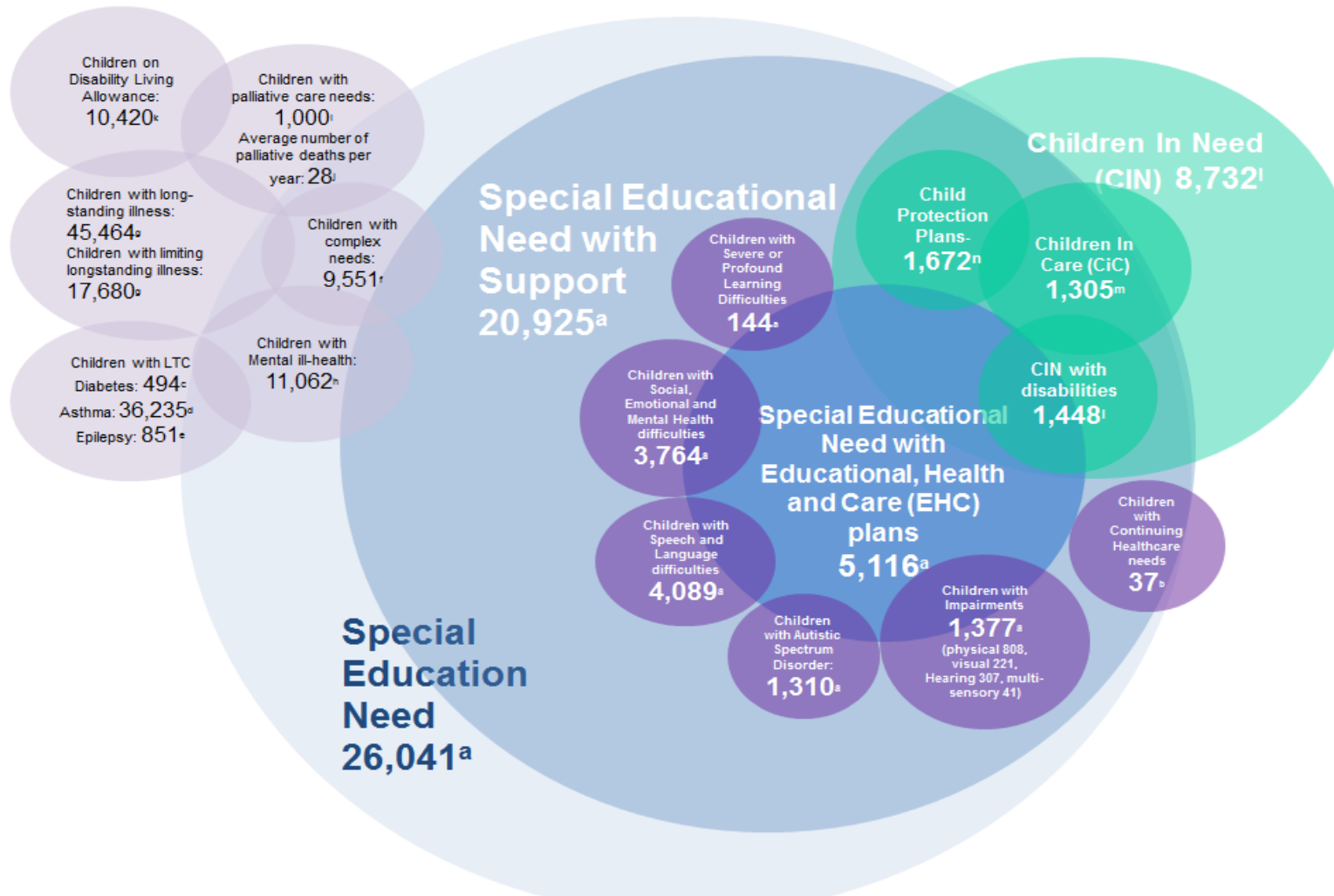


Fig 1: Hampshire's population of children with SEND, May 2017

Source: Hampshire Public Health

Notes on sources of information for groups of children with SEND

Key to Figure 1

White type denotes census data.

Greyed out figures and black type denote estimated/extrapolated figures

- a. January 2016 SEN School Census
- b. Children or young people under the age of 18 with continuing healthcare needs, 2015. *Children and Maternity Commissioning Collaborative Working Across 5 Hampshire CCGs Actual Figures*
- c. Estimates - Prevalence rate of 195.4 per 100,000 from the *2015/16 National Paediatric Diabetes Audit* applied to the 2017 estimated population of children under the age of 15 in Hampshire using the 2016- based HCC Small Area Population Forecasts (SAPF)
- d. Estimates - Prevalence of lifetime doctor-diagnosed asthma rates of 17% among boys and 12% among girls from the *2010 Health Survey for England (HSE)* applied to the 2017 population of children under the age of 15 in Hampshire using the 2016-based SAPF.
- e. Estimates - Proportion of children and young people with a diagnosis of epilepsy and receiving antiepileptic drugs of 0.30% based on the *2013 National Institute of Health and Care Excellence (NICE) guidance on the Diagnosis and management of the epilepsies in adults, children and young people* applied to the 2017 population of children aged 17 years or younger in Hampshire using the 2016-based SAPF
- f. Local dataset on numbers of children and young people aged 0 to 25 with serious or complex needs managed by specialised paediatric health services as defined by the Specialised Services National Definitions Set (SSNDS) for Children published in 2010 and applying the International Statistical Classification of Diseases and Related Health Problems version 10 (ICD-10) diagnostic codes to hospital data systems. Hospital activity data received via SUS. Extracted from Hampshire Data-warehouse 2014/15.
- g. Prevalence of 18% children aged 0-15 with 'longstanding illness' and 7% with a 'limiting longstanding illness' from the 2009 HSE child trend tables applied to the 2017 population of children under the age of 15 in Hampshire using the 2016-based SAPF.
- h. Prevalence of 12% of children aged 10 to 15 reporting high or very high 'total difficulties scores' in the SDQ based on the *UK Household Longitudinal Survey - Understanding Society (2011 to 2012)*, applied to the 2017 population of children aged 10 to 15 in Hampshire using the 2016-based SAPF.
- i. Prevalence of 32 per 10,000 children (0–19 years) in 2009/2010 living with a life-limiting or life-threatening condition that may benefit from palliative care services based on Leeds study by Fraser et al. (2012), applied to the 2017 population of 0-19 year olds in Hampshire using the 2016-based SAPF.
- j. ONS Annual Death Extract. Average annual deaths registered in the period 2010-14. Mortality statistics for Hampshire resident children and young people (aged 0-24 years inclusive, excluding neonates) with conditions likely to have required palliative care based on work by Cochrane et al. (2007) that used a list

of causes of death which were likely to have required palliative care to estimate numbers.

- k. DLA recipients* aged 0-25 by disabling condition, August 2016. Office for National Statistics, (ONS) from Nomis, Accessed May 2017.
- l. Children in need (CIN) census, children aged under 18 years, 31st March 2015 DfE
- m. Looked-after children (LAC) or 'children in care (CiC) or 'children looked-after (CLA)'. Department for Education. SSDA 903. Children under the age of 18, 31st March 2016 DfE
- n. Number of children who were the subject of a plan at 31 March 2015 - CIN Census data DfE

Context

This JSNA summary document describes the needs of children and young people aged 0-25 years who have special educational needs or a disability (SEND). Educational success is not just a personal achievement, it is affected by a child's environment and their health; their social and economic advantage (or disadvantage), how and where they live and individual factors affecting physical, mental, sensory, emotional and behavioural wellbeing. For this reason, a holistic approach to children and young people's additional learning needs (ALN) should be considered including whether they have SEND.

In this report children and young people up to 25 years are quantified to align with the *Special Educational Needs and Disability Code of Practice: 0 to 25*.¹

Overall demographics

Key messages

- In Hampshire there were 14,357 live births in 2015 compared with 14,453 in 2014 (a decrease of less than 1%). Trends over the past decade show an overall rise (6%) in births from 13,537 in 2005 to 14,357 in 2015.
- The 2015 mid-year estimate of the number of children and young people in Hampshire aged under-25 years (i.e. up to but not including the young person's 25th birthday) is 381,940. This represents just under a third (28.2%) of the Hampshire population.
- Basingstoke and Deane (51,074), the New Forest (44,287), Winchester (37,144) and Eastleigh (37,015) have the highest numbers of children and young people.
- Population projections suggest 8,238 more children and young people aged under-25 will live in Hampshire by 2021, which is a 2.2% growth over six years.
- In January 2016 Hampshire's schools' population was 187,426 (pupils headcount). The school population differs from the resident population, as some school aged children travel across council boundaries to attend school and it does not include the post-16 school aged population.

Implications

With no programmes to prevent risks and ensure early intervention, natural increases in births will result in a corresponding increase in the number of children with SEND impacting on the need for educational provision to meet need.

Where absolute numbers of young people are large or increasing there will also be a proportionate rise in the numbers of the SEND population, even if the prevalence of SEND stays constant.

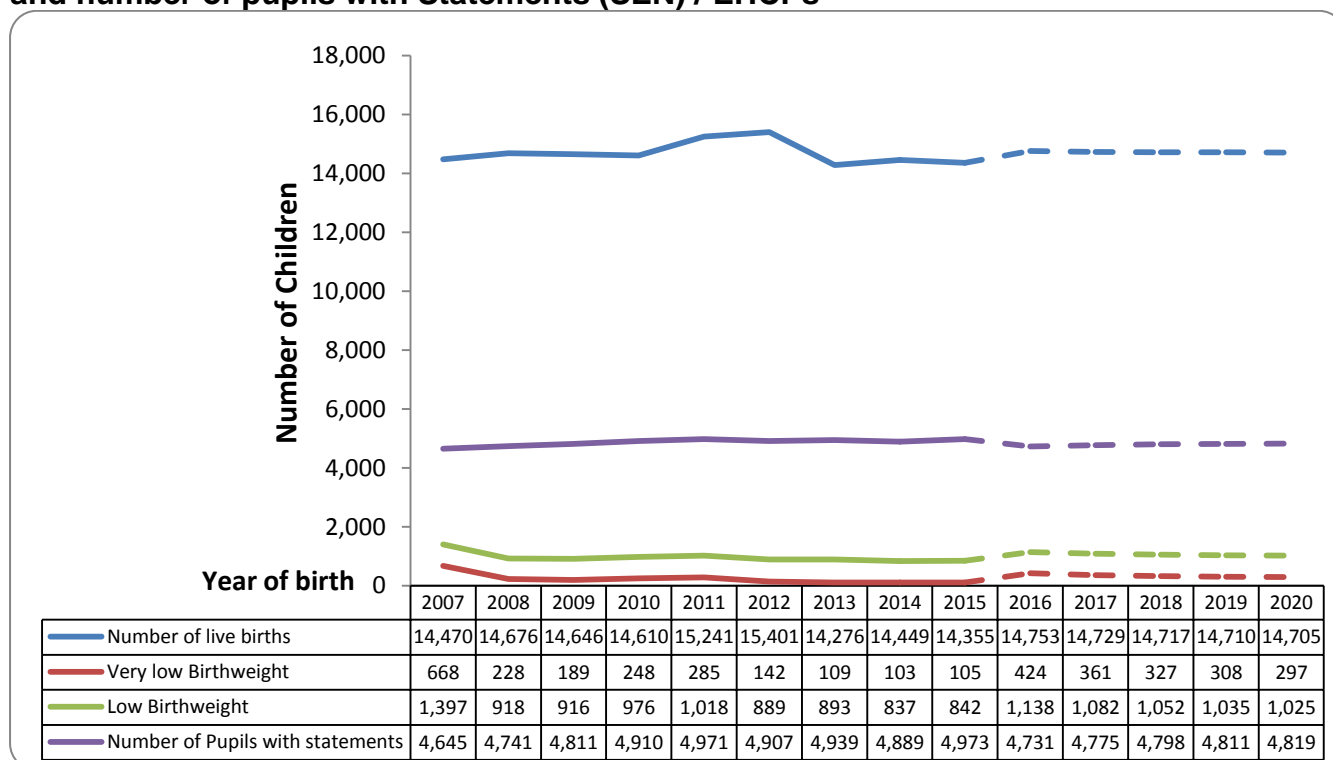
It is important to recognise that due to the size of the Hampshire population a small percentage, may equate to a large absolute number of children and young people. This is important for service planning.

Drivers influencing the SEND population

Key messages:

- Low birth weight, is a major determinant of morbidity, mortality and disability in infancy and childhood and also has an ongoing impact on outcomes throughout adult life². In 2015, 5.9% of live births in Hampshire were low birth weight (under 2.5kg). There were 842 babies weighing under 2.5kg and 105 very low birth weight babies, weighing under 1.5kg. Variation in the proportion of low birth weight births exists between Hampshire districts, ranging from 3.9% in Fareham to 8.3% in Havant. Figure 2 shows the relationship between low birth weight and pupils with SEN statements/EHCPs and the modelled projected estimates using SAPF¹ figures.

Figure 2: Live births per year compared with low and very low birth weights and number of pupils with Statements (SEN) / EHCPs



Source: Hampshire Public Health

- Multiple pregnancies, largely related to in vitro fertilisation (IVF) treatments, are associated with a higher risk of disability in children³, including cerebral palsy and thus contribute to SEND. In 2015 there were 208 multiple maternities in Hampshire resulting in a total of 420 multiple births. At 14.5 multiple maternities

¹ Hampshire County council uses local information to produce the Small Area Population Forecasts (SAPF) that give an accurate indication of the current and future population

per 1,000 maternities, the Hampshire multiple maternity rate is lower than the England rate of 16.1 per 1,000.

- Prematurity is an important predictor of SEND⁴. Applying the national preterm estimate of 7% to babies born in Hampshire would equate to around 1,005 premature births in 2015.
- Smoking during pregnancy remains a significant risk factor for a baby being born with a low birth weight and therefore at risk of poorer childhood development⁵. Between 2010/11 and 2015/16 the proportion of women smoking at the time of delivery decreased from 12.6% to 9.0% (equivalent to 1,246 women) in Hampshire. This is significantly lower than the overall England average of 10.6%. Although this is a welcome trend the Hampshire rate is still higher than that of some of our statistical neighbours and there is considerable room for further improvement.
- Foetal alcohol syndrome (FAS) is a relatively prevalent alcohol-related birth defect⁶ and is the commonest single cause of learning disabilities. It is the most severe and visibly identifiable form of foetal alcohol spectrum disorder (FASD), and completely preventable. Applying figures on the European prevalence of alcohol use during pregnancy (25.2%) from the Lancet study by Popova et al. to the number of live births translates to approximately 53 children being born with FAS in Hampshire.
- Substance misuse in pregnancy is a key public health issue not only because of the associated negative impacts on foetal outcomes, including low birth weight and/or premature birth and infant outcomes, but because these harms also are preventable and can be remedied or at least attenuated⁷. The National Institute for Clinical Excellence estimates that around 4.5 per cent of pregnancies (or 30,200 women per year) will involve a substance abusing mother⁸. This is equivalent to 639 pregnancies of the 14,204 Hampshire maternities in 2015. In addition, parental substance misuse may negatively on child development. Twenty five per cent of people seeking help for drug problems are female and 90% of female drug users in treatment are of reproductive age⁹
- Domestic violence is more likely to begin or escalate during pregnancy¹⁰. It has been linked to preterm births, low birth weight infants¹¹, foetal injury¹², higher rates of postnatal and neonatal complications and results in long-term disability for a child¹³. Around 15% of women report violence during their pregnancy¹⁴ and this would translate to an estimated 2,131 pregnant women in Hampshire.
- There is a large body of evidence to suggest that increased maternal BMI is linked to adverse child health outcomes¹⁵. Local data on the prevalence of maternal obesity are not available, but South of England commissioning region statistics¹⁶ from the Health and Social Care Information Centre (HSIC) show 19% of pregnant women in January 2017 were classed as obese, with a BMI ≥ 30 when they attended their first appointment.
- Pre-existing medical conditions such as epilepsy, diabetes, congenital or known acquired cardiac disease, autoimmune disorders, and certain medications in

pregnancy can affect the baby's development in the womb. Women with existing serious medical conditions should have pre-pregnancy counselling at every opportunity¹⁷.

- Folate supplementation given around the time of conception and continued through early pregnancy has been shown to reduce the risk of birth defects such as spina bifida¹⁸. Despite recommendations for women to start supplementation pre-conceptually, uptake is low. Studies¹⁹ have suggested rates of pre-conceptual uptake to be 31% in England, with lower uptake in younger age groups and ethnic minorities.
- Early access to maternity care is vital for a child's development, life chances and achievement. Women who book late are more likely to come from disadvantaged backgrounds, and are therefore at a greater risk of complications, poor outcomes and inequalities²⁰. The most recent 12 week maternal assessment data at CCG level (Q1 2015/16) shows that the percentage of women who have seen a midwife or maternity health care professional by 12 weeks and 6 days of pregnancy ranged from 82.3% in South Eastern Hampshire CCG to 93.8% in North East Hampshire and Farnham CCG.
- Women at both ends of the spectrum of childbearing age are at increased risk of poor birth outcomes including factors that are linked with low birth weight and prematurity. In 2015 there was a continued fall in childbearing in women aged under 20. The rate of women over 45 years giving birth in Winchester where delayed childbearing is the highest in Hampshire, was similar to England at 1.1/1,000. Older women have a higher risk of stillbirths and of having babies with genetic abnormalities, such as Down's syndrome.
- The impact of deprivation on learning and the prevalence of disabling conditions is well recognised²¹. Additionally, levels of deprivation are correlated with safeguarding activity. Whilst the proportion of children in Hampshire that live in income deprived families has reduced from 12.1% to 11.8% the number of children affected (29,269) has remained almost the same because of an increase in the population aged 0-15.
- In 2014, 11.5% of dependent children under the age of 20 were living in relative poverty in Hampshire. The proportion varies across Hampshire with the highest levels seen in Havant where 1 in 5 children were living and growing up in poverty. The district of Hart had the lowest proportion at 6.5%.
- Data on children eligible for Free School Meals (FSM) provide additional information about childhood poverty and identify children possibly in need of additional learning support. The January 2016 school census survey shows that the average proportion of children eligible for FSM has decreased from the 2010 figure of 9.4% and the 2015 figure of 9.1% to 8.8% in 2016. This includes children in nursery, primary, secondary and special schools, and in pupil referral units. In pupil referral units, FSM eligibility and uptake has increased drastically, from 12.3% in 2011 to 23.6% in 2015 and further still to 34.1% in 2016. Although the increase is large as a percentage, the change in actual figures is low due to the small population of children in these units. Among special schools the

increase in the proportion of children claiming FSM was less extreme, from 23.9% in 2011 to 28.7% in 2016.

- Whilst ethnic minority children may have a higher prevalence of certain conditions, they are less likely to report SEND and are at risk of facing barriers to accessing services, or experiencing prejudice and discrimination²². From the January 2016 school census data, there are 17,766 children in primary, secondary and special Hampshire schools from a minority ethnic group. They form 11.4% of the Hampshire school population, compared to 29.7% nationally. There are 467 Hampshire school children from Irish Traveller or Gypsy/Roma ethnic groups, less than 1% of the school population. Trends suggest increasing ethnic diversity over the past eight years based upon information collected in the annual school census, which is also reflected among the special school population.

Implications

There are variations in the drivers that influence our children's SEND that are related to the socioeconomic circumstances they grow up in. Change in any of these risk factors is likely to influence the future incidence and prevalence of SEND. Increases will lead to widening inequalities in the prevalence of SEND.

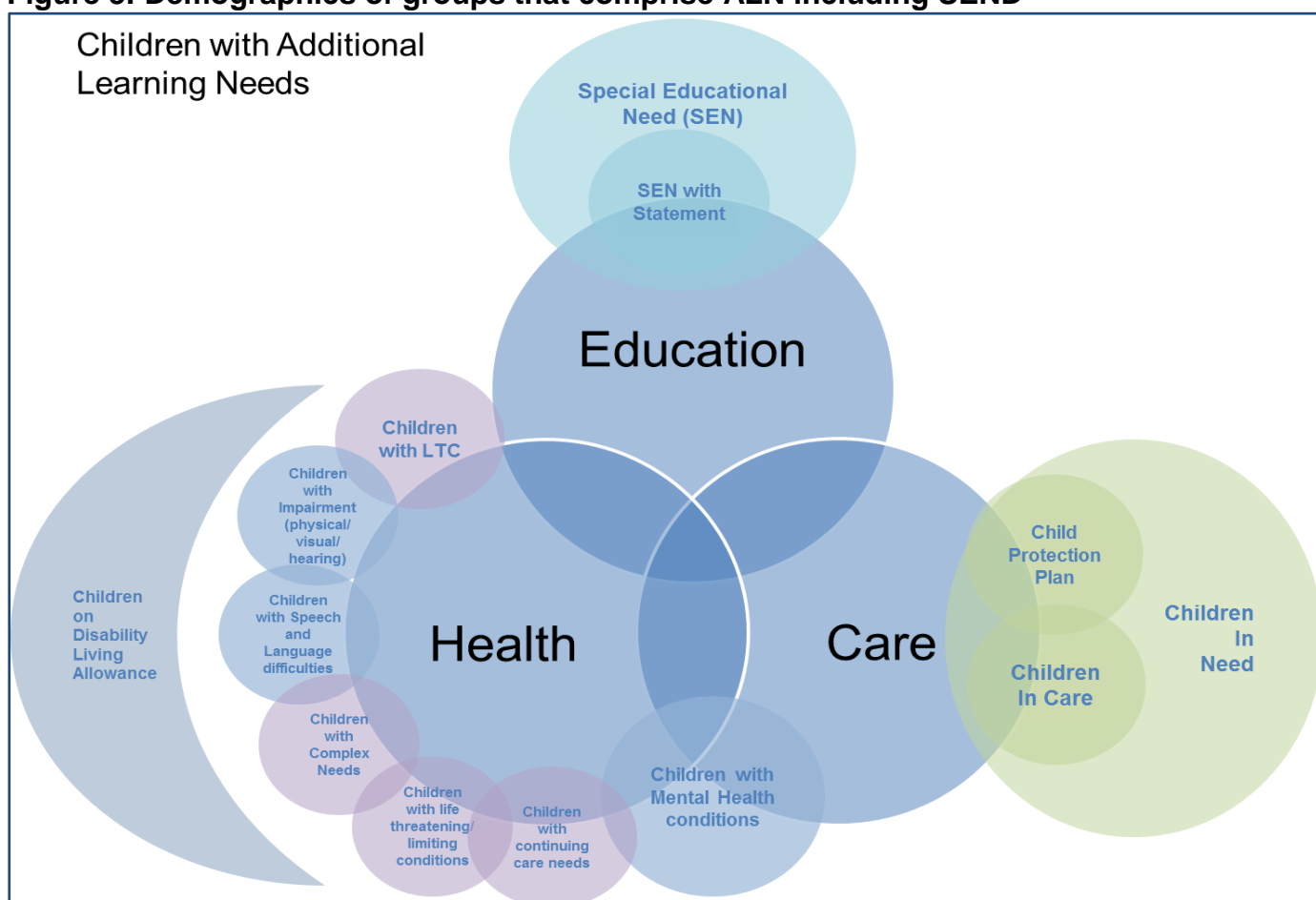
Findings on the drivers that influence SEND should be contextualised when comparisons are made against national figures, especially when we consider that Hampshire's population is generally healthier and wealthier and better educated than that of England in general.

Whilst drivers that influence SEND in Hampshire are varied and very diverse, they suggest that Hampshire fares well. However, although the prevalence of low birth weight and children affected by deprivation suggests small percentages, they mask large absolute numbers due to Hampshire being the third most populous county in England.

Demographics of groups that comprise SEND

The diversity and overlapping nature of need across and within the domains of education, care and health, make it challenging to quantify the absolute numbers of children and young people with additional learning need, including SEND. A variety of sources have been used to estimate the prevalence of children with additional learning needs, but no single source is accurate and complete (Figure 3).

Figure 3: Demographics of groups that comprise ALN including SEND



Source: Hampshire Public Health

Transition

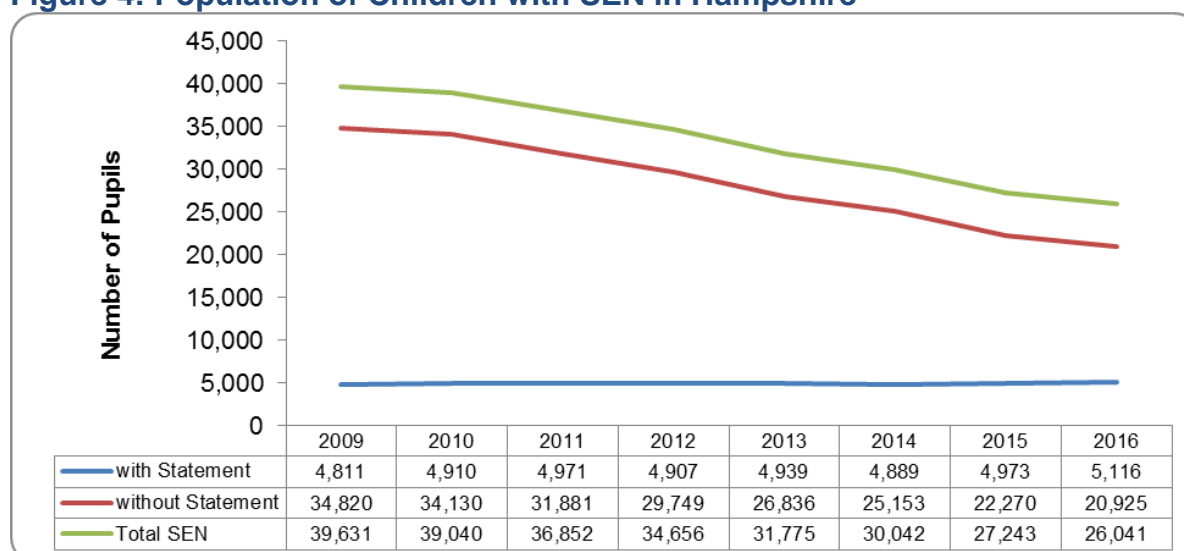
As more disabled children are surviving into adult life, transition to adulthood is an increasing issue for health, education and social services. To allow smooth transition to adult services age-appropriate personalised services are key. The National Institute (NICE) has developed guidelines²³ to help young people and their carers have a better experience of transition. Guideline recommendations are that discussion needs to happen with the young person's parents or carers to understand their expectations about transition. The guidelines also state that data from education, health and care plans should be used to inform service planning. However, local data and intelligence on effective preparation for adulthood are lacking.

Education

Key Messages

- Around 26,041 (13.9%) of Hampshire school pupils (187,426) were identified as having a SEN based on the January 2016 school census. Of these pupils, 11.2% (20,925) were characterised as having ‘SEN support’, the new category replacing the previous ‘School Action’ and ‘School Action Plus’ categories. Around 2.7% (5,116) have statements of SEN or an educational, health and care (EHC) plan, lower than the average of Hampshire’s statistical comparators (2.9%), the South East (2.9%) and the England proportion of 2.8%.
- Declining trends in the number of children with SEN without statements/EHC plans may be due to more accurate identification of those with SEN following implementation of the SEND reforms (see figure 4).

Figure 4: Population of Children with SEN in Hampshire



Source: Hampshire Public Health

- School census data indicates that almost all (99.6%) provision for Hampshire pupils with SEND support was in mainstream primary and secondary schools, with only 0.4% of pupils in special schools.
- Of the pupils with a statement/EHC plan in mainstream (state funded) schools, 17.6% were educated within resourced provision or SEN units. However, of all pupils with a statement/EHC plan 55.0% (2,560) were educated in special schools.
- The classification of ‘Social, Emotional and Mental Health’ need was created in 2015 to replace behavioural, emotional and social needs (BESD) in 2015. This accounted for 16.0% (3,764) of children with SEN support including to replace ‘social emotional and those with a statement/EHC plan, across all schools (primary, secondary and special). Only 3.0% (808) had a physical disability recorded as their primary need.

Hampshire County Council

- 'Moderate Learning Difficulty' at 30.7% (7,209) was identified as the most common primary need. Around 0.6% (144) of pupils have a profound and multiple learning difficulty (PMLD). This varies slightly from the England average where 24.2% of pupils have a moderate learning difficulty and 1% have a PMLD.
- Around 5.6% (1,310) of children with SEN had their primary need recorded as Autistic Spectrum Disorder (ASD) in Hampshire.

Care

Key Messages:

Children in need (CIN) are a wide group of children and young people who have been assessed as needing the help of services to achieve a reasonable standard of health or development. The CIN Census is an annual data collection that covers all children who are referred to children's social care services, even if no further action is taken. This includes children looked after (CLA), those supported in their families or independently (CSF/I) and children who are the subject of a child protection plan (CPP).

- Children in need (CIN) census data indicate that during 2015/16 there were 16,753 children in need of social services in Hampshire, a rate of 594.2 per 10,000.
- The number of children in need at 31st March 2016 was 8,732. Around 1,448 of Hampshire children in need had a disability recorded, resulting in a prevalence of 16.6%, compared to 12.7% nationally.
- Of those children in need with a disability, 16.1% of children were assessed as having ASD/Asperger syndrome.
- There were 4,143 school aged children in need at 31st March 2016 and 47.8% were identified with SEN (28.5% with SEN support and 19.4% had either a SEN statement or an EHC plan). This is a relatively high figure against the prevalence of 13.9% among pupils in the general population.
- Of the 700 school aged looked after children in Hampshire at 31st March 2016, our data suggest that 58.1% have SEN, higher than the general pupil population prevalence of 13.9% in school aged children who are not looked after.
- Looked after children are one of the most vulnerable groups of children with SEN. However, fewer looked after children in Hampshire, had their annual health assessment compared to the England average (78.8% v/s 90%.) and fewer had dental assessments (70.9% v/s 84.1%).
- Between 2012 and 2016, Hampshire has seen a significant increase in the rate of looked after children (as at 31st March of each year). In 2012 the rate was 39 per 10,000 children and this has increased to 46 per 10,000 children, a rise of 18% versus a 2% rise nationally.
- Hampshire experienced a highly significant upward trend in the rates of children referred to children's social services between 2011/12 and 2014/15 (an increase of 64.5%), the latest data do show a small decrease (0.7%). The 2015/16 CIN data show a Hampshire referral rate of 591.2 per 10,000 under-18s, which is higher than the England rate of 532.2 per 10,000. About 10% of referrals result in no further action. Significant increases in social care and safeguarding activity are observed. Some of this rise may be due to real or perceived need or changes to thresholds of care. There are a range of contributory factors responsible for

this rising need - effects of policy, research evidence, economic factors, demographic issues and significant presentation of the “Toxic Trio”: the prevalence of domestic abuse, parental mental health and parental substance misuse.

- During 2015/16 there were 1,672 children who became the subject of a child protection plan (CPP) in Hampshire, a rate of 59.3 per 10,000, which is higher than the national rate (54.2 per 10,000). Between 2012 and 2016 there has been a big rise (80%) in the yearly rate of children on CPP in Hampshire (28.4 per 10,000 to 51.1 per 10,000 respectively). In England, the rise in CPP rates was smaller at 14% during the same period.
- In 2016 GCSE educational attainment measured as the percentage of pupils with five or more GCSE (KS4) passes at grades A*–C (including English and Mathematics) for Hampshire children was 61%. However for different groups of pupils variations in performance are evident, this is particularly the case for looked after children (15.9%), children in need (16.2%) and disadvantaged children (39.4%).

Health

Key Messages:

- Information from the January 2016 Hampshire school census indicates that 0.9% (221) children with SEN had a visual impairment, 1.3% (307) had a hearing impairment, 17.4% (4,089) had a speech, language and communication need and 0.2% (41) had multi-sensory impairment.
- Overall, the number of 0-25 year olds in receipt of Disability Living Allowance in Hampshire in August 2016, was around 10,420. However not all of these children will have SEN. Musculoskeletal, mental ill health, hyperkinetic disorders and neurological diseases account for some of the most disabling conditions among children and young people in Hampshire but how many of these children also have a SEN is not clear.
- Currently there is no single data source that provides detailed information on health needs of children, and for some health conditions that impact on educational needs, there are little or no data.

Long term conditions

- Long-term chronic conditions and disability affect a significant minority of the adolescent population. These conditions include asthma, diabetes, allergies, epilepsy, cancer and physical and mental impairment. Results for England from the Association for Young People's Health report *Key Data on Adolescence 2015*²⁴ found that one in seven young people (15%) aged 11-15 reported that they had been diagnosed with a long term medical illness or disability. This would equate to around 11,383 young people in Hampshire.
- Applying prevalence figures from various reports to Hampshire's 2017 population provides an estimate of 494 children and young people with diabetes²⁵, 36,795 with asthma²⁶ and 851 with epilepsy²⁷.
- Aggregated data on unplanned hospital admissions for asthma, diabetes and epilepsy in under 19s show variations across Hampshire, with rates fluctuating over the years 2010/11 to 2014/15. At 425 unplanned admissions per 100,000 population, North Hampshire CCG had the highest overall rate of the five Hampshire CCGs, also significantly higher than the national rate of 327 per 100,000. This CCG had the highest unplanned admission rate for each individual long term condition - diabetes (65.1 per 100,000 v/s 55.8 per 100,000 nationally), epilepsy (138.3 per 100,000 v/s 74.6 per 100,000 nationally) and asthma (240 per 100,000 v/s 216.1 per 100,000 nationally). Unplanned admission rates for epilepsy in both North Hampshire and South Eastern Hampshire CCG (122.7 per 100,000) were significantly higher than the national average..
- National trends in the Royal College of Paediatrics and Child Health (RCPCH) report²⁸ indicate a rising use of urgent/emergency healthcare among all age groups, in particular those with long-term conditions (LTCs), impacting on school

attendance and educational attainment. We do not why admission rates for LTC in children are increasing and understanding the reasons behind this rise remain challenging.

Mental health

- There is a lack of specific data on SEND. However it is likely that children and young people with SEND will be at least as likely to have mental health issues as other people their age given the challenges they may face. Estimates from the Understanding Society²⁹ (2011 to 2012) show that around 12% of children aged 10 to 15 reported high or very high total difficulties scores, equivalent to 11,062 children suffering from mental ill-health in Hampshire.
- High hospital admission rates as a result of self-harm among the 10-24 year old age group (493.4 per 100,000 in 2014/15) and for mental health disorders among the 0-17 year old age group (89.5 per 100,000) may be indicative of a rise in levels of psychological distress in young people in Hampshire. However they may also reflect better data collection. Our rates of self-harm admissions are high compared to England and our statistical neighbours and have been the subject of investigation and continue to be so. Better working on Future in Mind³⁰ proposals such as Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme, can help improve our children and young people's mental health and wellbeing.
- Emotional wellbeing and mental health in children and young people is increasingly a strategic priority in Hampshire. There is a joint Hampshire strategy for emotional wellbeing and mental health in children and young people called "Make it Worthwhile"³¹ which runs from 2014 to 2017. Emotional resilience in children and young people is a priority in Hampshire's strategy for improved public health "Towards a Healthier Hampshire"³² which runs from 2016 to 2021. The emotional wellbeing and mental health strategy is currently being refreshed. A needs assessment to inform the new strategy is underway and the aim is to have a completed strategy by November 2017, which will also be available on line.

Continuing care and complex health needs

- The 2016 National Framework for Children and Young People's Continuing Care³³ defines continuing care as: '*A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone*'. Continuing care affects relatively small numbers of children, approximately 35 per year in Hampshire, but the cost of continuing care is disproportionately high relative to the few children requiring continuing care. Whilst it has not been possible to access figures on children's continuing health care expenditure, nationally the spend on NHS continuing healthcare totals around £2.5 billion per annum and around 60,000 individuals are in receipt of NHS continuing healthcare at any given time.³⁴

- The care of unusual or complex conditions is concentrated in specialised settings, which is part of the direct specialised commissioning function of NHS England. Specialised paediatric services tend to be regarded as complex due to the severity and complexity of the clinical conditions in children and potential interdependencies with other specialised services. In 2015/16 there were 13,346 admissions for specialised paediatrics. A total of 9,551 paediatric patients were responsible for these admissions.

Palliative care need

- Applying the Leeds study (2012 Fraser et al³⁵.) estimates of the prevalence of children (0-19 years) living with a life-limiting or life-threatening condition that may require palliative care services, as 32 per 10,000, to Hampshire's 0-19 population, equates to 1,000 children living with a life-limiting or life-threatening condition.
- On average, there were around 28 deaths a year of Hampshire children and young people dying from causes likely to have required palliative care in the six years from 2010/11 to 2015/16.

Implications

The diversity and overlapping nature of need across and within the domains of education, care and health, make it challenging to quantify the absolute numbers of children and young people with SEND. Thus a variety of sources have been used to estimate the prevalence of children with SEND but no single source is accurate and complete.

Education

Translation of the SEND reforms locally will continue to transform service delivery. More accurate identification of children with SEN has led to declining trends in the number of children with SEN without statements/EHC plans. Focused and inclusive practice will ensure children with SEN receive the right support in the right setting, enabling them to thrive and develop. Flexibility of SEN provision is needed to address complicating social factors in children in need and those looked after with SEN. This group of children do need additional focus to support them achieving better educational results.

The focus of SEN support in mainstream schools (funded via the delegated SEN budget) needs to reflect both the complexity of different needs as well as the profile of need. Work with schools to incrementally increase the number of children with SEND accessing mainstream education and succeeding is important and is being catalysed through government initiatives³⁶. This can enable access to appropriate support so that positive outcomes are achieved. Thus there is a need to vary capacity and focus SEN provision depending on the numbers of children with SEN and complexity of need.

Care

Significant increases in social care and safeguarding activity are observed. Some of this rise may be due to real or perceived need or changes to thresholds of care. There are a range of contributory factors responsible for this rising need - effects of policy, research evidence, economic factors, demographic issues and significant presentation of the "Toxic Trio": the prevalence of domestic abuse, parental mental health and parental substance misuse. With regard to ASD, the majority of children with ASD will not meet Hampshire Children's Services criteria for social care and will therefore not be on the CIN database. This doesn't necessarily suggest unmet need, as needs may be met in other ways. However, this should be an area of focus, linking where relevant, with autism needs assessment work and the *Autism Strategy for Children and Young People in Hampshire 2014-17*³⁷.

Health

The prevalence of children and young people with healthcare need is increasing. Demographic factors alongside the increasing rate of survival of children with once life-threatening conditions has led to rising numbers as well as increasing complexity of need. Children with sensory impairments will continue to require appropriate support to enable them to achieve their academic potential. Indications are that more children with a severe disability are living longer due to advances in medical technology. Optimising the management of their conditions and improving their health outcomes will positively impact on their life chances (educational attainment, living independently, and employment opportunities).

Building on the close working of health with education and schools, and social care to emphasise the co-dependent nature of health and education outcomes is key. Importantly, the future cost to education, health and care of not preventing and addressing SEN needs to be recognised.

Summary recommendations

Every child and young person in Hampshire deserves to be provided with the best learning opportunity to achieve their full potential, academically and in life. The key messages and implications identified within this JSNA summary document should be used to inform local strategy and corresponding action plan for commissioners and providers to deliver.

Recommendations to address key issues for our children include:

Definition

1. Collaboratively agree a single, simple definition of additional learning need/SEND across Health, Education and Social Care to ensure the incidence and prevalence of additional learning need/SEND is understood and enable it to be measured. Develop effective and efficient data collection and sharing systems to meet this need, especially intelligence around transition.

Reducing Future Risk and Drivers Influencing SEND

2. Improve access for maternal education prior to conception and during pregnancy, targeting support to improve the health and development of the unborn child. We need to ensure that we maximise the opportunity that early access to maternity services presents – to offer preventative advice on risks such as smoking, alcohol, substance misuse, domestic violence, medical conditions and diet including folate uptake; advice which can help reduce the risk of SEN, improve life chances and reduce health inequalities.
3. Improve the reach of the Healthy Child Programme (Public Health Children's Nursing services – Health Visiting and School Nursing) through 'Universal', 'Universal Plus' and 'Universal Partnership Plus' services, 'Early Help' interventions, the 'Supporting Troubled Families' initiative and the Family Support Service (FSS) to ensure early identification of need, enable access to the right evidence-based services, improve the resilience of families and thus support good development. Various partnership initiatives to target childhood poverty should be escalated. Children and young people with a long term condition or SEND also need to be able to access holistic, child-friendly mental health and public health services. Importantly, Designated Medical Officers need to continue to do more to support schools with their duties under the 'Supporting Pupils with Medical Conditions' guidance.

Improving Outcomes

4. Maintain and improve on the indicators where Hampshire children with additional learning needs/SEND fare better than statistical comparators, with a particular focus on addressing inequalities across the county.

5. Undertake a review of and act on the indicators where Hampshire fares worse than the statistical comparators, in particular indicators for children in need, for example, a sharper focus on early identification and effective management of disability, increasing the proportions of looked after children undergoing assessments; and identifying opportunities for working with partners to improve attainment.
6. Continue to focus on early and accurate identification of children with SEN to ensure the right support. Work with schools to incrementally increase the number of children with additional learning need/SEND accessing mainstream education and succeeding. This is key to achieving positive outcomes in education, employment and independence to have more choice and control over the support received and the ability to lead fulfilled lives.
7. Ensure children with sensory impairments receive appropriate support to enable them to achieve their academic potential.
8. Strengthen our understanding into the underlying causes for the rising admission rates for long term conditions (LTC) in children as well the management of these conditions in the community. Use the evidence on the variations in the management of long term conditions (LTC) by CCGs to learn from best performers, including Royal College of Paediatrics and Child Health (RCPCH³⁸) recommendations. Improve the management of LTCs for children through integrated models of care to improve school attendance and learning, particularly for those children with additional learning need/SEND. Also, engage children on public health messages such as resilience, self-care and the importance of better management of LTCs.
9. Ensure timely CAMHS provision to prevent the escalation of mental health disorders in children and young people and reduce the devastating impact on their future. Outcomes for child and adolescent mental health problems can be improved by supporting (alongside Mental Health networks):
 - Continued roll out of the *Children and Young People's Improving Access to Psychological Therapies* (CYP IAPT) programme
 - Improvements in Crisis Care and CAMH Intensive Treatment Services (Tier 3.5)
 - Development of robust comprehensive 'Transformation Plans'
 - Delivery of 'Future in Mind' proposals
 - Build on work of the '*Children and Young People's Mental Health and Well-Being Taskforce*' and implement recommendations
 - Improved perinatal mental health access and outcomes, including early identification and risk assessment
10. Understand palliative care activity and need by working with paediatric palliative care, the charitable sector, hospices and specialised commissioning to better plan and deliver sustainable services.

11. Work in partnership to deliver recommendations in the *Special Educational Needs and Disability Code of Practice: 0 to 25*. Develop a comprehensive, individualised outcomes-focused approach to performance monitoring for all partners (health, care and education) to be able to demonstrate that interventions have supported children with SEND to achieve their full potential and maximise future opportunities. Importantly, the emphasis should be on reducing SEN through prevention, early identification and effective management of SEND.
12. Ensure that children and young people benefit from an integrated approach as they grow up. A range of agencies and professionals provide support for children and young people at different stages of their development. Recent developments to drive integrated care across the NHS and children's social care, such as mechanisms to drive pooling of resources, or the use of the NHS number as a common identifier are key.

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