

# LONDON BOROUGH OF HAVERING

## Special Educational Needs and Disability (SEND)

2016

A Deep Dive

Joint Strategic Needs  
Assessment

*By LBH Public Health Service  
(with contributions from:  
Learning and Achievement;  
Children Social Care;  
Business & Performance Services,  
Havering CCG, CSU and NELFT)*

HAVERING

J S N A

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## ABBREVIATIONS/KEY TERMS

ARP	Additional Resourced Provisions
ASD	Autistic Spectrum Disorder
BESM	Behavioural, Emotional, Social and Mental health needs
BMI	Body Mass Index
CAD	Children and Adults Team for people with disabilities
CCG	Clinical Commissioning Group
Children in Need	A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled
Child Protection	Child protection is the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect. It involves measures and structures designed to prevent and respond to abuse and neglect
CO	Carbon Monoxide
EHC/P	Education and Health Care / Plans
FSP	Foundation Stage Profile
GP	General Practice
HSCIC	Health and Social Care Information Centre
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAC	Looked After Children
LD	Learning Disabilities
Local Offer	Local Offer gives children and young people with special educational needs or disabilities and their families, information about what support services the local authority think will be available in their local area. Every local authority is responsible for writing a Local Offer and making sure it is available for everyone to see
NEET	Not in Employment, Education or Training
NELCSU	North East London Commissioning Support Unit
NELFT	North East London Foundation Trust
NHS	National Health Service
NOO	National Obesity Observatory
OFSTED	Office for Standards in Education, Children's Services and Skills
POET	Nationally developed tool for capturing the views of children, young people, their parents and carers
SALT	Speech and Language Therapy

SEN(D)	Special Educational Needs and Disability
SLCN	Speech, Language and Communication Needs
YOS / YOT	Youth Offending Service / Youth Offending Team

# 1. EXECUTIVE SUMMARY

## 1.1 Context

This needs assessment about children and young people from birth to age 25 with Special Educational Needs or a Disability (SEND)<sup>1</sup> is part of the Havering Joint Strategic Needs Assessment (JSNA). It reflects the new obligations contained within the Children and Families Act 2014. The Act seeks to ensure that all children and young people, irrespective of disability, are better prepared to lead a full, active and productive life. The JSNA is a crucial element in the ensuring that this happens.

Health and Wellbeing Boards are required to capture the needs of vulnerable children and young people, including those with SEND, in the JSNA and reflect them in the local Health and Wellbeing Strategy (HWBS). Local partners must use the insight captured within the JSNA and the priorities identified in the HWBS to shape their commissioning for children and young people with SEND. Their coordinated commissioning will form the 'Local Offer' which sets out the range of facilities, activities and support available for children and young people with SEND, and their parents and carers. Education, Health and Care (EHC) plans will set out the outcomes that are important to the individual child and any services from the 'Local Offer' necessary to meet their needs. Overtime, the needs of all children with an EHC plan will be collated to refresh the JSNA and thereby improve the fit between the Local Offer and the needs of local children.

The Act makes clear that: -

- children and young people, together with their parents and carers must be at the centre of the process;
- education, health and social care services must work together, if that helps them do better for children and young people with SEND.

This needs assessment seeks to describe:-

- what we know about children and young people with SEND, including risk factors for SEND and vulnerable groups
- key services within the local offer and how they work together
- outcomes for children with SEND in terms of their education attainment

Recommendations are made about:-

- how key partners work together to develop and implement relevant strategy
- the local offer in terms of services, how they work together and the further development of staff

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<sup>1</sup> Department for Education's definition of SEND encompasses all children (or young people up to the age of 25) who have significantly greater difficulty of learning than the majority of others of the same age or... a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions .... including those with mental health needs

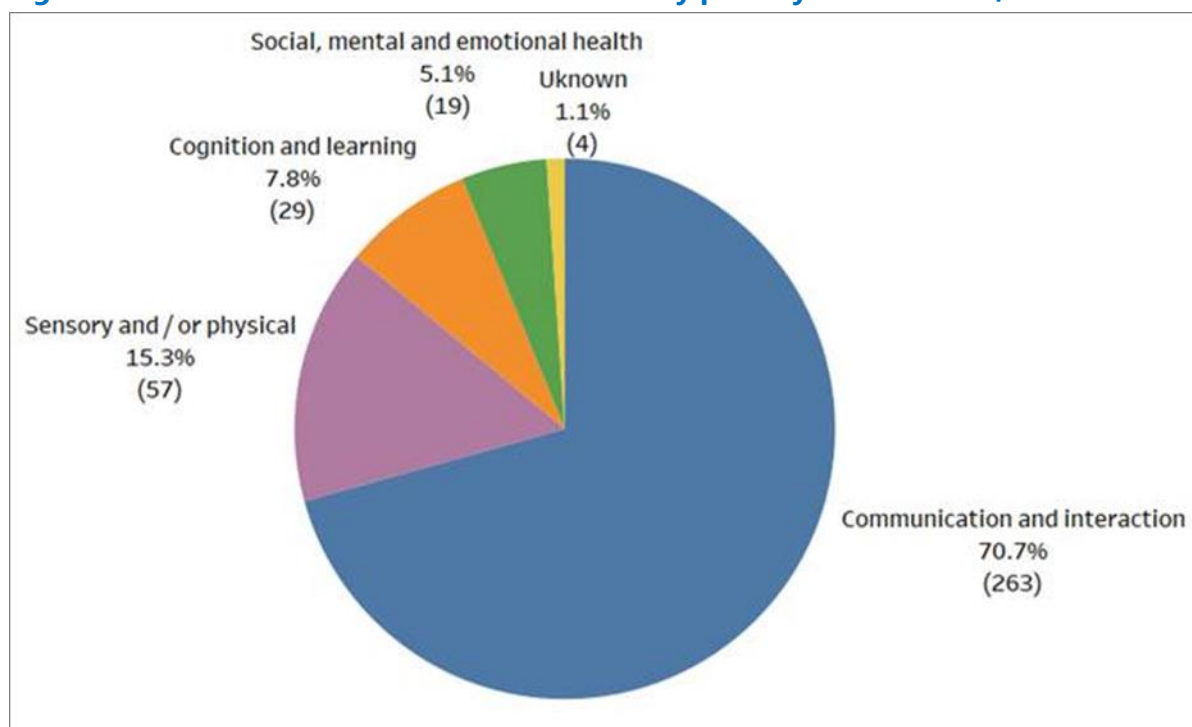
- the future development of the JSNA to improve our understanding of the needs of children and young people with SEND

## 1.2 What do we know about CYP with SEND?

### 1.2.1 Children aged 0-5

Our best measure of the prevalence of SEND amongst younger children is the number of children known to the 0-5 Children and Disabilities (CAD) team. There were 372 children in 2015, up from 164 in 2014 and 138 in 2013. The great majority of referrals and most of the growth in referrals relate to communication and interaction issues (see Figure 1).

**Figure 1: Number of referrals to CAD 0-5 team by primary need of child, 2015**



Source: London Borough of Havering Children and Disabilities Team

### 1.2.2 School aged children

- Currently, there are more than 3400 children with SEND in Havering schools. Very few children with SEND are formally recorded as such before they enter school. About 120 boys and 50 girls are identified with SEND in Year Reception. The number of children with SEND in each year group then increases to around 230 boys and 100 girls in Year 2 to Year 6 and thereafter slowly decreases to 160 boys and 70 girls in Year 11.
- Small numbers of children with SEN attend *alternative provision*<sup>2</sup> (n = 13) or are home schooled (n=8).
- The proportion of school age children and young people in Havering recorded as having SEND (≈10%) is low compared with London and national averages (> 15%). This may reflect the success Havering previously achieved in implementing a 'Statement-less'

<sup>2</sup> *Alternative provision is for pupils who can't attend mainstream school for a variety of reasons, such as school exclusion, behaviour issues etc*

schools policy. If so, and given national policy has changed, the % of children recorded with SEND may increase over time closer to the national average.

- Either way, the number of children and young people in the borough, including those with SEND, will increase as a result of an increasing birth rate and the steady influx of families from elsewhere, particularly other London boroughs.
- In line with national trends more than 2/3<sup>rd</sup> of children with SEND are male. The evidence suggests that boys are more susceptible to harm e.g. from trauma and infection, both pre and post birth. However, there is also evidence the girls' needs may go unrecognised as they tend to exhibit less typical and intrusive behaviours in response to their difficulties.
- The number of Asian/Black or Black British children receiving SEN support is increasing but the proportion is still low in comparison to pupils in mixed or white British ethnic groups. This may be a cultural artefact whereby Asian/ Black families are less willing to have their children 'labelled' as having special educational needs.
- The prevalence of SEND varies with disadvantage – rates are around twice as high in Harold Hill and South Hornchurch compared to Cranham and Upminster.
- Havering schools attract significant numbers of children from adjacent authorities. Flows of children with SEND in and out of the borough are more balanced such that the net inflow is only 24 children. 240 children with SEND are placed out of the borough because their specific needs can be better met elsewhere and / or a desire to maintain an existing placement for young people who have moved into the borough.
- The primary need of statemented children (a sub-set of all children with SEND likely to have the greatest need) varies with age and care setting. The needs of a cohort of children, who were more likely to have behavioural, emotional and social difficulties or autistic spectrum disorder could not be met locally and attended out of borough special schools (see Table 1).

**Table 1: Statemented children in Havering by setting and primary need, 2014/15**

	Havering			Out of borough
	primary (n=310)	secondary (n=353)	special (n=294)	special (n = 77)
<b>Speech &amp; Language &amp; Communication Needs</b>	28.1%	17.3%	11.6%	
<b>Moderate Learning Disabilities</b>	16.8%	22.9%	19.7%	
<b>Autistic Spectrum Disorder</b>	26.5%	21.8%	27.6%	24.7%
<b>Severe Learning Disability</b>			21.1%	
<b>Behavioural, Emotional &amp; Social Difficulties</b>				36.4%

Source: London Borough of Havering Children and Disabilities Team

### 1.2.3 Children and young people with mental health problems

The new definition of SEND makes specific mention of children and young people with mental health problems. Improved mental health is associated with better outcomes in all aspects of life for people of all ages and backgrounds. This includes better educational achievement, increased skills, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. Based on national

predictive models, it's likely that around 1 in 10 children in Havering aged 5 to 16 years (3,093 children) currently have a mental health disorder.

This figure can be broken down as follows:

- 3.5% (1,194) have emotional disorders such as phobias, anxiety, OCD
- 5.5% (1,862) have conduct disorders such as aggression and vandalism
- 1.5% (505) have hyperkinetic disorders including hyperactivity and ADHD

The recently agreed [Havering CAMHS Transformation plan](#) provides detailed information about the:

- mental health needs of local children and young people;
- action to strengthen levels of mental wellbeing and prevent mental illness;
- current treatment services and how they will be improved

### 1.3 Risk factors for SEND

What happens in pregnancy and early childhood impacts on physical and emotional health throughout life, including the risk of having SEND.

#### 1.3.1 Pre-natal and birth factors affecting the risk of SEND

- The majority of permanent disabilities have their origin in neonatal disease or trauma. Exposure in-utero to infection; poor maternal nutrition and maternal obesity; maternal smoking, alcohol and substance misuse increase the risk of premature birth, traumatic birth, low birth weight and congenital anomalies; all of which carry an increased risk of developmental delay or permanent disability.
- One in ten women in Havering smoke during pregnancy. Midwifery services at BHRUHT have adopted the *BabyClear* programme to maximise the impact of advice given to women who continue to smoke during pregnancy. The Council has decommissioned smoking cessation services but has committed to reinstate support for pregnant women.
- Teenage pregnancy is associated with a range of negative health and social outcomes for both mother and baby. Teenage pregnancy rates in Havering have declined and are similar to the national average but higher than the average for London.
- The risk of problems during pregnancy and at delivery; and congenital anomalies rises with maternal age. The risks are more marked for women aged 40 and over. Nonetheless the majority of pregnancies will be unaffected and the trend towards later maternal age is driven by a range of personal, cultural and social factors that are unlikely to change soon.
- Fertility treatment is also associated with an increased risk of poor outcomes, in part due to the increased risk of multiple pregnancy. Twins and triplets are more likely to suffer congenital anomalies, and are also at increased risk of growth restriction and preterm birth, which in turn are associated with disability including cerebral palsy and learning difficulties.

Participation in the complete programme of personalised maternity care affords the opportunity to:-

- Support the adoption of healthier lifestyle choices.
- Offer screening for serious genetic and developmental abnormalities
- Effectively monitor and manage difficulties should they occur during pregnancy

- Targeted outreach to vulnerable and socially excluded groups can reduce the proportion of women who access maternity services late.
- Premature birth can have long term effects on motor development, behaviour and later educational achievement. The prevalence of premature birth in Havering (7.6%) is similar to that in comparable London boroughs.
- Premature birth is associated with visual impairment. Retinopathy of prematurity (ROP) affects 65% of babies weighing less than 1250g at birth to some degree, but only 6% will have advanced ROP requiring treatment. All low birth weight babies or babies born at or before 32 weeks gestation will have regular eye screening examination until the risk is passed. Treatment can limit the harm caused but a small proportion of babies will nonetheless have significant vision loss.
- The risk of hearing impairment is also increased for premature babies because of prior oxygen starvation or as a side effect of the treatment they may require e.g. the use of antibiotics or noise induced deafness as a result of being in intensive care.
- Once sensory impairment is identified, early support is key to development of age appropriate skills, again this has implications for early support services and sensory specialist advisory teachers.

### 1.3.2 Post-natal factors affecting the risk of SEND

The mother-child attachment bond shapes baby's brain, with effects on self-esteem, their expectations of others, and their ability to develop and maintain successful relationships in later life which in turn influences a range of outcomes including educational achievement. Described below are a number of factors that influence parental attachment.

*Breastfeeding* is good for babies in so many ways. It helps to reduce the risk of infection and childhood obesity as well as promoting attachment between mother and baby. Only 1/3<sup>rd</sup> of women in Havering breastfeed beyond 6-8 weeks of birth; significantly below both the London and England average.

*Maternal mental illness* has adverse effects on the mother herself, but also on the future development of her infant. A handful of new mothers in Havering each year will experience acute and severe mental illness (e.g. post-partum psychosis); many hundreds will have less severe problems that may impair attachment between mother and child. Screening for perinatal mental illness, primarily by health visitors and the provision of appropriate support and treatment where necessary is effective and cost effective.

*Child abuse and neglect* can impair brain development with long-term consequences for cognition, language skills and education attainment, and pre-dispose to mental illness.

- The proportion of children who come into local authority care in Havering has increased in recent years but is still relatively low compared with rates elsewhere in London and the country as a whole. Nonetheless, the Council is 'parent' to nearly 250 **Looked After Children** (LAC) who are at high risk of having SEND as a result of their experiences in earlier life.

- In addition, in 2014/15, an average of 173 children were on a **child protection plan**<sup>3</sup> at any one time; the average for 2013/14 of 124. Proportionally more children (49 / 100,000) were on a child protection plan in Havering than London (47) as a whole; but fewer than the national average (54).
- Havering has a low rate of **children in need**<sup>4</sup> (500/10,000) compared to the London (818) and national (674) rates. Disability was identified as the primary need for relatively few children and parents when compared to our statistical neighbours.

*Child poverty* is both a cause and an effect of SEND. About 1 in 5 children in Havering live in poverty. The prevalence of SEND is highest in those areas with the highest levels of disadvantage i.e. Harold Hill and South Hornchurch.

## 1.4 Pupil and Parent Voice

The Children and Families Act and the SEND code of practice are clear that children and their families should be at the centre of everything we do – at the level of the individual child but also in strategic planning to meet the needs of all children.

Locally, children are involved in a variety of ways:-

- The child's voice is strong in each individual Assessment and EHC planning process.
- *ViewPoint*, the Council's tool for gaining feedback from all children, including those with SEND, involved in children's social care statutory processes is used and consideration given to feedback in service delivery and development.
- Pupil forums are being developed through the *Advocacy for All* contract and work is underway to establish the School Council Pupil network.
- POET, a nationally developed tool for capturing the views of children, young people, their parents and carers was used successfully last year and will be used each year going forward.

Similarly, parents are involved in a variety of ways at different levels:

- Parents are central to the development of individual EHC plans for their children.
- Havering has an established Parent Forum. The Council also uses wider events and targeted consultations to reach as broad an audience as possible
- Parents were involved to the development of the process employed to develop EHCs generally; the Local Offer web site and reviews of existing commissioned services e.g. Transport.
- A task and finish group, comprising officers and parents, was established to create and then implement a new vision for children and young people's preparation for adulthood. The new vision is now in place, new provision opens in September 2016 and work is underway to create a CAD Preparation for Adult team.

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<sup>3</sup> *If, following a child protection conference, the local authority decides that a child is suffering, or is likely to suffer, significant harm, it will draw up a child protection plan setting out how the child can be kept safe, how things can be made better for the family and what support they will need from the Council and other partners.*

<sup>4</sup> *Children in need are defined in law as children who are aged under 18 need local authority services to achieve or maintain a reasonable standard of health or development and / or prevent significant or further harm to health or development.*



- A similar approach will be employed to progress the agreed future work programme including the continued development of our personal budget offer and the re-commissioning of short break provision.

## 1.5 Key services within the local offer

The Havering Local offer is accessible to local residents [on-line](#) and provides information, including contact details, about the help and services available for children, young people and adults with SEND. The JSNA focuses on key statutory sector services and how they work together.

### 1.5.1 Children and Adults with Disabilities (CAD) Service

The 0-25 Children and Adults with Disabilities Service (CAD) brings together the key functions and responsibilities of the Local Authority regarding Education and Social Care for those aged 0-25 years and with SEND, into a single management arrangement. The multi-disciplinary teams within CAD are focussed on delivering joined up social care and education involvement for our SEND children, putting them and their families at the centre of what we do. The teams together with health partners and schools work to identify outcomes for children and, using available resources, help children to meet them.

#### 1.5.1.1 CAD Assessment and Placement

The Assessment and Placement team within CAD works collaboratively, across the 0-25 age range, with schools, parents and support services including those from the voluntary sector. The main function of the team is to collate a range of information relating to individual children and young people and distil it into Education, Health and Care plans (EHCP) in an accessible format. The team prepares and presents information to a panel which determines the outcome of requests for statutory assessment and the placement of children and young people following assessment. The team works closely with providers to ensure that all children and young people are in education or training. The team works alongside schools, health and social care to determine, review and disseminate information about processes involved in requesting an EHCP, holding Annual Reviews and converting existing statements into EHCPs.

#### 1.5.1.2 CAD Educational Psychology

The educational psychology service is delivered as part of the multi-disciplinary CAD teams offering a collaborative service to children and families. Educational Psychologists primarily work in schools and settings where they plan and carry out assessments of individual children and young people and deliver training for school staff. Educational psychologists support children with academic development, emotional wellbeing and ability to lead independent lives into adulthood through school staff and in collaboration with health and social care colleagues.

#### 1.5.1.3 CAD 0-5

The CAD 0-5 Support team works with agencies across education, health, social care, the voluntary sector and with early years settings, schools and parent/carers to provide appropriate support packages and early intervention.

The team includes Area SEND Coordinators, keyworkers, specialist teachers, an educational psychologist and social worker.

The CAD 0-5 Support Team provides access to:-

- **Home-based support** – working with parents / carers to:-
    - Carry out an in-depth, on-going assessment of their child's needs and set targets to gauge progress.
    - Jointly plan and model appropriate learning opportunities
    - Provide information and guidance on the best approach to help their child.
    - Specific support provided may include :-
      - **Home Learning Support** – for children aged 1–3 years with additional needs; to develop their existing and emerging skills through play.
      - **Social Communication Support** - keyworkers work with parent/carers to support children with social communication needs.
      - **Early Support** – for children with complex needs requiring significant multi-agency support from birth to five; help with coordination of services, keyworker support and multi-agency meetings.
  - **Setting-based support:**
    - Area SEND Coordinators - advise and support early years care providers
    - Specialist Teachers - support teaching staff in maintained nurseries and schools
  - **Sleep service** – offering weekly sleep advice drop-in sessions and a helpline. A full sleep assessment and individual sleep programme is devised for children with significant sleep issues.
  - **Groups** - to help parents understand their child's needs and how to support them to achieve best outcomes. The range of activities offered include; swimming, baby massage, a developmental group, baby signing, messy play and stay and play sessions.
- 
- More than 70% of all referrals to CAD 0-5 are for support with communication and interaction problems. Area SENDCos support the greatest number of children, working with early years care providers. The early support and home learning support teams work with smaller numbers of children with more complex problems.
  - The CAD 0-5 Early Support Team receives referrals from the community paediatricians, therapy services and health visitors. Early years settings make referrals for Area SENDCo input for children with SEND.
  - The CAD 0-5 team chairs a monthly multi-agency planning meeting to discuss children with complex medical needs with the Early Help Service and relevant health professionals including community paediatricians, therapy services, health visiting. The neonatal team at Queens Hospital send a discharge summary to the Community Paediatrician Service regarding premature births and babies with health care needs. The paediatricians then

present these cases at the monthly planning meeting. Thereafter, children with complex needs are reviewed biannually by a joint education, health and social care panel.

### **Recommendation**

The resulting improvement plans for therapy services should reflect recent / predicted increases in demand and rapid implementation should be a priority.

#### *1.5.1.4 Transition into school*

- 161 children with SEND were transitioned to primary school in 2015; 2/3<sup>rd</sup> with communication and interaction problems.
- A child centred planning meeting is held involving parent/carers, school and early years setting staff, and any other agencies working with the family to put in place an action plan for the child's transition.
- Children with high needs are tracked from pre-nursery and identified on the Early Years Transition list. The child centred approach used ensures that schools are fully prepared for these children and a dedicated team of key workers from the 0-5 and 5-19 CAD teams is allocated to the highest need children to further liaise and work with settings and schools in the Summer Term prior to transition into Reception and Year 7.
- A local nursery offers up to sixteen places for children in the year prior to Reception with social communication difficulties and /or another diagnosis needing highly specialist support.
- Not all children transitioning need continuing help from the CAD team or the help needed may change significantly. Some children progress as a result of early intervention such that a differentiated approach isn't required when entering mainstream schooling. Some parents want to develop the expertise to act as their own key worker. Child centred planning facilitates the agreement of an appropriate, bespoke plan for each child.

#### *1.5.1.5 CAD 5-19*

- The 5 -19 CAD Support Team offers support to children and young people with a range of difficulties, their schools, settings and families. The areas covered are sensory (visual, hearing and multi- sensory difficulties); medical and physical; speech, language and social communication needs; complex needs; learning difficulties and transition into Key stage 4 and Key Stage 5. The team includes educational psychologists, social workers, family support workers, specialist advisory teachers, specialist assistants and a 'mobility and habilitation' officer. The team will support children and families wherever they are; at home, out of borough, in school, nursery or clinic.
- In addition to the increasing numbers of children with social communication difficulties, ASD, and complex or challenging behaviour; the CAD 5 – 19 team continues to support significant numbers of children with sensory, medical or physical impairments (> 300 children on the caseload of 3 key workers).

#### *1.5.1.6 Transition to adult services*

- Havering has developed a multi-agency protocol to ensure effective transition from child to adult support. The protocol improves the coordination of support so that every young person with SEND aged of 13-25 years and their parents/carers have a smooth and positive transition. Work is underway to embed the protocol more fully into operation and a Preparation for Adulthood Team within CAD is being established.

This should mean:

For young people that they.....	For their parents/carers that they .....	That during / after transition .....
make decisions and take the lead or are supported by people that can advocate for them.	see agencies working together and pursuing agreed plans but remaining flexible to accommodate change.	young people and their families are well informed and fully involved in the process to make their own choices.
are supported so they can plan for what they want to achieve.	are listened to and fully involved.	the process is coordinated, systematic and consistent with close partnership working between all professionals and agencies
are able to access the same opportunities as other young people.	have a single point of contact.	every young person receives services and support according to need and eligibility
have access to services.	feel supported.	at the level of the individual young person, the need for services is identified early and planned for in good time
can try things out beforehand.	receive consistent messages.	post 16 services and opportunities are commissioned effectively, based on an accurate assessment of collective needs for young people in the borough as a whole.
can change their mind.	have easy access to understandable information.	

#### 1.5.1.7 *Child protection and social care*

- Disabled children present additional challenges when fulfilling the statutory functions of child protection and care proceedings. Specialist workers within CAD lead this work and provisions such as foster care for both long and short term are difficult to source but work is underway to increase provision in this area.
- The provision of short breaks can prevent families reaching crisis point. Commissioned services include a range of activities: holiday clubs, pre-school sessions, buddy and befriending services and youth clubs. Nearly 250 young people currently access commissioned short breaks from 6 providers. Approximately 150 families are in receipt of Direct Payments.

#### **Recommendation**

Ensure the planned re-commissioning of short breaks includes input from health so that a joint approach can be developed and implemented.

## 1.5.2 Health services for children and young people with SEND

Historically, data systems within the NHS locally have not recorded the SEND status of children and young people. Hence, it is not currently possible to identify and describe the health services used by this specific cohort. The new iteration of RIO (the local child health information system) has the facility to identify children with an EHC plan but EHC plans will not be in place for all children until 2018. Until then and or until a bespoke SEND database capturing the health, social care and education support provided for all children with SEND in the borough is established, we must make use of the available proxies for SEND status e.g. relevant medical diagnosis and / or look at the activity and performance of health services likely to be accessed by children with SEND.

### 1.5.2.1 General Practice

People with learning disabilities are known to have higher levels of obesity and physical inactivity and a greater risk of developing chronic illness including diabetes and heart disease. To address this risk, GP practices are funded to provide enhanced care to people with learning disabilities aged 14 and over. As at June 2016, 43% of patients on practices' learning disability registers had had an annual health check and 33% were recorded as having had a health action plan completed.

### 1.5.2.2 Community health services

North East London Foundation Trust (NELFT) provides community health services to children aged 0-19 registered with a Havering GP in a variety of settings including home, community clinics and early years and educational settings. NELFT operates a **Single Point of Access (SPA)**, so children are referred in once and can then be referred internally to multiple services. This is often needed for children with complex, life-long limiting illnesses; with both physical and mental health needs. Individual children may be engaged with multiple community health services for extended periods of time.

Services include:

- **Community Paediatrics** - Almost 1700 children were under the care of community paediatric services in 2014/15, up by 22% from 2012/13. Just under 60% were aged 0-5 and a further 30% aged 6 – 10. The service received nearly 1100 new referrals in 2014/15. The interval between referral and first appointment is 18 weeks. 14% of first appointments are not attended. 80% of looked after children are seen within 4 weeks of referral.
- **Occupational Therapy** - Almost 500 children were under the care of occupation therapy in 2014/15; up by 2/3<sup>rd</sup> since 2012/13. About 40% were aged 0 – 5 years and similar proportion were aged 6 – 10 years. The service received 232 new referrals in 2014/15. The interval between referral and first appointment is 27 weeks. 19% of first appointments are not attended. 14% of looked after children are seen within 4 weeks of referral.
- **Physiotherapy** - Paediatric physiotherapy services as a whole received 694 new referrals in 2014/15. The interval between referral and first appointment is 9 weeks. 15% of appointments of first appointments are not attended. 14% of looked after children are seen within 4 weeks of referral.
- **Child and Adolescent Mental Health Service (CAMHS)** - More than 2400 children were under the care of CAMHS in 2014/15; up by a third from 2012/13; 60% were aged 11 to 16.

See [Havering CAMHS transformation plan](#) for more information about current services and priorities for development.

- **Speech and Language Services** – Over 1800 children were under the care of NELFT speech and language therapy services in 2014/15, up by 10% from 2012/13. More than 60% were aged 0-5 years and a further 30% 6 – 10 years. The service received more than 1000 new referrals in 2014/15. The interval between referral and first appointment is 14 weeks. 12% of first appointments are not attended. 18% of looked after children are seen within 4 weeks of referral.

NB. Speech and language therapists (SLT) operate as part of a joint health and education service with specialist advisory teachers and specialist teaching assistants. Assessments and care are largely provided in the school setting. Children are assessed and prioritised based on severity to receive support from an SLT; a specialist teacher /assistant or from within the school's own resources which include access to Language Link and Speech Link, a commercial package which identifies difficulties and provides a programme of intervention. This approach supports over 3000 children each year.

### Recommendation

Ensure the data presented in the JSNA regarding community health services informs the on-going review(s) of therapy services.

#### 1.5.2.3 Palliative care

90% of support and care provided by Haven House is to children living with life limiting conditions. End of life care per se is provided to very small numbers of children but this is necessarily intensive and often at very high cost. BHR CCGs intend to review all forms of hospice support in 2016 with the aim of developing new models of care with providers.

### 1.5.3 Schools and engagement in education

#### 1.5.3.1 School provision for children with SEND

- Havering seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are four primary and three secondary schools with Additional Resourced Provisions (ARPs) or targeted additional funding; each with a particular specialism - hearing impairment (x2), language difficulties (x2), ASD (x2) and social, emotional and mental health.
- Capital money has increased and improved the provision at 2 of the above ARPs and has been used to develop a new Primary ARP due to come online in January 2017.
- Rather than being taught in a single school as was previously the case, pupils with visual impairment are now supported in their local school by an Advisory Teacher for VI and the 'Habilitation Officer'. Training for individual schools is given and borough-wide training is also offered regularly.
- For children with more complex needs, Havering has three special schools. One designated for children with severe learning disability (71 places from ages 2 – 16, and an additional 23 places for post-16 students) and two for moderate learning disability (198 places in total). However, about half of pupils attending the latter have ASD with complex or challenging behaviour, and the schools have adjusted their curricula to reflect this change.
- A similar change is evident amongst Havering's mainstream schools where the pupil population is becoming more complex as, in line with the new SEND Code of Practice,

mainstream inclusion is considered as the first line response in most instances. A range of training is offered to grow expertise and confidence about supporting pupils with additional, complex needs.

#### 1.5.3.2 Permanent exclusion

- National data show that children with SEND are far more likely to be excluded. In Havering, there were in total 22 permanent exclusions from Maintained, Academies and Free Schools during the academic year 2013/14 of which 9 related to children with SEND.
- Havering employs two vulnerable children's officers to support pupils and parents where there is the threat of a permanent exclusion. Parents of pupils with SEND can also receive impartial information and advice from Havering's Parents in Partnership (PIPs) service. Where necessary, officers will challenge schools to employ alternative strategies such as managed moves or alternative provision. There is also a team of behaviour support specialists that can advise and support schools where they experience challenging behaviour from pupils, including those with special educational needs.
- A secondary school 'exclusions concordat' is being developed which includes the following:
  - *'Before considering fixed term or permanent exclusion, schools should consider whether continuing disruptive behaviour might be the result of unmet educational or other needs. At this point, the school should consider a multi-agency assessment and the possible use of alternative provision'*
- A Fair Access Panel (IYFAP) meets monthly to consider cases of pupils at risk of exclusion. In the case of pupils/young people with a statement of SEN/EHC plan, the Panel will seek advice and support from the CAD team.

#### 1.5.3.3 Fixed term exclusions

- There were 1053 fixed term exclusions days from Academies and Free schools in Havering during the academic year 2013/14; 300 related to pupils with SEND.
- The rate of exclusion of children with SEND in Havering is lower than that in comparator areas but still much higher than the average for all children in Havering.
- Work continues to assist schools to develop strategies to maintain pupils successfully; challenging behaviours linked to with ASD and ADHD is a particular priority.

#### 1.5.3.4 Persistent absenteeism

Persistent absenteeism is defined as being absent for more than 15% of sessions at school. 12% of children with a statement or EHC plan (likely to have the greatest needs) were persistently absent in 2013/14 which was higher than in comparator areas and nearly four times the rate recorded for all children in Havering.

### 1.5.4 Equipment

- Equipment can promote independence, assist carers and facilitate access to education. Many agencies have a responsibility to provide equipment but this has led to a level of confusion around who provides what and in what circumstances. Work is underway on guidance and eligibility criteria covering provision across health, social care, education and schools. The intention is then to explore the possibility of centralised equipment purchase and recycling to achieve more timely provision and greater efficiency across partners.



- At present, equipment used in nursery settings and mainstream schools is purchased by the Council. Total spend has doubled since 2012 to £59K in 2016. In addition, a further £8K spend was avoided through recycling. This reflects the changing population in mainstream schools.
- Special schools have historically purchased their own equipment out of delegated funds. They have purchased more and more equipment as the complexity of their pupils has increased and a joint mainstream/special school equipment stock is being considered.
- Children's hearing aids demonstrate some of the complexities of current arrangements. Pupils with a hearing impairment in mainstream provision often have a hearing aid rather than Teaching Assistant support and so provision and maintenance of equipment is crucial for access to the curriculum. The upgrading of hearing aids by Paediatric Audiology has necessitated upgrading the type of Radio Aid provided – by Education. Education and health colleagues work closely together to co-ordinate these upgrades and changes.

### **Recommendation**

Implement the findings of the review of equipment services across education, health and social care to further improve user experience and outcomes.

#### **1.5.5 Transport and assistance with traveling**

402 young people were provided with travel assistance in the 2015/16 academic year, 80% by bus, the remainder taxis. Following a refresh of our transport policy, the Council is working with parents/carers to develop a range of flexible travel options.

#### **1.5.6 Youth Justice**

- The Youth Offending Service (YOS) is designed to address the offending of all entrants into the Criminal Justice System. It is a multi-agency team (CAMHS, Prospects, Police, Social Work, Drugs and Alcohol, Probation) to address the varied drivers for offending.
- The YOS is hosted within Early Help facilitating intervention with young people likely to offend in the future via Targeted Youth Support (TYS).
- The number of first time entrants into the criminal justice system in Havering has fallen almost five fold from nearly 150 in 2010/11 to just over 30 in 2014/15. Only 3 of the 440 cases over this period were recorded by the YOS as having SEND. Just over 50 young people received a custodial sentence in the 5 years 2010/11 – 2014/15. None were recorded as having SEND. The YOS acknowledges that it hasn't consistently recorded SEND in the past.
- Nonetheless, the service recognises that a significant proportion of clients have speech, language and communication needs and it is currently seeking to increase speech therapy input.

#### **1.5.7 Leisure Services**

- London Borough of Havering is committed to providing leisure services that are appealing and accessible to everyone including children and young people with SEND. Central Park Leisure Centre, Hornchurch Sports Centre and Chafford Sports Centre have disabled parking bays, full access into the facility, accessible toilets and changing areas and pool hoist into the swimming pool. The former two sites have accessible equipment in the gym area. Further improvements will be made once the new leisure contract is awarded.



- A Havering Disability Group has recently been established to liaise with relevant stakeholders about the activities children and families with SEND want. Subsequently, a first Para Active Open Session Event was held in February 2016 Half Term and attended by 13 children. Further sessions have been held during subsequent holidays and have attracted greater numbers – up to 26 (10 returners and 16 new) during May Half Term. Feedback showed that 100% of the participants enjoyed the event. Coaches from local clubs have contributed to Para Active Sessions. Other local clubs who deliver all inclusive sessions have been invited to come along to future events and promote their sessions via the dedicated webpage: [www.havering.gov.uk/paraactive](http://www.havering.gov.uk/paraactive).

## 1.6 Educational attainment of children with SEND

### 1.6.1 Monitoring and quality assurance of educational outcomes

- Over the last two years, there have been no adverse references to SEND provision or achievement within any Ofsted report. A quality assurance review of every school is undertaken annually looking at a wide range of areas including provision, policy, curriculum and compliance with regards to SEN. Where significant issues are identified, support is brokered through the Havering Education Providers Monitoring Group, as set out in the Havering Education Providers Quality Assurance Framework, and progress is monitored regularly.
- The Education Providers Monitoring Group meets monthly and comprises representatives from all relevant council services including the SEND team. Any concerns regarding schools are discussed and relayed back to the provider; actions are agreed and implementation monitored. Detailed SEND reviews have been commissioned in response to concerns about provision for SEND pupils resulting in recommendations to the school's leadership team and governors. Where whole school reviews are undertaken, a SEND specialist is included within the reviewing team where the data suggests possible underachievement or poor provision. Support can then be brokered through a school to school support partnership and/or from Council officers.
- Strategic Leads regularly review school websites for compliance, quality and ease of access. Where there are issues, for example with published SEN information, this is brought to the attention of the school's leadership team.
- Governor services support the development of governors, including training and advice on SEND issues for governors generally and those with specific responsibility.
- Head teachers and leaders are regularly briefed and offered training sessions including regular input from the specialist SEND team. Additionally, we hold school-led network meetings for inclusion leads and a SENDCos development network which aim to keep practice current and compliant and to share ideas and strategies. We have invested in the NAHT "Aspire" programme for the past three years for a substantial cohort of schools, and a key driver of this programme is focused on systematic development of inclusion and support for SEND and vulnerable pupils, placing this at the centre of school improvement.

### 1.6.2 Educational attainment of children with SEN

Various measures of development and educational attainment are reported at the end of each key stage for children with no identified SEN, children in receipt of SEN support and statemented children enabling comparisons to be made between the different pupil cohorts as they progress through school in Havering and elsewhere in the country: -

- Unsurprisingly, the attainment for children with statements or identified SEN is lower than that for children with no identified SEN in Havering and elsewhere.
- Nonetheless a significant proportion of children with identified SEN support achieve the expected minimum level of attainment at the end of each key stage and that proportion tends to increase over the primary school period demonstrating the effectiveness of the support provided within local schools. However:-
  - the attainment of children with identified SEN support locally tends to be lower than that reported for relevant comparators. But fewer children are identified as having SEN support in Havering and as such they are thought likely to represent a different, more complex cohort than in other areas
  - the proportion of children with SEN support meeting the benchmark attainment drops back in secondary schools – most likely reflecting the complexity of those pupils who still require SEN support in Secondary school.
- A lower proportion of children with statements achieve the expected level of attainment at the end of each key stage than children with SEN report or no identified SEN but performance is similar to that reported for relevant comparators, possibly because 'statemented children' represent a more consistent cohort of children across areas.

### 1.6.3 SEND Transition post-16

The Young People's Education & Skills team commissions *Prospects* to fulfil the Council's statutory duty to ensure young people participate in education, employment or training and to provide Targeted Information Advice & Guidance for all learners.

The Not in Education, Employment or Training (NEET) cohort receive specific targeted interventions from a range of local and neighbouring education and training providers making use of bespoke programmes tailored to the specific needs of this cohort and funded using European Structural & Investment Funds (ESIF).

Advisors support learners and their families with transition e.g. assisting with the completion of applications, attending interviews at potential placements and arranging taster sessions.

The Prospects team work with the 16-25 resident SEND cohort in Havering and robustly track their participating in compliant education, training, apprenticeships and volunteering.

Achievement in Havering is similar if not better than that in comparable areas with a higher proportion in learning and a lower proportion NEET, unknown or in non-compliant destinations (see [Table 2](#)).

**Table 2: Participation of 16-25 resident SEND cohort in Raising the Participation Age (RPA) compliant learning, Havering and Bexley, June 2016**

	Havering	Bexley
<b>Total</b>	318 (100%)	345 (100%)
<b>In learning</b>	280 (88.0%)	281 (81.4%)
<b>NEET</b>	18 (5.7%)	31 (9%)
<b>Unknown</b>	5 (1.6%)	12 (3.5%)
<b>Other destinations non RPA compliant</b>	15 (4.8%)	21 (6.1%)

Source: Department for Education

## 1.7 Recommendations

The SEND Needs Assessment Steering Group made a series of recommendations under 3 broad headings:-

- Strategic – about how key partners work together to develop and implement relevant strategy.
- Services – in terms of what is available and how services work together to better meet the needs of children and their families.
- Technical – to assist service delivery and improve our understanding of the needs of children and young people as presented in future iterations of the JSNA.

<b>STRATEGIC</b>	1	Undertake a review of the groups responsible for local strategy, commissioning and planning of education, health and social care services relevant to children and young people (0-25) with SEND to eliminate duplication; reaffirm terms of reference and membership and confirm governance with the Health and Wellbeing Board
	2	Use the SEND JSNA to develop strategic commissioning intentions and service development priorities across education, health and social care
	3	Give greater transparency regarding the eligibility criteria for health, education and social care services to aid partnership working and give clarity to children and families.
	4	Ensure key services e.g. community health services are commissioned for outcomes and reports on these outcomes are shared via the refreshed governance structure.
	5	Fully implement the personal budget policy in conjunction with health, where appropriate
	6	Ensure a continued focus on prevention and early intervention (universal services and targeted support) to address the risk factors for SEND
	7	... including healthy lifestyle support for pregnant women / women considering pregnancy to address maternal obesity, smoking in pregnancy etc
<b>SERVICE</b>	8	Review the joint EHC planning and resource allocation meetings to ensure the process and membership enables timely sign off of plans
	9	Implement the findings of the review of equipment services across education, health and social care to further improve user experience and outcomes
	10	Ensure the planned re-commissioning of short breaks includes input from health so that a joint approach can be developed and implemented.
	11	Ensure the data presented in the JSNA regarding community health services informs the on-going review(s) of therapy services
	12	The resulting improvement plans for therapy services should reflect recent / predicted increases in demand and rapid implementation should be a priority
	13	Continue to provide appropriate challenge to any educational provision not achieving good outcomes for children and young people with SEND and other vulnerable groups including LAC and children in need
	14	Monitor the delivery of the recently implemented Transitions Plan
	15	Establish a framework to collate and analyse service user and family feedback to better inform policy, practice and commissioning across health, education and social care services

	16	Work with local GPs to improve uptake of health checks for (young) people with learning disabilities and the subsequent agreement of health action plans to address lifestyle issues and lower the risk of long term conditions
TECHNICAL	17	Create a single database of children and young people with disabilities and /or complex health needs (0-25) across health, social care and education beginning with those with EHC plans
	18	Ensure the new child health information system (CHIS) records children and young people with a EHC plan
	19	The Youth Offending Service should review its processes to identify and record children and young people with SEND so they can better target support as required
	20	Formalise a systematic approach whereby midwives, health visitors and school nurses alert CAD of new born babies and / or children newly resident in the borough likely to have SEND.

## 2. INTRODUCTION

### 2.1 Background

Support for children with Special Educational Needs and Disabilities (SEND) is undergoing radical reform. The Children and Families Act 2014 extends the SEND system from birth to 25; replacing statements of special educational need with a new birth-to-25 Education Health and Care plan (EHC); broadens the definition of SEND to include any disability including mental health; and, offers personal budgets to those families with children affected by SEND.

The act puts children, young people, parents and carers at the centre of the process. Providers are required to make available and easily accessible the full range of support in the Local Offer. A key feature of the Act is that health, (locally this is Havering's Clinical Commissioning Group (CCG), and NHS England), are required to make joint commissioning arrangements to secure Education, Health and Care provision for children and young people for whom the authority is responsible for as well as those who have special educational needs.

The Special Educational Needs and Disability Code of Practice requires Health and Wellbeing boards to consider the needs of vulnerable groups, including those with SEN and disabled children and young people, those needing palliative care and looked after children. In order to ensure that the reforms are implemented successfully the Department for Education is introducing a new SEN Ofsted and Care Quality Commission (CQC) Inspection Framework for Local Areas.

An up-to-date JSNA is a mandated part of the Ofsted and CQC measurement framework. As a result Ofsted and CQC have chosen to assess the strength of arrangements in local areas as a whole, rather than the contribution of individual agencies against 3 broad strands. These 3 strands have been used to summarise the JSNA findings.

**What we know about children and young people with SEND, including risk factors for SEND and vulnerable groups? (Systems to identify need)**



**What are the key services within the local offer and how do they work together? (Assessing and meeting needs)**



**How effective is the local area in improving outcomes for children and young people who have SEND? (Outcomes achieved)**

This document represents an accurate picture of known data and information available as of June 2016. A key recommendation of the JSNA is to improve the sharing of data between

health, social care and education, and it is recommended that this JSNA is refreshed once a single database is introduced.

### **Recommendation**

Undertake a review of the groups responsible for local strategy, commissioning and planning of education, health and social care services relevant to children and young people (0-25) with SEND to eliminate duplication; reaffirm terms of reference and membership and confirm governance with the Health and Wellbeing Board.

## 2.2 National Context

### 2.2.1 Definition

The recently published Special Educational Needs and Disability Code of Practice<sup>5</sup> sets out the statutory guidance for all organisations which work with and support children and young people who have special educational needs or disabilities. Changes from the SEN Code of Practice (2001) reflect the changes introduced by the Children and Families Act 2014. The Code of Practice (2014) covers the 0-25 age range and includes guidance relating to disabled children and young people as well as those with SEN.

The Department for Education's definition of SEND in England encompasses all children (or young people up to the age of 25) who have:

**'significantly greater difficulty of learning than the majority of others of the same age or.. a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions'**

For the first time, this explicitly includes those with mental health needs.

### 2.2.2 Joint Strategic Needs Assessments

The Code of Practice sets out the relationship between population needs, what is procured for children and young people with SEN and disabilities, and individual EHC plans (see [Figure 2](#)). Guidance from the SEND Code of Practice states that the JSNA will inform the joint commissioning decisions made for children and young people with SEN and disabilities, which will in turn be reflected in the services set out in the Local Offer. At an individual level, services should co-operate where necessary in arranging the agreed provision in an EHC plan. Partners should consider how they will work to align support delivered through mechanisms such as the early help assessment and how SEN support in schools can be aligned both strategically and operationally. They should, where appropriate, share the costs of support for individual children and young people with complex needs, so that they do not fall on one agency.

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<sup>5</sup> [Department for Education and Department of Health, SEND Code of Practice, 0-25 years, 2015](#)  
[Accessed 1 March 2016]

Figure 2: JSNA Process, SEND Code of Practice



Source: SEND code of practice, Department for Education/Department of Health (June 2014)

### Recommendation

Use the SEND JSNA to develop strategic commissioning intentions and service development priorities across education, health and social care.

## 2.3 Local Context

Havering has a long term vision to create a fully integrated service for children and young people with special educational needs and disabilities as defined in the Children and Families Act and the SEND code of practice. Phase One of this process has been to create a 0-25 Children and Adults with Disabilities Service (CAD). Phase two is to move, over time, to full integration with health teams. CAD provides the key functions and responsibilities of the Local Authority regarding Education and Social Care for those age 0-25 with SEND, into a single management arrangement. The CAD staff team consists of Case Officers, Educational Psychologists, Social Workers, Family Support Workers, Specialist Teachers, Specialist Assistants, Mobility and Rehabilitation Officer, Early Years SENDCos and Early Years Workers .

A key focus of the service is to work in a person centred way based on an asset based approach, i.e. seeking to support children and young people to maximise their abilities and aspirations. EHC Plans are focussed on achieving desired outcomes for children and ensuring that the provision identified is clearly defined and ensures progress for the child in meeting



these outcomes. A key element of the team is a focus, from the earliest stages, on preparation for adulthood. The team and its work is driven by a commitment to ensure the children and young people supported by the team are prepared fully to lead the most full, active and productive lives.

Since the CAD service was established in September 2014, the service has made progress in developing the local offer, establishing the processes around delivering assessment and Educational Health Care plans and developing staff to work in a person centred way. There has been parental and family engagement and there are close working relationships with health providers. Policies have been developed to underpin these developments and form the offer to our children and young people, their parents and carers, in Havering.

### **Recommendation**

- Ensure the new child health information system (CHIS) records children and young people with an EHC plan.
- Review the joint EHC planning and resource allocation meetings to ensure the process and membership enables timely sign off of plans.

### **Key Priorities for Children and Adults with Disabilities Service**

- ✓ Further develop the personal budget policy linked to the uptake of direct payments including direct payments for health provision.
- ✓ Explore options for greater integration with health providers.
- ✓ Refresh the Short break offer to meet parental and child priorities within available resources.
- ✓ Review data recording and case records to establish a single database for children and young people with SEND to assist in better information sharing, performance management and needs analysis.
- ✓ Build on work already taking place to strengthen parent /carer and child voice in all future CAD developments.
- ✓ Build further educational and social care provision to meet the needs of the child/young person including schools, colleges, short breaks and where necessary fostering and adoption arrangements.
- ✓ Strengthen the preparation to adulthood pathway, through the work across the whole team, including new local provision, e.g. transition pathways between children and adult's social care, a wide ranging local offer including housing, leisure, employment and 16-25 integrated provision.

In Havering, like many areas there are targeted services that are designed to meet the needs of children with disabilities or adults with disabilities as well as transition teams that work with young adults who are making the move from one service to another. One of the challenges in effective transitions are the small number of parents in Havering who have children with special educational needs and disabilities that also have SEND themselves. Although we know that most parents with disabilities (including parents with a learning disability or mental health problem) go on to lead successful and fulfilling lives as parents by calling on the support they need when required, however for some this may provide an additional layer of complexity for families in such situations e.g. being a lone parent. The 'Supporting of disabled parents: A



family or a fragmented approach?' (2009)<sup>6</sup> report sought to examine the experiences of disabled parents and their families and to see how far council policies, services and practices were providing appropriate support. The findings in the report were taken from a national survey of 50 councils. To supplement the national picture, in-depth study workshops of services were conducted in four council areas. The report went on to find that many councils do not fully support disabled parents and their children. Although in Havering we offer robust and often bespoke packages of care to children, young people and adults with disabilities, we acknowledge that the families' complex needs may extend further than just the child.

### Joint commissioning

The CCG and the Authority are continuing to work together to further develop joint pathways of support. Key priorities have been agreed and work is beginning to take place on these key priorities. There are formal arrangements in place to support on-going discussions which provide the structure for joint commissioning and on-going integrated working.

Joint Commissioning Officers work closely together across BHR to review, redesign and re-commission health services. The individual Joint Commissioning Officers also work closely with their particular authorities and are central in supporting joint commissioning. Local Authority Joint Commissioning Unit was established in June 2016 and will be responsible for developing a strategic approach to commissioning across the council and with partners, especially Health. The aim of the service will be to improve outcomes for children and young people and adults in Havering, reduce duplication, increase efficiencies through effectively commissioning services across Children, Adults and Public Health teams.

The Joint Commissioning Unit will operate as a business unit providing high quality commissioning and other related functions on behalf of the relevant services. A centralised team will create more opportunities to commission across ages/groups thus improving the current market and therefore impacting on services offered locally and outcomes for residents.

## 2.4 Methodology

### 2.4.1 Scope

A working group comprising policy, research and intelligence officers from health, education and social care was formed to scope this JSNA and contribute data, analytical products and intelligence from their areas of expertise. The partnership arrangement expanded the knowledge base and ensured that all parties were represented in this cross organisation work. This joint strategic needs assessment (JSNA) looks at all the evidence available for children and young people with special needs and disabilities within Havering Council and all health partners, combined with nationally published statistics and research materials. The evidence base looks at current literature and Havering intelligence about the prevalence and trends in special educational needs and/or disability in the borough. It explores the characteristics of the children and young people and discusses the factors which can lead to a child having special educational needs and/or disability.

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<sup>6</sup> *Commission for Social Care Inspection, Supporting of disabled parents: A family or a fragmented approach?, 2009*

## 2.4.2 Data Sources and Limitations

### *Community Health Services*

NHS Havering CCG work with NELCSU to undertake a monthly Service Performance Review (SPR) of both the adults and children and young people community health services managed by NELFT. For children and young people community paediatric, occupational therapy, speech and language and physiotherapy services are monitored. The JSNA has highlighted that the data collated is activity and process driven, leaving a gap in details on the profile of children and young people and the outcomes achieved. Some of this issue will be addressed through the new national data collection process managed by the Health and Social Care Information Centre (HSCIC) called the Children and Young People's Health Data Set (CYPHS)<sup>7</sup>.

This will collate data on: personal and demographic; social and personal circumstances; breastfeeding and nutrition; care event and screening activity; diagnoses, including long term conditions and childhood disabilities; scored assessments

### *Children's and Adult Social Care and Housing*

The London Borough of Havering undertakes monthly performance reporting for adults, children and young people, and housing. For each of these service areas both statutory and locally identified measures are collected, however some National benchmarking information is only available annually and only on statutory those measures. It is also worth noting that some National benchmarking information has a significant delay and as such is often nearly a year out of date.

### *Children and Adults with disabilities Service (CAD)*

- The Not in Employment, Education or Training (NEET) and Unknown data provides a snapshot in time and does not reflect this in context of the overall population at that time.
- The placement data and student numbers are based on a snapshot in time – numbers will fluctuate depending on children and young people moving in and out of borough as well as changing placements mid-year.
- Impulse (commissioned service through Prospects and 15 Billion) only holds a limited amount of data for Post 16. Data in relation to activity for Post 16 young people is held on a different system.
- ✗ General Practices do not routinely collected SEND data on their systems so it is not possible to analyse primary care activity or level of support. Analysis of hospital admissions and A&E data showed that there was insufficient level of coding to interpret secondary care activity for children and young people with SEND.
- ✗ Data accessibility and quality proved to be one of the limitations with regards to analytical insights. The focus needs to continue on developing joint robust data collection and recording with responsibilities for SEND.
- ✗ There are related datasets from various council teams or services working with SEND. Integration of all related SEND datasets within the council is an important first step and is beginning. A second step is the integration with datasets from other relevant local partners

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<sup>7</sup> Children and Young People's Health Data Set <http://www.hscic.gov.uk/maternityandchildren/CYPHS>

and organisations. This will be important in ensuring that across all parties both capacity can be evaluated, gaps identified and addressed.

- ✘ National data sources did not contain local level data particularly at ward level for some indicators; this meant that within Havering comparison were difficult to produce for those indicators.
- ✘ A significant proportion of the analysis was based on school census. The school census collects only a limited range of statutory indicators for 5-16 age range. This should be noted when interpreting the outputs produced.

### 3. WHAT DO WE KNOW ABOUT CHILDREN AND YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS & DISABILITIES?

The estimated population of the London Borough of Havering is 245,974. It has the oldest population in London with a median age of approximately 40 years old. The Borough experienced a net population loss of 6.3% from 1983 to 2002 but the population has increased year on year from 2002, with a 9.3% increase from 2002 to 2014. As well as increases in the number of births in Havering, there has been an increase in the general fertility rate from 54 (per 1,000 women aged 15-44) in 2003 to 66 in 2014. This equates to an additional 12 births per 1,000 women aged 15-44 within the period. From 2009 to 2014, Havering experienced the largest net inflow of children across all London boroughs. 4,606 children settled in the borough from another London borough during this six year period. It is projected that the largest increases in population will occur in children (0-17 years) and older people age groups (65 years and above) up to 2030.<sup>8</sup>

#### 3.1 Prevalence

The true prevalence of SEND is unknown. The recorded prevalence has varied overtime in response to changes in national policy and its interpretation at local level.

Nonetheless we do know referrals have gone up which correlates with:

- Increase in pupil numbers
- Changes in diversity of the population with greater need
- Improved identification and referral processes

There are opportunities to reduce SEND:

- Early booking and excellent antenatal / maternity care
- Prevention of known risk factors including smoking, alcohol, drug use
- Early identification and support for post-natal depression and support to increase
  - parental attachment
- Early intervention such as access to support services to improve communication skills
- Supporting at risk children and those on the edge of care

Populations in our Special schools are changing with a general rise in pupils with Speech Communication and Language needs (SCLN) and with Autism Spectrum Disorder (ASD). An innovative model has been successfully implemented in primary schools and this could be rolled out to secondary schools to support colleagues in these schools.

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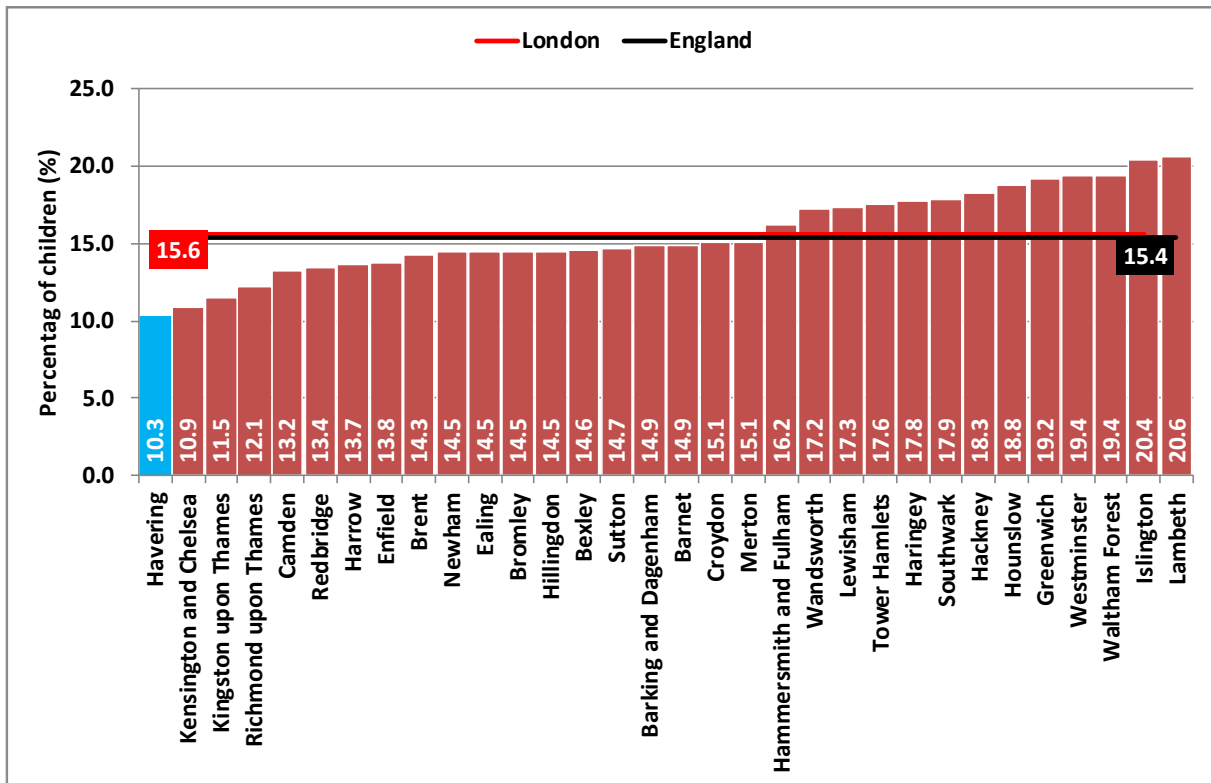
<sup>8</sup> London Borough of Havering, *This is Havering, 2016*

### 3.1.1 Current prevalence

The prevalence of identified SEND in Havering is recorded at 10.3% which appears to be the lowest compared with all London boroughs, London and England.

Figure 3 is for all school children aged 5-18 years old as identified by Statements/EHCP/SEN Support/School Actions (SA)/School Action Plus (SA+).

**Figure 3: Total prevalence of SEND across all London boroughs in 2015 (As identified as Statements/EHCP/SEN Support/SA/SA+)**



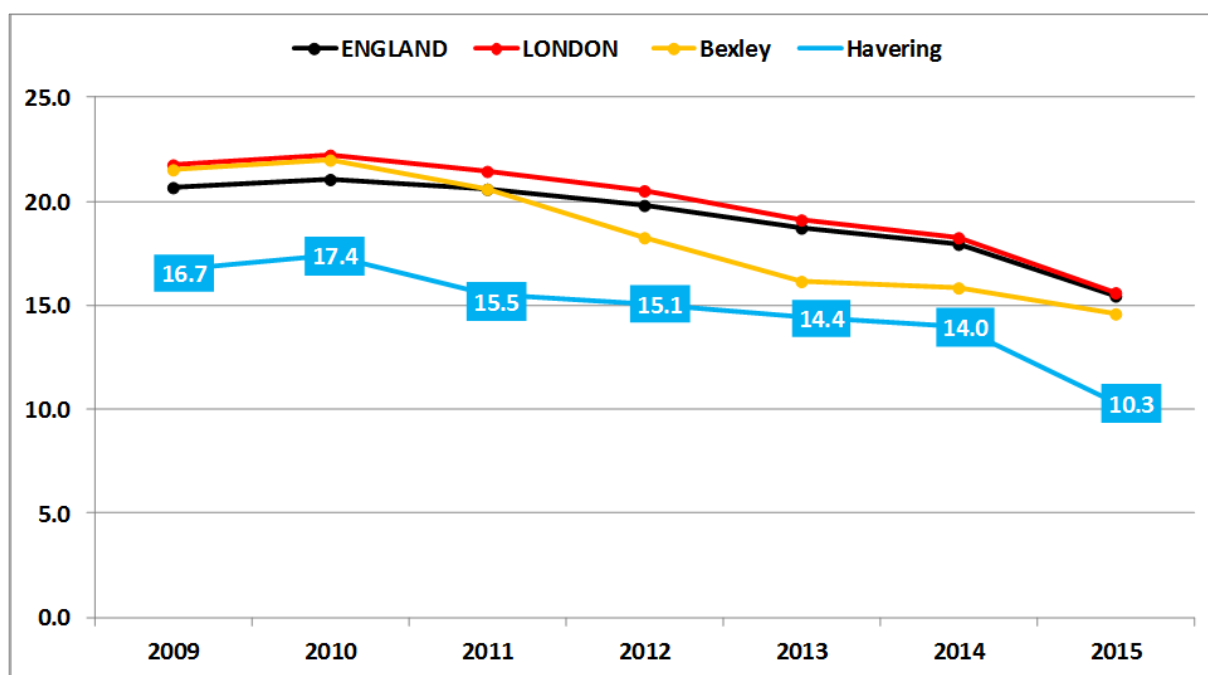
Source: SEN statistics, Department for Education (2014/15)

### 3.1.2 Trend

#### Statements

Analysis of data over the past 6 years shows a steady decline in recorded prevalence of SEND as measured by Statements/EHCP/SEN Support/SA/SA+ in Havering, London and England (Figure 4). This is due to a “validated hours” policy, which operated until recently. This policy was developed to ensure that pupils’ needs were identified, and resources provided via a ‘validated hours’ approach, rather than statementing children unnecessarily. As a result of this approach, those children with statements were defined as those attending Havering or other out of borough special schools and those with very high needs in mainstream schools.

**Figure 4: Prevalence of SEND (as identified as Statements/EHCP/SEN Support/SA/SA+) from 2009 to 2015**



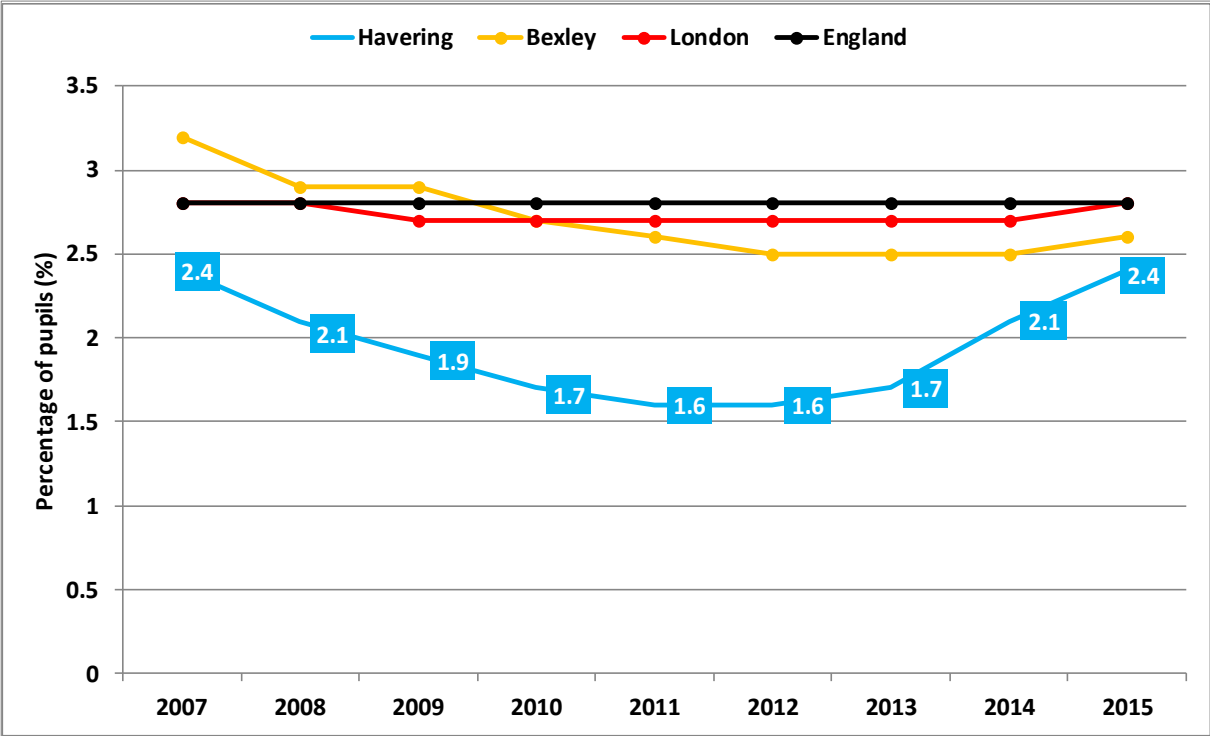
Source: SEN statistics, Department for Education (2014/15)

The prevalence of SEND (as identified as Statements/EHCP/SEN Support/SA/SA+) peaked in 2010, this coincided with a National Ofsted SEN and disabilities review, where it was found that nationally a quarter of all children identified with SEN did not have SEN. Havering SEN Team worked with colleagues in schools and settings to support more accurate identification of pupils with SEN and improve differentiated delivery of the curriculum and interventions used. Having moved to a model of “non-statementing” except for those children and young people in special schools, a funding model was developed which provided targeted support rather than “labelling children” approach. The biggest drop in identified SEN, in 2015, related to the implementation of the new Act and new processes which took time to implement.

#### *As Percentage of Pupils*

The proportion of school children with special educational needs appears to be lower in Havering compared to London, Bexley and England throughout the whole period between 2007 to 2015; whilst London, England and Bexley appear to show a broadly constant proportion during the 8 year period, Havering shows a clear dip in proportions from 2008 to 2012 where it rises again (see [Figure 5](#)).

**Figure 5: Percentage of pupils with SEN Statements from 2007 to 2015, comparing Havering with London, England and Bexley**



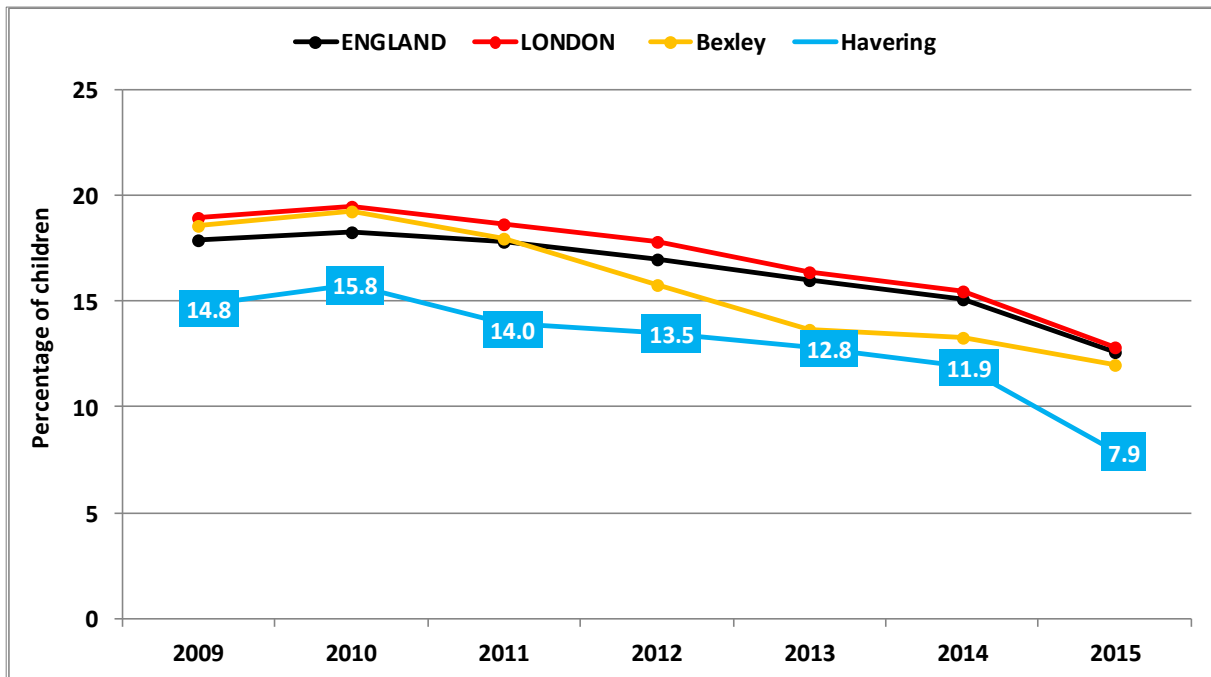
Source: SEN statistics, Department of Education (2014/15)

**3.1.3 SEN Support**

Figure 6 gives a clearer picture of the impact of the Ofsted SEND review of 2010 as stated pupils are not included in this data as the data reported on is for SEN Support only. The decline in numbers continued steadily until 2014 and then there was a sharp drop following the Children’s and Families Act, 2014 and new SEND Code of Practice (January, 2015). It also captures the drop and rise in SEN Support (School Action, School Action Plus) due to Havering’s policy of ‘Statement-less’ schools and validated hours.

Havering chose to follow a policy of reducing statements and moving over to a ‘validated hours’ approach. This was very successfully rolled out between 2008-2012 but, with changes in the delegation of funds from Local Authorities to schools, the trend towards ‘Statement-less’ schools was reversed and we saw a rise in the number of issued statements. These figures need to be seen in conjunction with SEN support figures shown in the previous table. In the corresponding years the numbers of children with SEN support was high then decreases. This is due to a better understanding of SEN specific needs and less categorisation of difficulties which are not at the SEN threshold and a move to issue statements to those children at the higher levels of need.

**Figure 6: Time trends showing the percentage of children receiving SEN support, comparing Havering with London, England and Bexley**



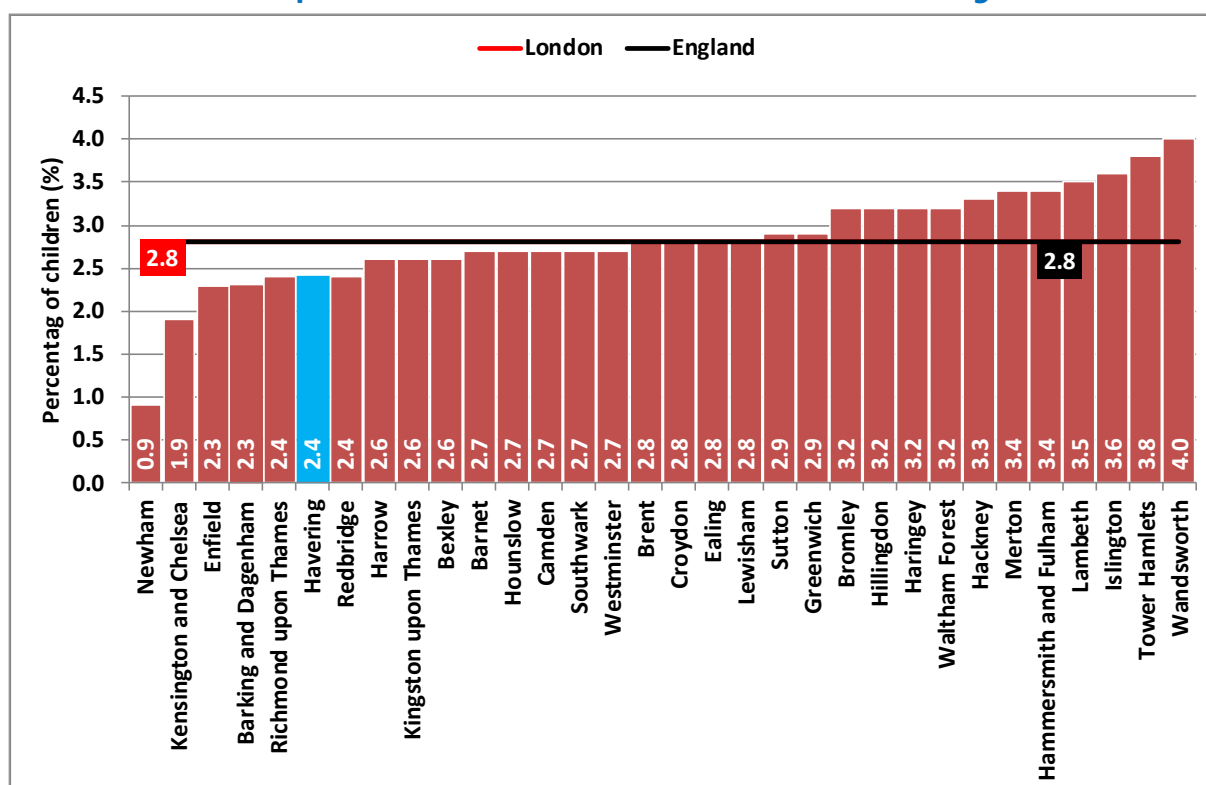
Source: SEN statistics, Department for Education (2014/15)

As of the end of March 2015 the percentage of children with a statement of special educational needs in all schools was 2.4% in Havering; whilst this is among the lowest proportions in London and lower than both the London and England average (2.8%) there is insufficient data to calculate confidence intervals (and thus determine whether this is statistically significant) (see [Figure 7](#)).

The level of children with a statement being under the national average can be linked to Havering’s previous policy of ‘Statement-less’ schools. Since 2012, the rate of issuing statements has risen but not necessarily caught up with the national average. Support services work hard with colleagues in settings and schools to raise awareness of SEND and implement strategies/interventions to improve attainment and progress. This reduces the need to progress to EHCP assessment.



**Figure 7: Percentage of children as a proportion of the school population by borough with a statement of special educational needs across all London boroughs in 2015**



Source: SEN statistics, Department of Education (2014/15)

## 3.2 Identification

The initial identification of a potential disability or special educational need can happen in a number of different places but primarily the main areas are: within the home where a parent or carer identifies a difficulty; within health where a health professional identifies concerns; or within an educational establishment where a teacher may express concern with learning. Within SEND learner support, the majority of referrals for very young children come from health professions including health visitors, therapists, paediatricians, other consultants and specialists within the field of Hearing Impairment/Visual Impairment e.g. audiology professionals, although very few referrals are actually via GPs.

### 3.2.1 Health Sector Services

#### *Maternity Services*

Strong links with maternity services are essential to ensure risk prevention where possible and early identification and referral to services as required. Havering supports a comparably high proportion of women to receive a full health and social care assessment by 12 weeks, 6 days compared to 95.7% for London and England.

Within maternity services the neonatal team at Queens hospital send a discharge summary to the Acorn Centre of premature births and babies with health care needs. Paediatrician's receiving the discharge summary take the information to the multi-agency planning meeting

for appropriate services to be involved. It is recommended that there is a focus on healthy lifestyle support and advice in maternity services to address risk factors for SEND including obesity, maternal diet and smoking

Low birthweight babies (infants under 2,500g) are at increased risk of problems at birth, early childhood, and in later life. A baby's low weight at birth is usually a result of a preterm birth (before 37 weeks of gestation) or due to restricted growth during pregnancy. The latter may be a result of maternal diet prior to and during pregnancy. The risk of having a low birthweight baby increases with increasing deprivation. There were 3,014 births in Havering in 2013, of which 7 per cent (211) were born with birth weight less than 2500grams. This was similar to London and England, 2013.

Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth and placental complications which could lead to disabilities. Whilst the proportion of women smoking at time of delivery is decreasing year on year in Havering, the Borough does still have a high percentage of pregnant women who smoke (10.4%), compared with the rest of London (4.9%), although slightly lower than England.

The Council's Public Health Service implements *BabyClear* locally, which is a major initiative to promote smoking cessation to pregnant women. As part of the *BabyClear* programme, midwives now systematically and routinely test for carbon monoxide (CO). To ensure that Havering women who smoke then receive the right support to quit, the Council is currently entering into a partnership with Barking and Dagenham's smoking cessation support team, who will provide advice and support to enable women to stop smoking during their pregnancy and so help to give their babies the best start in life.

### **Recommendation**

Formalise a systematic approach whereby midwives, health visitors and school nurses alert CAD of new born babies and / or children newly resident in the borough likely to have SEND.

#### *Maternal mental health Services*

Maternal mental health can have an adverse effect on the woman herself, and also on her marriage, family and, in particular, on the future development of her infant. Maternal depression and stress related disorders are the most common maternal mental health conditions in Havering, recording as being 150-300 per 1000 births.

Havering residents can access a perinatal mental health service that is commissioned across four local CCGs. The service aims to reduce the impact of maternal mental health upon children; ensuring early diagnosis and better intervention and support. The service does not operate a waiting list, but have allocated emergency clinic space for priority patients. The team work closely with the Primary Infant Mental Health Service.

#### *Health Visiting Services*

The health visiting team undertake an assessment of a child's growth and development at every contact either in a community setting or in the family home. Early identification of a delay in a child's growth and development is essential to ensure that relevant services are

accessed in a timely way, a referral is made to the appropriate service with parental consent and families are supported through this process.

Premature births have long term effects in motor development, behaviour and academic performance compared to term births. These types of impairments can be prevented through early parental guidance, monitoring by specialized professionals, and interventions. The proportion of premature live births and still births in Havering was 7.6% of total births in 2012-14, similar to other London boroughs that are statistically comparable, Bexley (7.1%) and Bromley (7.4%). Early identification via newborn hearing screen and Health Visitor vigilance for sight problems in premature babies is essential. Once identified early support is key to development of age appropriate skills, again this has implications for early support services and sensory specialist advisory teachers.

### **3.2.2 School Services**

The school nursing service provides a pivotal role in identifying and supporting SEND needs. They carry out a health assessment for all reception year pupils including health and sight tests.

### **3.2.3 Services related to vulnerable children**

#### *Child abuse and neglect*

Child abuse and neglect have been shown to cause important regions of the brain to fail to form or grow properly, resulting in impaired development. These alterations in brain maturation have long-term consequences for cognitive, language, and academic abilities and are connected with mental health disorders. Havering have a 28% higher percentage of cases with Neglect recorded as the category of abuse when compared to our statistical neighbours (59.0% compared to 46.1%). Similarly, Havering have a 86.5% greater percentage of Physical Abuse cases compared to statistical neighbours (13.8% compared to 7.4%).

#### *Looked After Children*

Even the best early intervention cannot prevent some children needing to come into care. This section sets out the current picture of demand from children entering into Havering's care system. The evidence over the past few years demonstrates the upward trend of children being placed in care in Havering. Over the past financial year the number of children on average who are looked after has increased from 205 to 240, which is subject to constant monitoring. Comparisons with national and statistical neighbour data on the rate of children who are looked after shows that: The Havering rate at 45 per 10,000 is lower than the national average of 60 per 10,000 and London average of 52 per 10,000 and our statistical neighbour of Bexley at 50 per 10,000.

#### *Youth Offending Service*

YOS has received 440 First Time Entrants over the past 5 years, and only 3 of them had a SEND status recorded when their case was open. None of the young people sentenced to custody had a SEND status recorded over the past 5 years. The YOS often receives young people who have been excluded multiple times from multiple schools and so miss out on any formal diagnosis before being excluded. This could in part explain the under-representation of young people with SEN known to YOS and the custody service. There needs to be a greater

relationship between YOS and Speech and Language Therapy (SaLT) and new funding from the CAMHS Local Transformation Plan will help to address this issue by providing SaLT support to those young people in the YOS. Recording of SaLT needs to increase within YOS.

### Recommendation

The Youth Offending Service should review its processes to identify and record children and young people with SEND so they can better target support as required

## 3.3 Projected growth

SEND projected growth by place of support offers useful information for planning purposes and future commissioning priorities. Projected growth by place of support (primary, secondary, special and out of borough schools) is outlined below. There are data challenges to measuring projected growth based on unknown population changes over the next 10 years.

Full details of the projected growth methodology used and accompanying data tables are in [Appendix 2](#). The projections outlined are for stated SEND pupils only and does not include SEND support.

The total SEND population

- *Primary schools:* The number of stated SEND pupils in 2014/15 accounts for 1.5% (310) of the Havering primary school population. This is projected to increase to 320 by 2024. The largest SEND groups in primary schools are for pupils with Speech and Language and Communication Needs (SLCN)<sup>9</sup> (28.1%), Autistic Spectrum Disorder (ASD) (26.5%), and Moderate Learning Disabilities (MLD) (16.8%).
- *Secondary schools:* The number of stated SEND pupils in 2014/15 accounts for 2.3% (353) of the Havering secondary school population. This number is projected to increase to 424 by 2024. The largest SEND groups in secondary schools changes slightly compared to primary schools with MLD as the largest group (22.9%), then ASD (21.8%) and SLCN (17.3%).
- *Special Schools (5-16 population):* This is projected to increase from 294 pupils in 2014/15 to 349 by 2024, a small percentage increase from 0.7% to 0.85% of the total Havering population aged 5-16 years. The largest groups are ASD (27.6%), SLD (21.1%), MLD (19.7%) and SLCN (11.6%).

Havering residents with a statement of SEN who attend an out of borough special school make up 0.23% (77) of the 5-16 year old population in Havering. These numbers are projected to increase to 91 by 2024. There is a strategy in place to develop new provision in Havering to ensure these needs can be met in borough. Pupils who attend out of borough have a different SEND make-up with 36.4% (28) with behavioural, emotional and social difficulties (BESD) as their primary SEND and 24.7% with ASD.

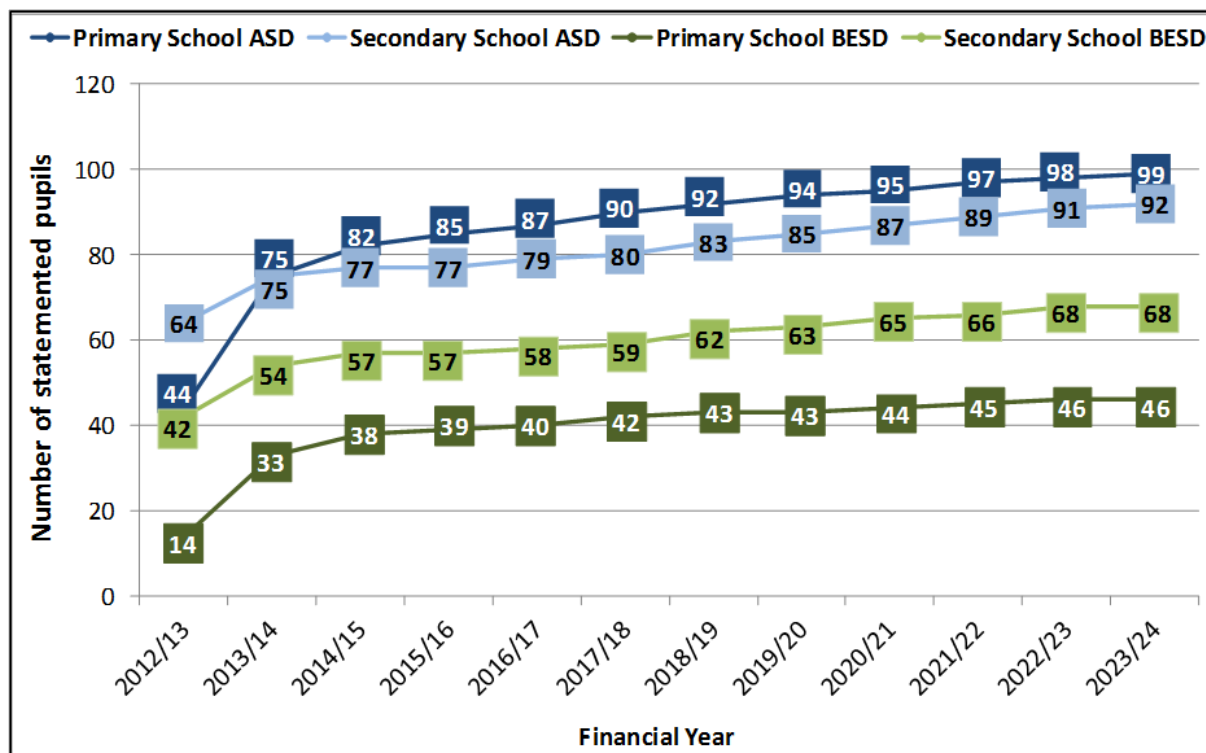
There is an identified trend in the rise in SEND for Havering, as shown below (see [Figure 8](#)), particularly in the area of SLCN and ASD. Havering changed its approach to the support for pupils with Speech and Language difficulties over ten years ago. In conjunction with Health

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<sup>9</sup> Based on 2014/15 SEND School Census data

colleagues in NELFT a joint service was formed comprising of Speech and Language Therapists, specialist advisory teachers and specialist teaching assistants (DSG, ie school funded, funding the advisory teachers and specialist teaching assistants).

**Figure 8: Projected numbers of children with statements of special educational needs by type and school in Havering, 2013/14 to 2023/24**



Source: Strategy for Children and Young People with Special Educational Needs and Disabilities 2015-20

The assessment and intervention work for children with SLCN was based mainly in the pupils’ schools and a priority caseload system was set up. Caseload reviews are held twice a year in every Primary school and some Secondary schools. Pupils are then prioritised into red – pupils requiring assessment and a language programme from a Speech and language therapist, blue – pupils who require support and advice from specialist teachers/assistants and green – pupils who require support and monitoring from within schools’ resources.

The impact of this joint approach has been huge; over 3,000 pupils are reached through this approach annually, the awareness of our schools is very high and therefore identification is higher and earlier. All primary schools have access to Language Link and Speech Link, a commercial package which identifies difficulties and provides a programme of intervention, which is used with all Reception pupils and moved in pupils.

Two years ago it was decided to also include the pupils with Social Communication needs or ASD in the caseloads reviews in each Primary school, this has given us a more accurate picture of the incidence of SCD/ASD in our schools. That need has to be supported and there has been a large increase in training and INSET offered to colleagues in schools. Closer links with colleagues in Health have been forged as the Community Paediatricians have included assessment and reports from colleagues in Education more widely in their pathways planning and assessment and diagnosis for ASD.

The noted difference of the incidence of MLD in Primary versus Secondary schools could, in part, be attributed to the rise in awareness and identification of Speech, Language and Social Communication difficulties; so rather than a pupil being classified as a more generalised MLD the school is supported to drill down to more specific difficulties.

As seen in the data the populations in our Special schools are changing with a general rise in pupils with ASD, changing the skill set and training needs required for colleagues in these schools.

A need has been identified in SLCN pupils at secondary. The 5 – 19 Support Team, CAD, hope to build on the successful model in Primary schools and roll it out to Secondary schools, this has begun on a small scale but obviously has implications for staffing, both in Education and Health, training and INSET needs and hence funding.

The data above dealing with Out of Borough placements and needs has led to the work taking place in Havering to increase in Borough provision its capacity to educate those pupils with BESD and the more extreme pupils with ASD. The authority already has a number of Additional Resourced Provisions for a range of needs both at secondary and primary. The new provisions are to provide for the rising demand for pupils with with ASD and challenging behaviours. Four new provisions are to be rolled out in 2016/2017 with other schools expressing interest. This will enable Havering to educate more of its own pupils in borough, enabling the young people to stay and learn in their own community.

## 4. RISK FACTORS FOR SEND

### 4.1 Prenatal and birth factors affecting the risk of SEND

GP practices are funded to provide enhanced care to people with learning disabilities aged 14 and over. Analysis of the data provides us with some of our most comprehensive available health data for this population. 43% of people recorded with a learning disability have had a health check completed. More engagement is required to increase the number of health checks for this population. For those identified with a learning disability a health action plan should be completed. As of June 2016 only 33% of people are recorded as having a health action plan completed. People with a learning disability will experience greater health inequalities compared to people without a learning disability. In Havering 8.7 people per 1000 people with a learning disability are recorded as having diabetes compared to 3.4 per 1000 people for those without a disability.

Obesity contributes to health inequalities linked to vascular conditions, cancers and poor mental health. 26% of people with a learning disability have a BMI over 30 compared to 13% of people without a learning disability. Targeted support is required to support healthy weight management with this population. BHR CCGs are currently undergoing a series of service reviews for NELFT therapy services with accompanying action plans. These aim to address service development needs including waiting times and DNA rates. There are current complexities with understanding health outcomes for children attending therapy services due to historic reporting arrangements. Commissioning for outcomes would help support a broader picture for children with SEND in Havering.

Protecting children from risk begins in utero, where exposure to maternal infections, nutrition, weight gain and behaviours such as smoking, alcohol and substance misuse increase premature birth, birth defects and low birth weight. These factors are strongly influenced by the living conditions of the mother: her income, wellbeing, housing and relationships.

Key vulnerabilities at this stage include:

- Immediate vulnerability: In utero exposure to maternal infections, nutritional deficiencies, maternal obesity, and environmental toxins, as well as poor care around birth, may lead to severe and irreversible damage to the brain and other organs. The failure of the mother and child to bond is an important determinant of the wellbeing of children
- Leading to short term outcomes: Increased risk of premature births, birth defects and low birth weight
- Leading to long-term conditions: Severe, potentially irreversible consequences for physical and cognitive growth and development. The majority of permanent disabilities have their origin in neonatal disease. Poor emotional and mental wellbeing will have long-term impacts on the ability of children and young people to succeed in life.

#### 4.1.1 Antenatal

All women should have access to maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experiences for mothers and babies. Reducing the percentage of women who access maternity services



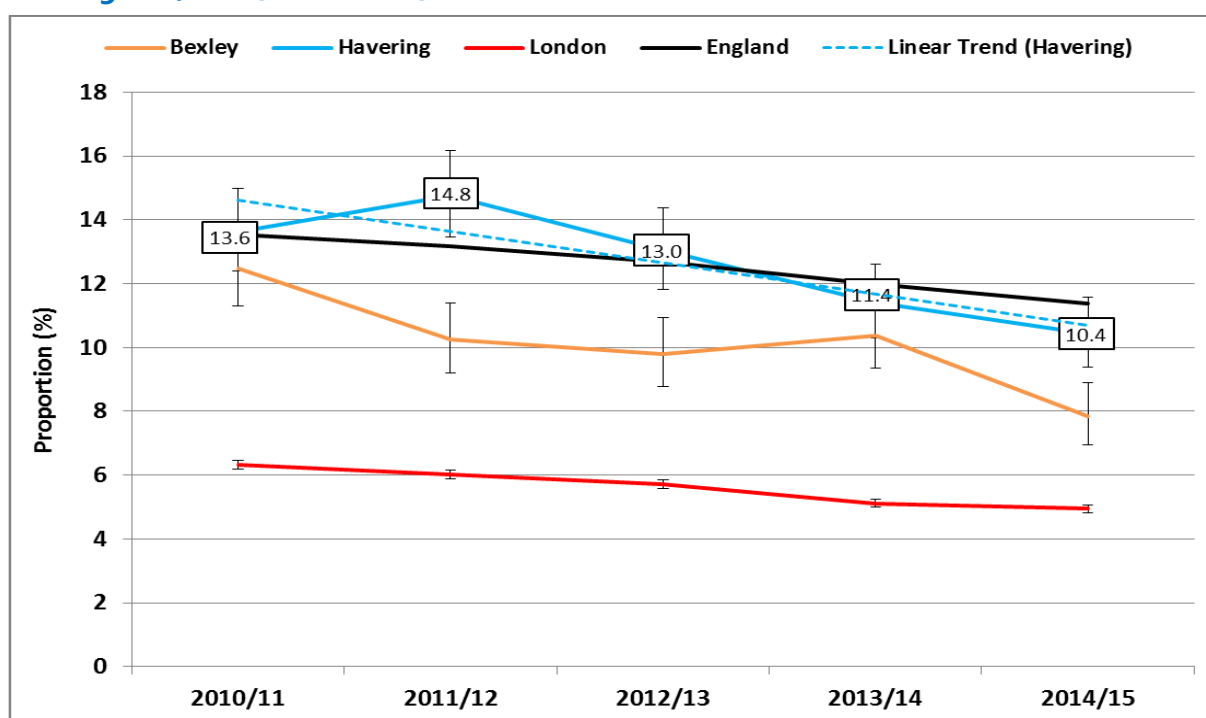
late through targeted outreach work with vulnerable and socially excluded groups will contribute to reducing the health inequalities faced by these groups, whilst also promoting personalised care for all pregnant women.

### 4.1.2 Smoking in pregnancy

Smoking in pregnancy increases the risks of miscarriage, stillbirth or having a sick baby, and is a major cause of child health inequalities. Whilst the proportion of women smoking at time of delivery is decreasing year on year in Havering, the Borough still has a high proportion of pregnant women who smoke (10.4%), compared with the rest of London (4.9%), although slightly lower than England (11.4%)<sup>10</sup> for 2014/15 (see Figure 9).

The Council’s Public Health Service has been working with local partners to implement *BabyClear* (a major initiative to promote smoking cessation to pregnant women). This initiative includes emphasising to expectant parents how the 4000+ chemicals in tobacco are absorbed through the lungs and move into the bloodstream, and how those chemicals are passed to the baby via the placenta, depriving the unborn infant of vital oxygen. As part of the *BabyClear* programme, midwives now systematically and routinely test for carbon monoxide (CO). Raised CO readings can indicate smoking, as well as second-hand exposure to cigarette smoke, inhalation of fumes from faulty exhausts, or poorly ventilated cooking or heating appliances. To ensure that Havering women who smoke then receive the right support to quit, the Council is currently entering into a partnership with Barking and Dagenham’s smoking cessation support team, who will provide advice and support to enable women to stop smoking during their pregnancy and so help to give their babies the best start in life.

**Figure 9: Smoking status at the time of delivery, Havering compared to Bexley, London and England, 2010/11 to 2014/15**



Source: Local Tobacco Control Profile (accessed November 2015)

<sup>10</sup> [Local Tobacco Control Profiles for the period 2014-15](#)

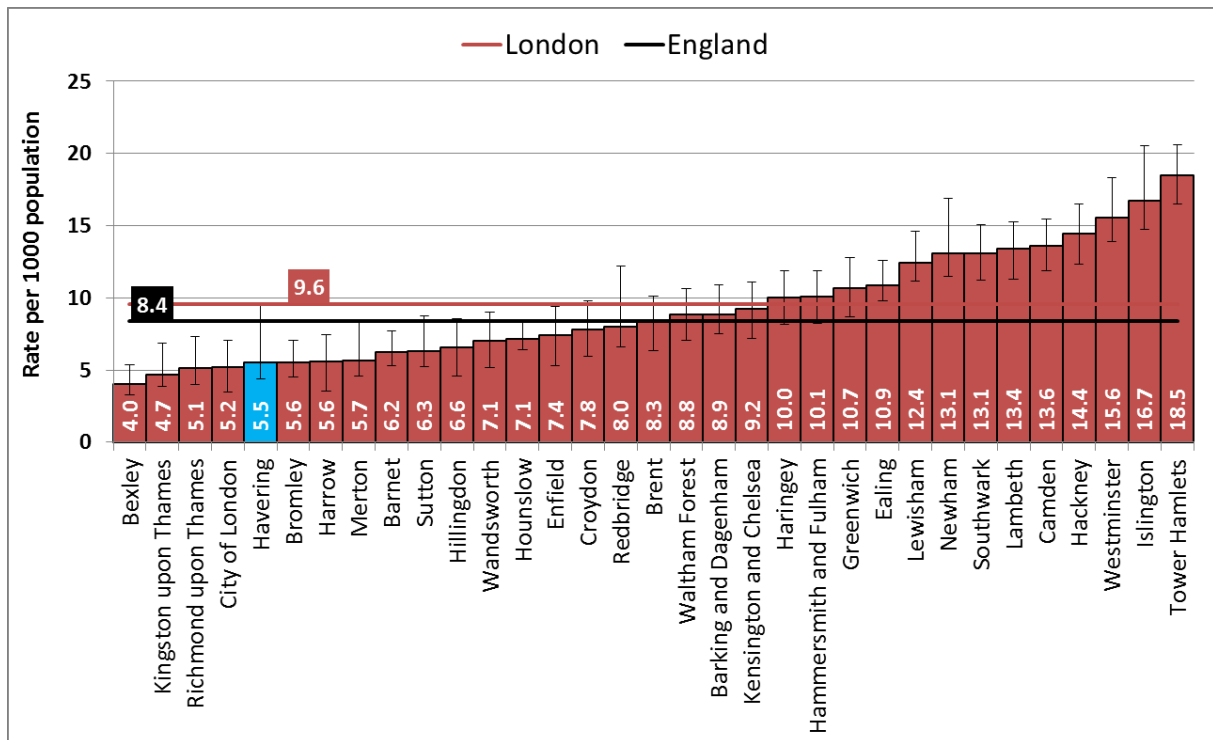


### 4.1.3 Substance misuse

#### Drugs

The use of drugs during pregnancy is a very serious problem which does not only threaten the mother’s health, but also the healthy development of the child. Data on drug use during pregnancy is not available. The rate of opiate and/or crack cocaine use in Havering was 5.5 per 1000 population aged 15-64 years, lower than England (8.4) and London (9.6). (see Figure 10)

**Figure 10: Estimated prevalence of opiate and/or crack cocaine users aged between 15-64 years, 2011/12**

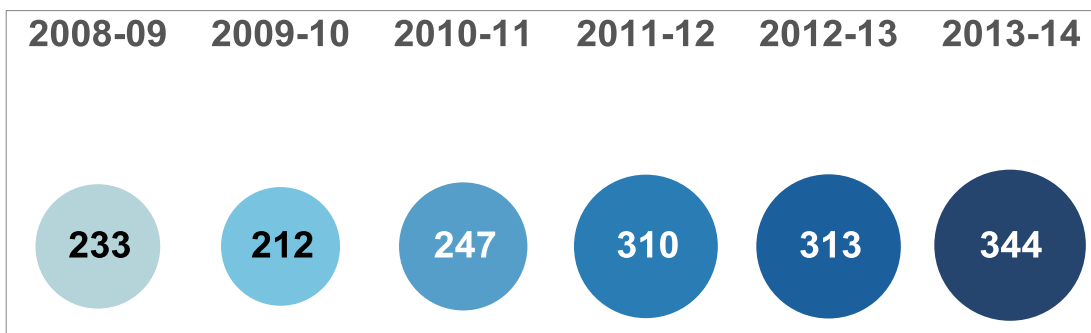


Source: Public Health England, Drugs and Mental Health, 2016

#### Alcohol

Evidence shows that drinking alcohol during pregnancy results in foetal alcohol spectrum disorder (FASD). Available national data shows a slight change in number of children admitted to hospital for FASD (see Figure 11).

**Figure 11: Number of finished consultant episodes (FCEs) with either a primary or secondary diagnosis of foetal alcohol syndrome in England, 2008-09 to 2013-14**



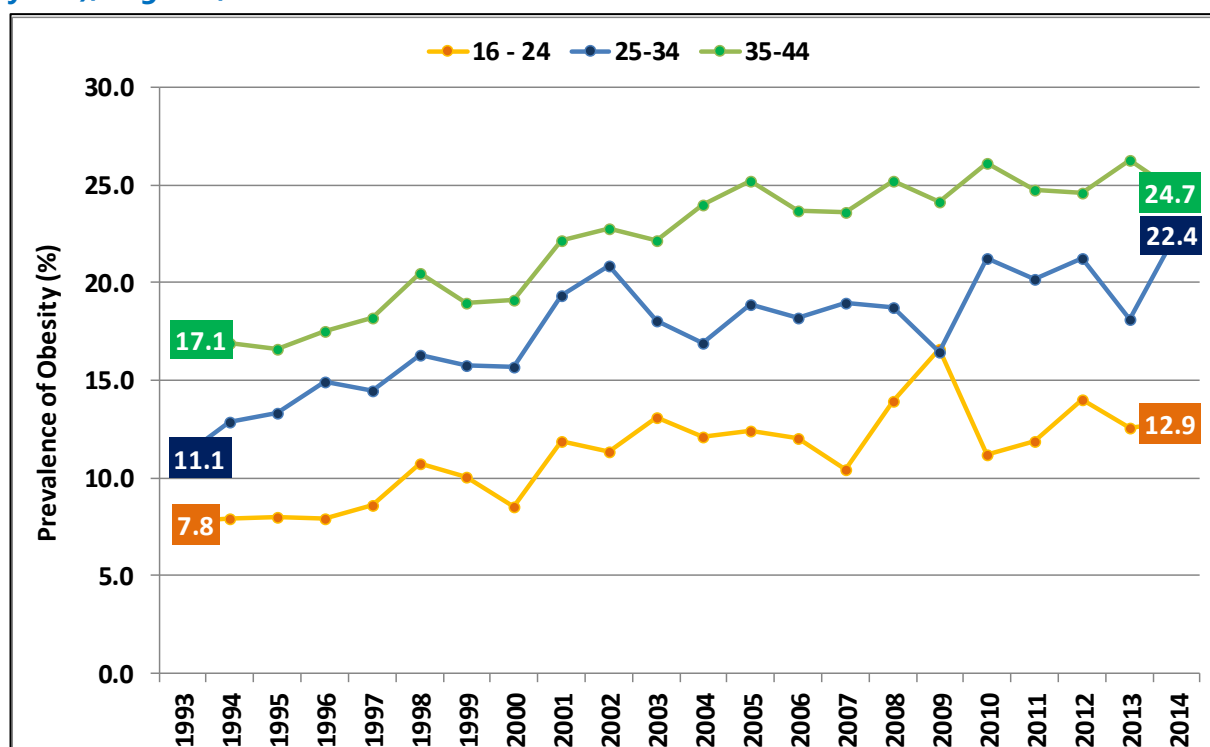
Source: Health and Social Care Information Centre, 2015

This rising figure will have a knock-on effect on schools as many of these children will have accompanying learning difficulties. Foetal alcohol syndrome can cause poor growth, small head and jaw, distinctive facial features, cerebral palsy, learning difficulties, mood/ attention/ behavioural problems, problems with liver, kidneys, heart or other organs, hearing and sight problems, epilepsy and a weak immune system. Early support cannot change these symptoms but can encourage better outcomes for these children. If figures continue to rise, this will have an effect on early support services, specialist input from advisory teachers and colleagues in Health.

#### 4.1.4 Maternal diet

Maternal obesity is defined as a Body Mass Index (BMI) of 30 kg/m<sup>2</sup> or more at the first antenatal consultation. Concern about maternal obesity has increased with the growing evidence that it not only represents a risk in the short term to the health of mother and baby but also a means by which a heightened risk of obesity is transmitted to subsequent generations. Data on the prevalence of maternal obesity are not collected routinely in the UK<sup>11</sup> but the Health Survey for England demonstrates that the proportion has steadily increased with currently up to 1 in 5 women of child bearing age are obese (see Figure 12).

**Figure 12: Obesity prevalence in women of child bearing ages (16-24, 25-34, and 35-44 years), England, 1993 – 2014**



Source: Household Survey for England (HSE). Analysis by NOO<sup>12</sup>

#### 4.1.5 Maternal age

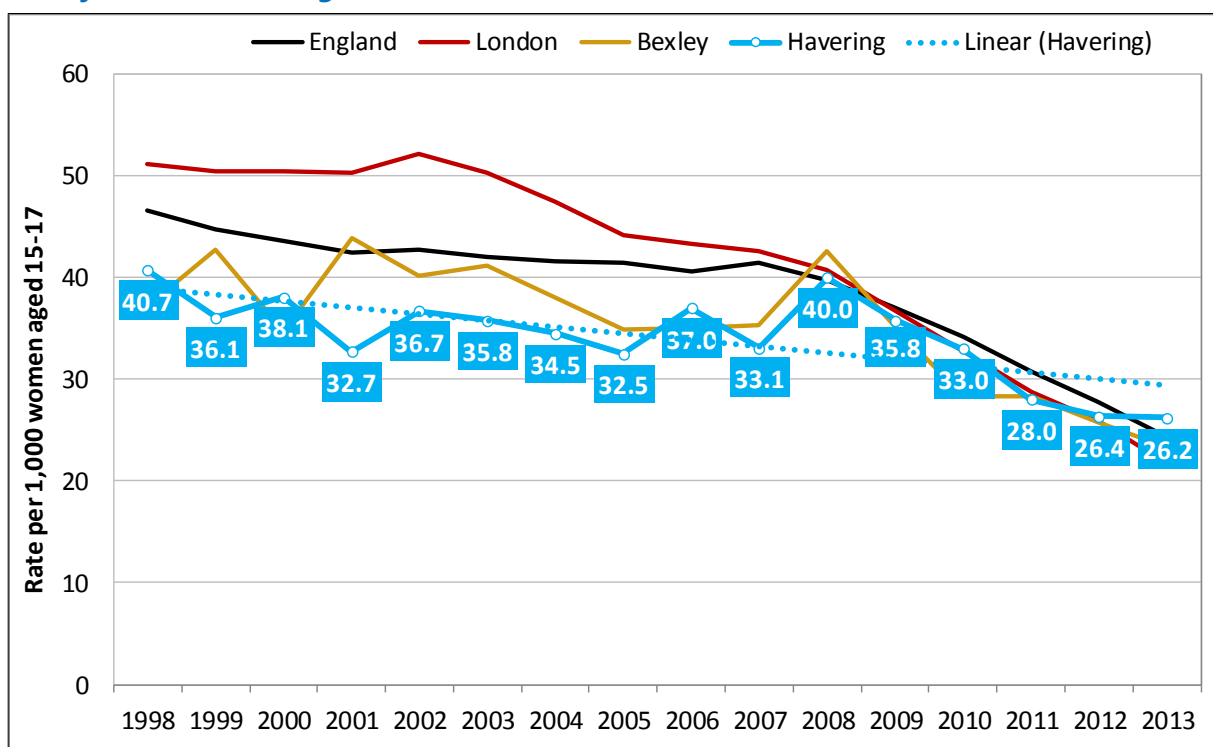
Maternal age has an effect on a wide range of adverse pregnancy outcomes.

<sup>11</sup> From November 2014, NHS-funded maternity service providers in England were mandated to collect data locally for inclusion in the Maternity Services Data Set (MSDS). Central submissions commenced in June 2015 and data will be available once the quality and coverage is at a sufficient level

<sup>12</sup> [http://www.noo.org.uk/NOO\\_about\\_obesity/maternal\\_obesity\\_2015/prevalence](http://www.noo.org.uk/NOO_about_obesity/maternal_obesity_2015/prevalence)

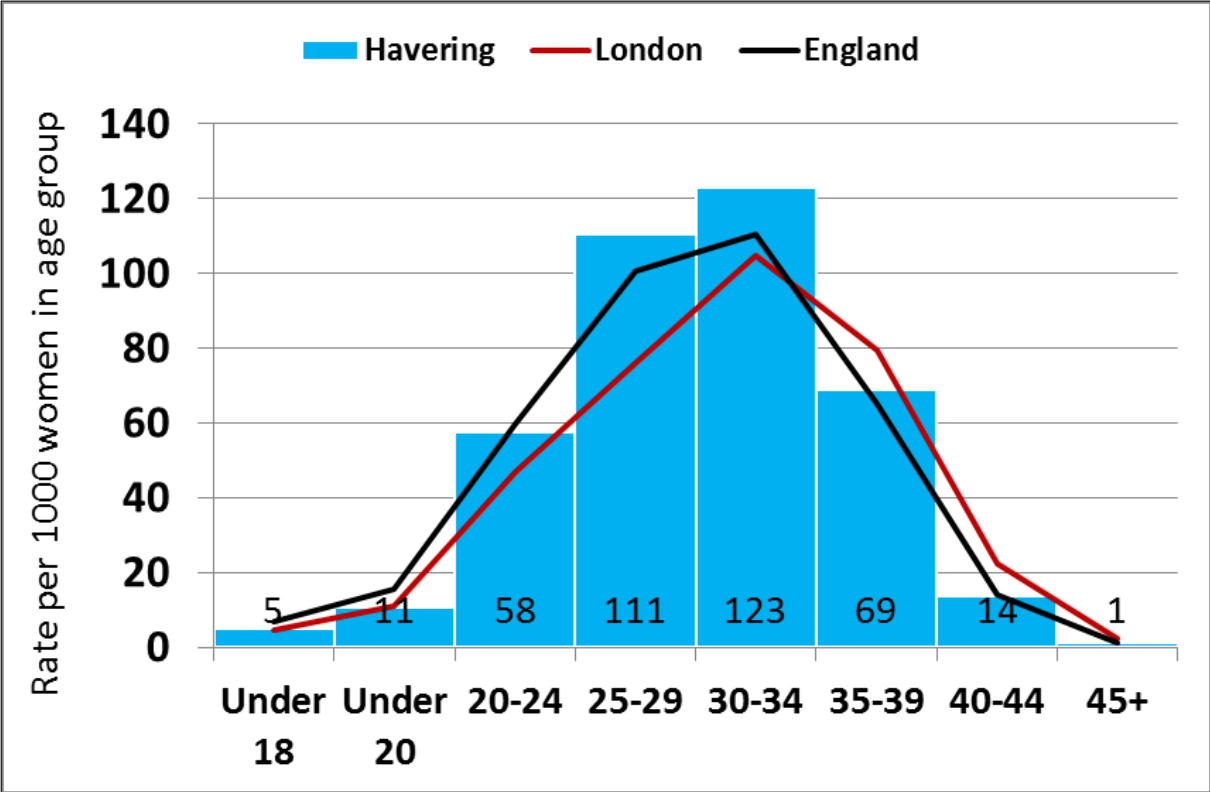
- Teenage pregnancy is associated with low birth weight and pre-term rates as well as being a contributory factor on child poverty. Havering's teenage (under-18) conception rate has almost halved since 1998. However, the Havering rate (26 per 1000 women under the age of 18) in 2013 is higher than both London (24 per 1000) and England (22 per 1000) (see [Figure 13](#)).
- Several studies have established an association between advanced maternal age (over 35 years) and adverse pregnancy outcomes including miscarriage, stillbirth, pre-eclampsia, gestational hypertension, gestational diabetes mellitus (GDM), preterm birth, delivery of a small- (SGA) or large- (LGA) for-gestational-age neonate and elective or emergency Caesarean section. Mothers aged 35 years and over residing in Havering had 20% of live births in 2014, similar to the national average and London average (see [Figure 14](#))

**Figure 13: Trend in under 18-conception rate per 1,000 women aged 15-17, Havering, Bexley, London and England, 1998-2013**



Source: Conception Statistics 2013 (published February 2015), Office for National Statistics

**Figure 14: Rate of live births per 1000 by age of mother for Havering, London and England, 2014**

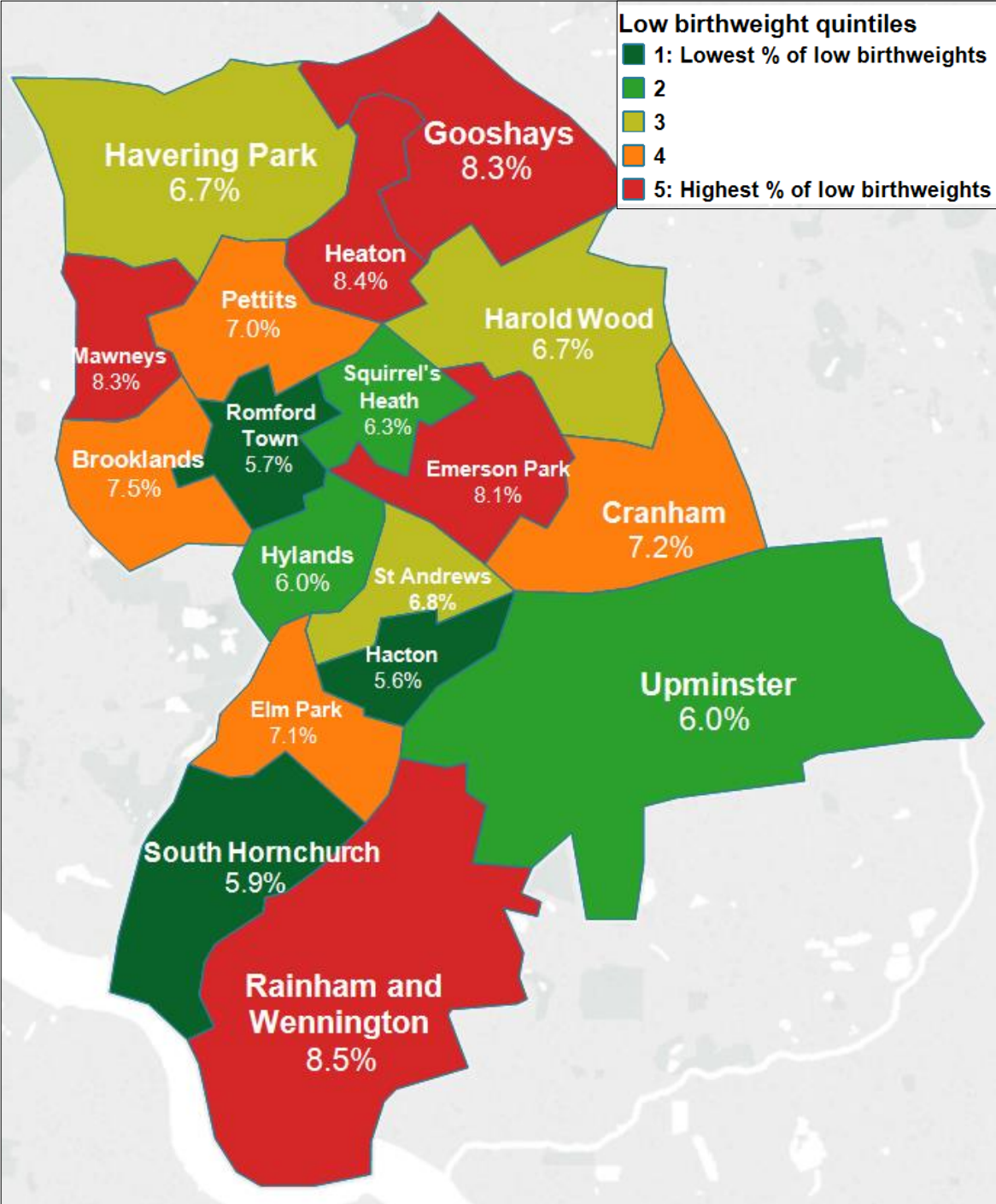


Source: Live Births by Area of Usual Residence, Office for National Statistics

**4.1.6 Low birth weight**

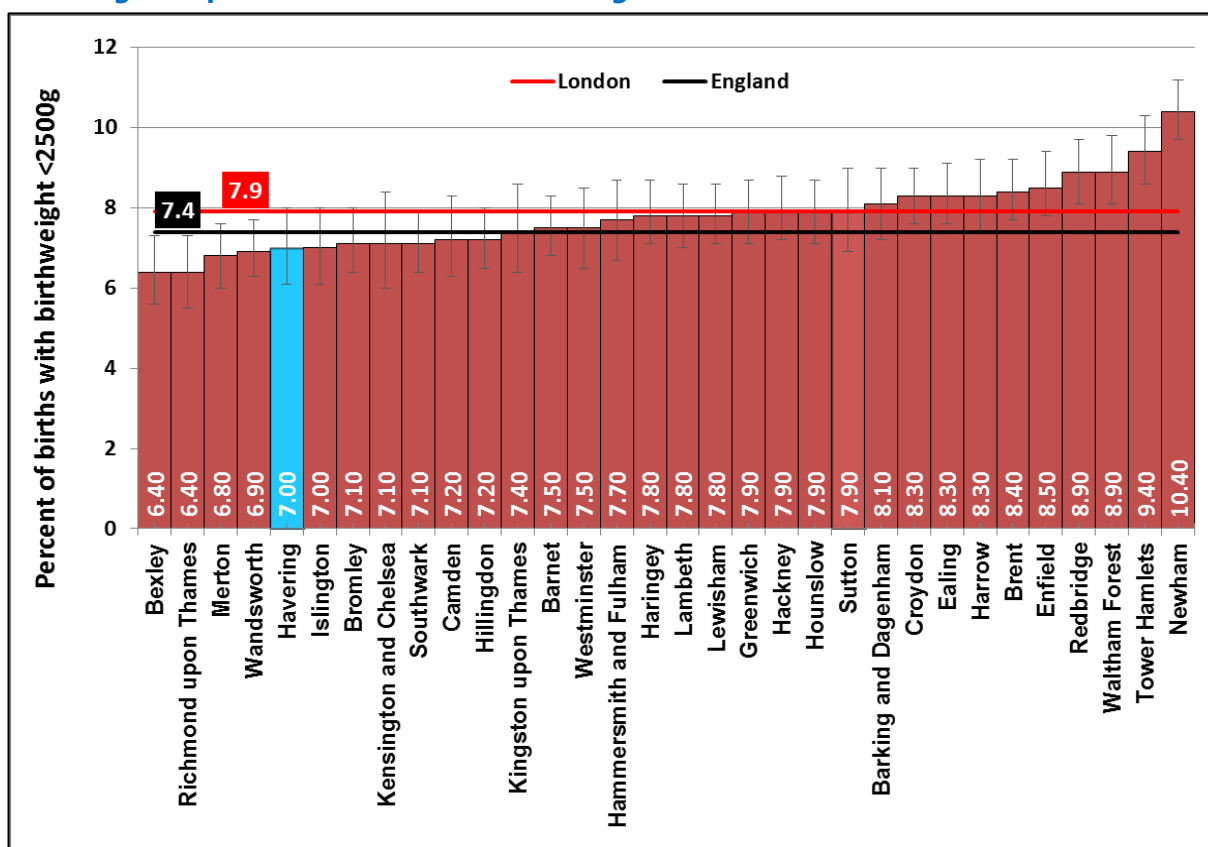
Low birthweight babies (infants under 2,500g) are at increased risk of problems at birth, early childhood, and in later life. A baby’s low weight at birth is usually a result of a preterm birth (before 37 weeks of gestation) or due to restricted growth during pregnancy. The latter may be a result of maternal diet prior to and during pregnancy. The risk of having a low birthweight baby increases with increasing deprivation. Figure 15 shows the percentage of low birthweight babies by ward. The areas of highest percentage of low birthweights correlate to the areas of highest deprivation. This analysis can help health and social care professionals target preventive work to the areas of most need. There were 3,014 births in Havering in 2013, of which 7 per cent (211) were born with birth weight less than 2500grams. This was similar to London and England, 2013 (see Figure 16).

**Figure 15: Percentage of births in Havering that were low birth weight split into ward quintiles**



Source: Office of National Statistics (ONS) birth files 2010-2014 (5 year average)

**Figure 16: Proportion of live and stillborn infants with low birth weights (<2500g) in Havering, compared to other London Boroughs, 2013**



Source: Health and Social Care Information Centre, 2015

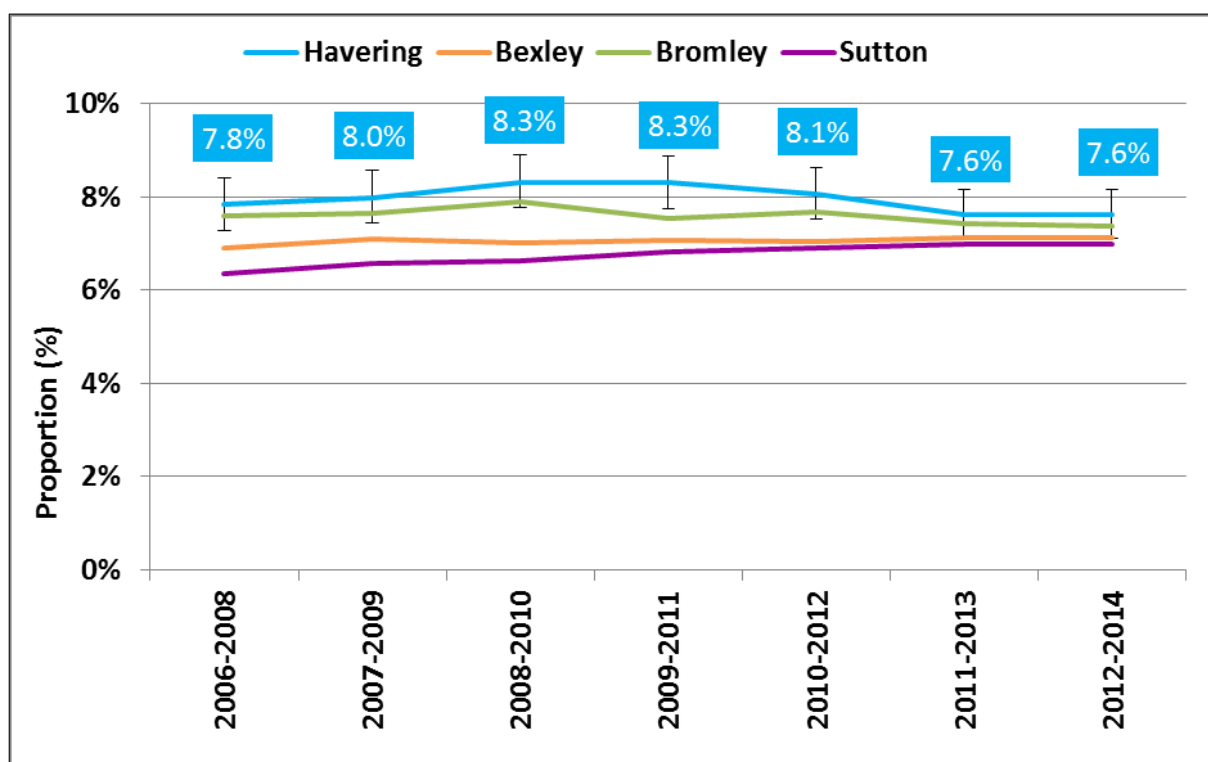
#### 4.1.7 Premature births

Premature births have long term effects in motor development, behaviour and academic performance compared to term births. These types of impairments can be prevented through early parental guidance, monitoring by specialized professionals, and interventions. There are strong links between premature births/low birth weight and visual impairment, most commonly retinopathy of prematurity which is abnormal blood vessel growth leading to scarring and damage or detachment of the retina. Generally, this condition affects 65% of babies weighing less than 1250g at birth, the condition can settle but the smallest babies will require treatment.

Hearing Impairment is not necessarily a direct outcome of prematurity but more the risk factors associated with prematurity i.e. use of antibiotics, noise induced deafness, as a result of being in intensive care, and the noise of life support machines, or lack of oxygen causing permanent hearing loss. Early identification via newborn hearing screening and Health Visitor vigilance for sight problems in premature babies is essential. Once identified early support is key to development of age appropriate skills, again this has implications for early support services and sensory specialist advisory teachers.

The proportion of premature live births and still births in Havering was 7.6% of total births in 2012-14, similar to other London boroughs that are statistically comparable, Bexley (7.1%) and Bromley (7.4%) – see Figure 17.

**Figure 17: Proportion of premature live births or still births in Havering, Bexley, Bromley and Sutton, 2006-08 to 2012-14**



Source: Premature live births or Stillbirths, Office for National Statistics

## 4.2 Postnatal factors affecting the risk of SEND

### 4.2.1 Breastfeeding

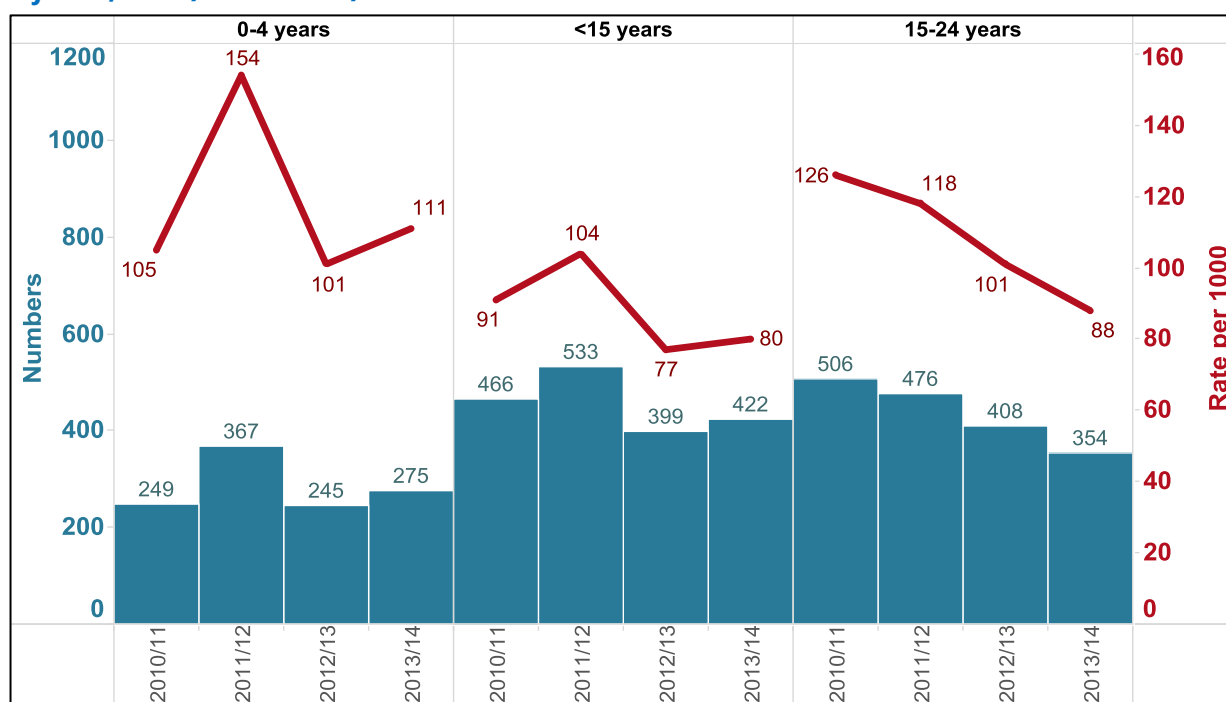
Breastfeeding is good for babies. Breastfeeding rates in the UK are among the lowest in Western Europe, with young mothers, women of lower socioeconomic status or those who left full-time education at an early age being least likely either to start breastfeeding or to continue breastfeeding beyond six to eight weeks. In 2014/15, about three quarters of Havering mothers breastfed at birth (73.2%, CI: 71.5-74.9%) and this is statistically similar to England (74.3%) but lower than London (86.1%). However, a significant proportion do not continue to breastfeed – at 6-8 weeks, only 35.8% continue to do so compared with 54.1% in London and 44.6% in England<sup>13</sup>.

### 4.2.2 Injuries to children and young people

Injuries to children and young people can often lead to lifelong disabilities and medical problems. The number of children and young people admitted with unintentional and deliberate injuries in Havering has generally been on the decline from 2011/12 to 2013/14. The rate of hospital admissions reduced for the under 4 years (154 to 111 per 1000), under 15 years (103.6 to 79.7 per 1000) and 15-24 years (117.5 to 87.9 per 1000) – see [Figure 18](#).

<sup>13</sup> Public Health Outcomes Framework NHS England Statistical Release: Breastfeeding Initiation & Breastfeeding Prevalence 6-8 weeks Q4 2014/15 published 2<sup>nd</sup> July 2015

**Figure 18: Number of children admitted to hospital with unintentional and deliberate injuries, 2010/11 to 2013/14**



Source: Public health England, Public health Outcomes Framework (PHOF), 2016

### 4.2.3 Maternal mental health

Women are at increased risk of suffering from mental health problems following childbirth, but women with pre-existing psychiatric disorders may also face a relapse or recurrence of their condition following childbirth. Mental illness occurring at this time may have an adverse effect on the woman herself, and also on her marriage, family and, in particular, on the future development of her infant. Maternal depression and stress related disorders are the most common maternal mental health conditions in Havering (see Table 3).

**Table 3: Prevalence of mental health amongst maternal population in Havering<sup>14</sup>**

MENTAL HEALTH CONDITION	NUMBERS	PREVALENCE (per 1000 maternities)
<b>All Maternities</b>	<b>3,088</b>	
<b>Adjustment disorders and stress</b>	463 to 926	150 to 300
<b>Mild-moderate depressive illness/anxiety states</b>	309 to 463	100 to 150
<b>Severe depressive illness</b>	93	30
<b>Post-traumatic stress disorder</b>	93	30
<b>Postpartum psychosis</b>	6	2
<b>Chronic serious mental illness</b>	6	2

Source: Births based on Office for National Statistics Mid-Year Estimates 2014

<sup>14</sup> Guidance for commissioners of perinatal mental health services, Joint Commissioning Panel for Mental Health 2012 (Births based on ONS Mid-Year Estimates 2014)



Havering residents can access a *perinatal mental health service* that is commissioned across four local CCGs. The service aims to reduce the impact of maternal mental health upon children; ensuring early diagnosis and better intervention and support. The service does not operate a waiting list, but have allocated emergency clinic space for priority patients. The team work closely with the Primary Infant Mental Health Service. [Table 4](#) shows level of activity as of December 2015.

**Table 4: Havering Perinatal Service Activity (December 2015)**

Havering Perinatal Service	
<b>New Referrals</b>	251
<b>Face to face contacts</b>	842
<b>Telephone contacts</b>	207
<b>Average caseload for team</b>	92

Source: North East London Foundation Trust

#### 4.2.4 Child abuse and neglect

Child abuse and neglect have been shown to cause important regions of the brain to fail to form or grow properly, resulting in impaired development. These alterations in brain maturation have long-term consequences for cognitive, language, and academic abilities and are connected with mental health disorders<sup>15</sup>. The immediate emotional effects of abuse and neglect – isolation, fear, and an inability to trust, can translate into lifelong psychological consequences, including low self-esteem, depression, and relationship difficulties.

#### 4.2.5 Looked After Children

Even the best early intervention cannot prevent some children needing to come into care. This section sets out the current picture of demand from children entering into Havering’s care system. The evidence over the past few years demonstrates the upward trend of children being placed in care in Havering. Over the past financial year the number of children on average who are looked after has increased from 205 to 240, which is subject to constant monitoring<sup>16</sup> (see [Figure 19](#)).

##### *Current picture and Trend*

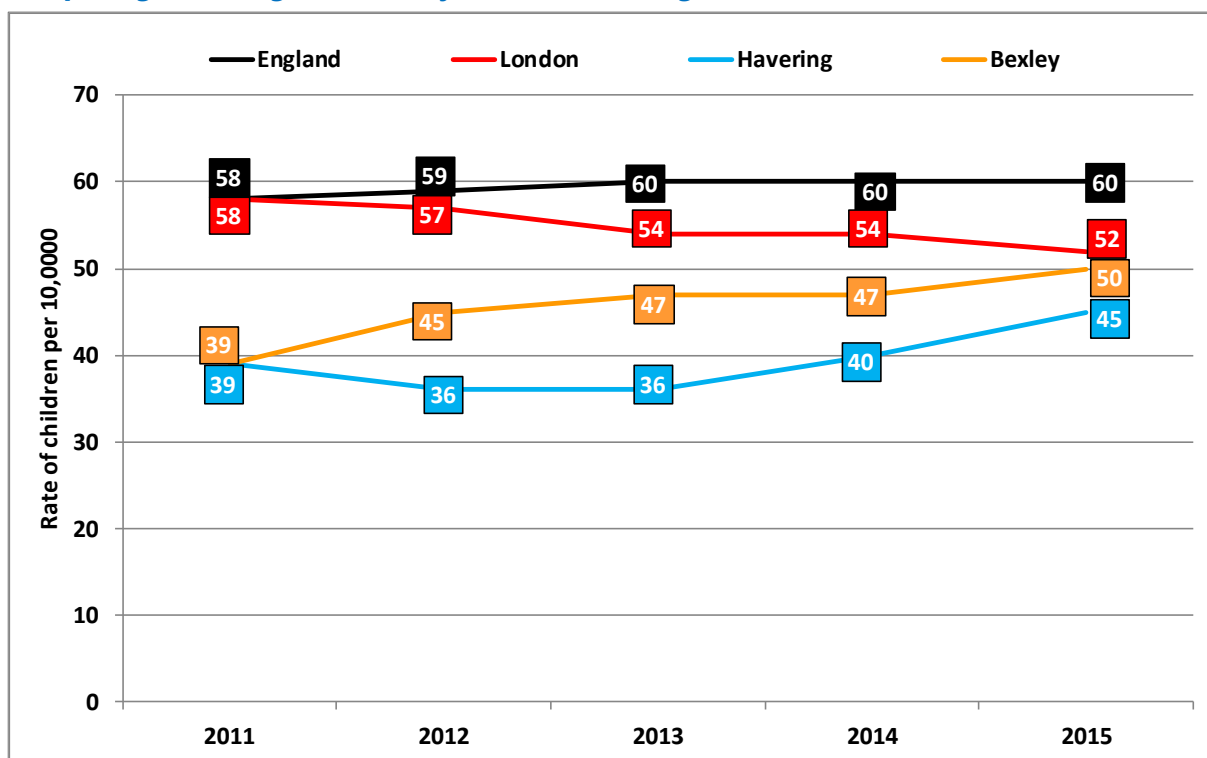
Comparisons with national and statistical neighbor data on the rate of children who are looked after shows that:

- The Havering rate at 45 per 10,000 is lower than the national average of 60 per 10,000 and London average of 52 per 10,000 and our statistical neighbour of Bexley at 50 per 10,000.
- It is comparable to our regional neighbors of Outer London at 47 per 10,000.

<sup>15</sup> [Tarullo, A. \(2012\). Effects of child maltreatment on the developing brain. CW360°](#)

<sup>16</sup> [London Borough of Havering - SSDA 903 Benchmarking data 2015](#)

**Figure 19: Children looked after at 31 March 2011 to 2015, rate of children per 10,000 comparing Havering with Bexley, London and England**

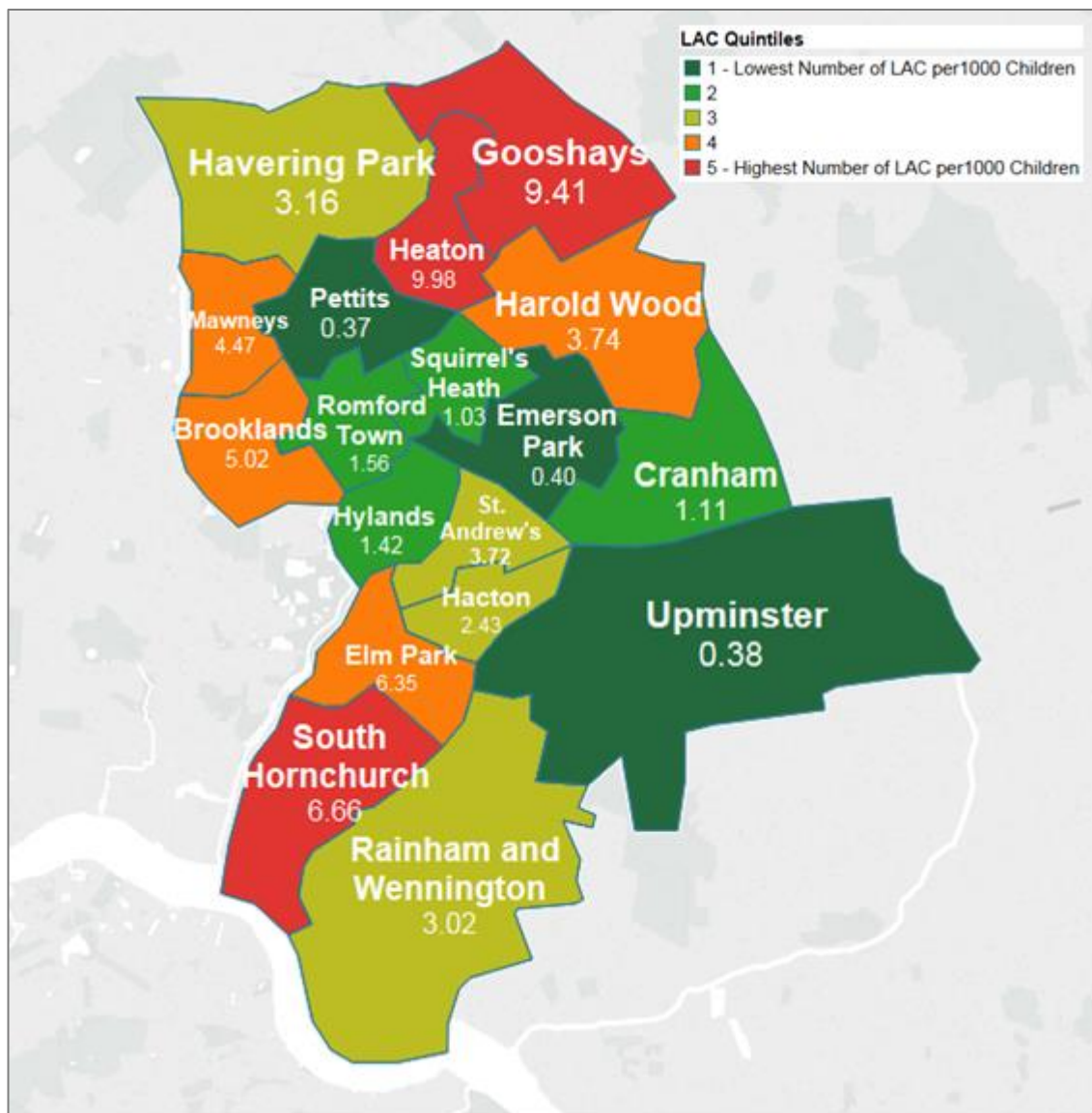


Source: Characteristics of Children in need 2014/15

### Geography

Based on ward of family residence: Gooshays, Heaton and South Hornchurch have the highest number of children looked after. This is in line with deprivation in the borough. About 8% of LAC come from out of borough (see [Figure 20](#)).

**Figure 20: Numbers of Looked After Children by ward, 2014/15**

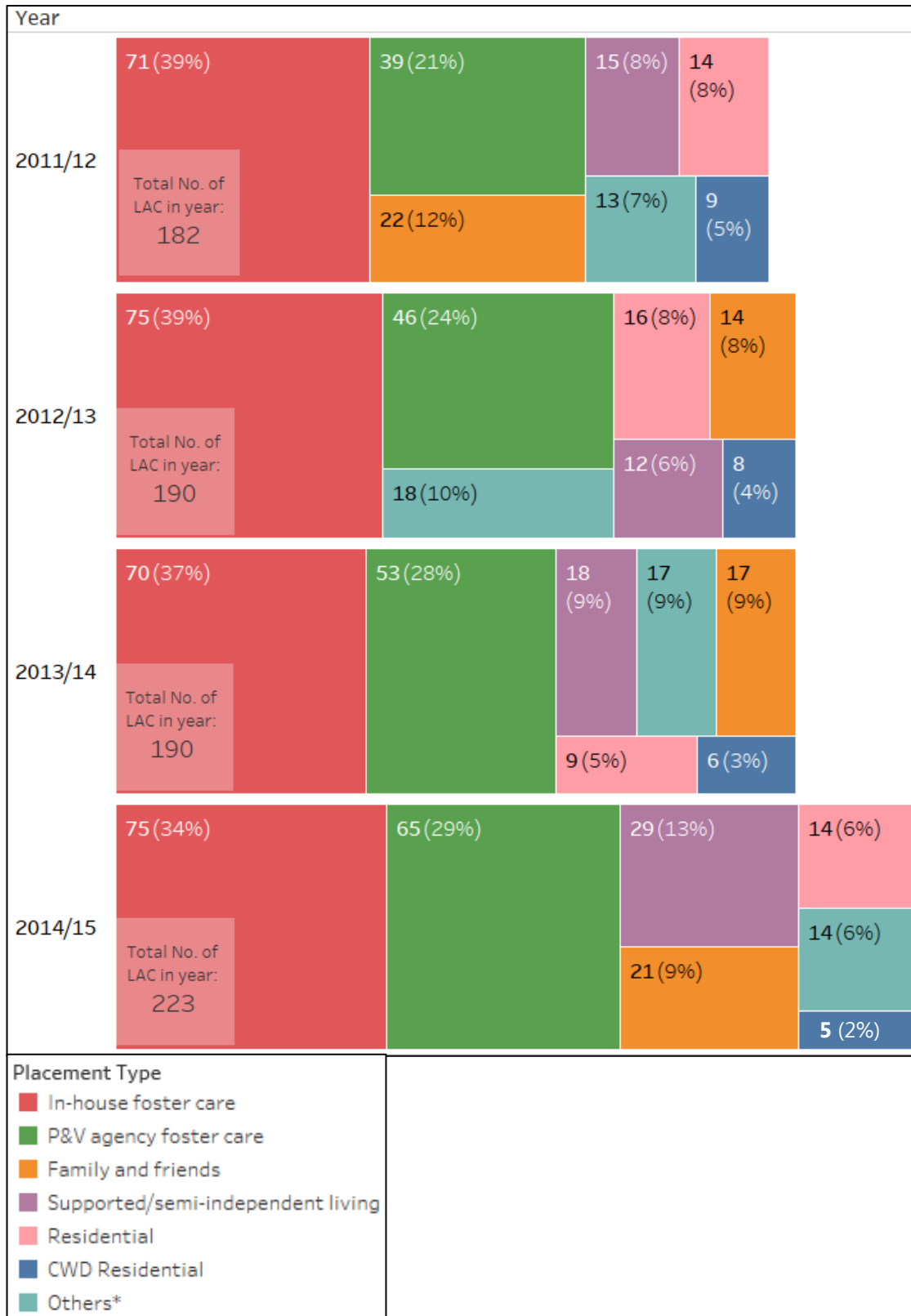


Source: Department of Education

*Placement Type*

- Below are key findings of placement type for Looked After Children for 2014/15 (see Figure 21):
- 63% in foster care placements (29% in agency foster care and 34% in in-house foster care)
  - Over the past 4 years there has been an increase in agency foster care (21%-29%) and a decrease in in-house foster care (39%-34%).
  - 6% in residential accommodation. Over the past 4 years there have not been any major changes in residential care (8%-6%)
  - 2% of LAC with a disability in residential accommodation
  - Over the past 4 years there has been a decrease in children with disability in residential care (5%-2%).

**Figure 21: Distribution of LAC by placement type, 2011/12 to 2014/15**



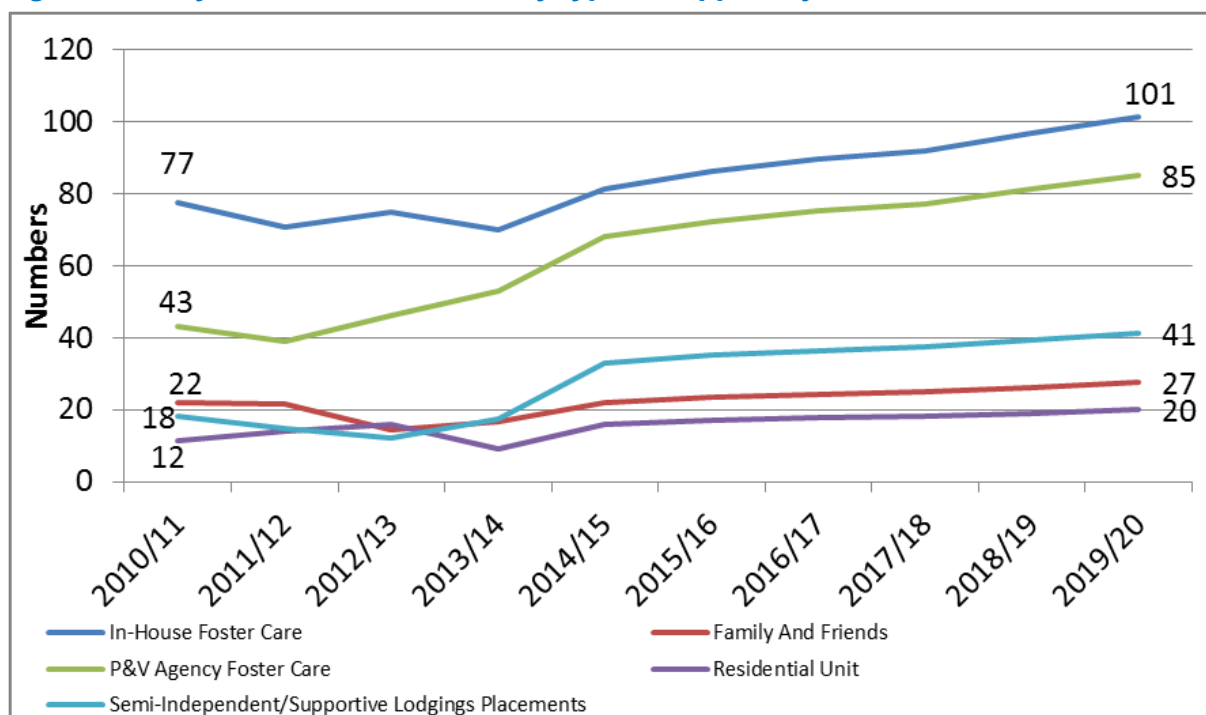
\*Others include: Placed with parents; Placed with prospective adopters; Secure accommodation; and Other, boarding school, health trusts, family units, etc.

Source: London Borough of Havering Children and Disabilities Team

### Projecting future demand

Data projections based on current service model and provision of care show a continuing rising trend of increase in numbers of LAC by support type by 2020 (see Figure 22).

**Figure 22: Projected numbers of LAC by type of support by 2020**



Source: London Borough of Havering Children and Disabilities Team

### Looked after children with complex needs/disabilities

In 2014/15, 8% of our Looked After Children were recorded with a disability and 2% of our Looked After population were placed within Residential accommodation for children with disabilities. The stresses and strains of caring for a child with a disability are reflected in this figure. The service currently case manages 19 Looked after Children (7 of which are Out of Borough).

An in depth analysis of looked after disabled children and young people was carried out in January 2016<sup>17</sup>. The findings showed that there were 17 children and young people Looked After in CAD. Of these 8 were subject to Care Orders, 7 in voluntary accommodation, 2 were receiving short breaks. Of the 8 children subject to Care Orders 5 live with foster carers in Havering or with agency foster carers and out of borough e.g. Kent. Of the children accommodated, 1 was placed in borough with the remaining in out of borough residential placements.

The findings outlined what was missing in meeting the needs of Looked After disabled children:

- o Ensuring the voice of the child – for non-verbal communicating children

<sup>17</sup> Amanda Fernando, Interim Social Care Lead, Children and Adults with Disability Service, 28 January 2016

- A higher level of understanding and specialist support when working with children and Autism and challenging behaviour
- Behavioural support and intervention
- More joint working especially with CAMHS in meeting the mental health needs of children and young people with severe and profound disability
- Speedier time to find an available permanent family for a child with disability
- Specialist family based local overnight short breaks to prevent accommodation requests for residential provision
- Art and play therapy
- More local activities close to where children are places that meets the needs for those with challenging behaviour
- Schools accessing the pupil premium allowance where the young people are places
- A speedier response in relation to cognitive assessments for young people aged 16+ in preparation for adulthood.

The findings set out how the gaps could be filled:

- Develop and provide more specialist foster carers locally in Havering
- Increase specialist training for foster carers in dealing with children and young people that have challenging behaviour
- Provide specialist family based overnight short breaks locally
- Provide specialist advice to the CAMHS where where young peson is placed
- Consider the use of advocated and independent visitors more
- Provide specialist safeguarding training for social workers
- Ensure workforce in residential setting is skilled in managing challenging behaviour and use of restraint

Havering has one dedicated LAC Mental Health Nurse in post. She provides a range of support as shown in [Table 5](#) below:

**Table 5: Therapeutic services offered by specialist LAC clinician**

Services Offered		Description
<b>Consultation</b>	<b>Families</b>	<p>Due to the distressed and distressing presentation of many LAC children intervention often begins with adoptive and foster families:</p> <ul style="list-style-type: none"> <li>• Consultation to parents / carers based on a Dyadic Developmental Practice (DDP) approach</li> <li>• Consultation to prospective adoptive and foster families in preparation for a child's placement</li> </ul>
	<b>Social Workers</b>	<ul style="list-style-type: none"> <li>• To think through cases which would not meet threshold for a service but could benefit from some structured social work input</li> <li>• To think through and offer strategies for direct work, life story work and narratives.</li> <li>• Discuss appropriate referrals and initial intervention</li> <li>• Regular attendance at team meetings for the under and over 12s teams and fostering team to consider mental health related issues</li> </ul>

Services Offered		Description
	<b>Schools</b>	<ul style="list-style-type: none"> <li>To consider challenging behaviour in the context of early experience and trauma</li> <li>To offer useful strategies for LAC children</li> </ul>
	<b>Other professional</b>	<ul style="list-style-type: none"> <li>Considering the presentation of LAC children and their specific needs</li> <li>Therapeutic input for child and family:</li> <li>DDP based family sessions</li> <li>Therapy play with child and parent / carer together</li> </ul>
<b>Therapeutic input</b>	<b>Children</b>	<ul style="list-style-type: none"> <li>Play Therapy</li> </ul>
	<b>Young people</b>	<ul style="list-style-type: none"> <li>Play Therapy Individual sessions using DDP, counselling and play therapy approaches</li> <li>Neuro-developmental assessment:</li> <li>ADOS (ASD) assessments</li> <li>QB (ADHD) testing</li> <li>Signposting to appropriate groups, services, resources and funding</li> </ul>
<b>Training and support groups</b>		<ul style="list-style-type: none"> <li>Attachment based, play and mental health training programmes for foster carers</li> <li>Safeguarding training for social workers</li> <li>Joint training with health colleagues</li> <li>Attendance at foster care support groups</li> <li>Possible pilot of DDP based workshops for foster carers</li> </ul>
<b>Inter-agency working</b>		<ul style="list-style-type: none"> <li>Regular peer supervision with Marie Pudney and Janet Chapman (YOT)</li> <li>Regular attendance at the <ul style="list-style-type: none"> <li>NELFT LAC Health group;</li> <li>LAC panel meetings</li> <li>LAC Virtual team meetings</li> <li>based at children services two days a week</li> </ul> </li> <li>Regular meetings with <ul style="list-style-type: none"> <li>Marie Pudney – LAC nurse</li> <li>Helen Potter – Participation worker for Havering Children Services and facilitator of the Child in Care Council</li> <li>social work teams</li> </ul> </li> </ul>
<b>Joint Working</b>		<ul style="list-style-type: none"> <li>Cases are often also open to one of the teams psychiatrists for monitoring, medication and risk management</li> <li>Assessments are often undertaken jointly with other therapists within the team</li> </ul>
<b>Assessment</b>		<ul style="list-style-type: none"> <li>Initial assessments, Risk assessments, State of mind assessments, Therapeutic assessments</li> </ul>
<b>Statutory</b>		<ul style="list-style-type: none"> <li>Recording – both on RIO and Children Services</li> <li>Supervision – managerial with CAMHS and Children</li> </ul>

Services Offered	Description
	services, clinical and child protection <ul style="list-style-type: none"> <li>Mandatory training</li> </ul>
<b>CYP LAC IAPT</b>	<ul style="list-style-type: none"> <li>Regular attendance at LAC IAPT forum at the Anna Freud Centre</li> <li>Completion of screening, monitoring and outcome measures for LAC child and parent/carer</li> <li>Pilot of reporting on outcome measures with the support of Children Services admin provision.</li> </ul>

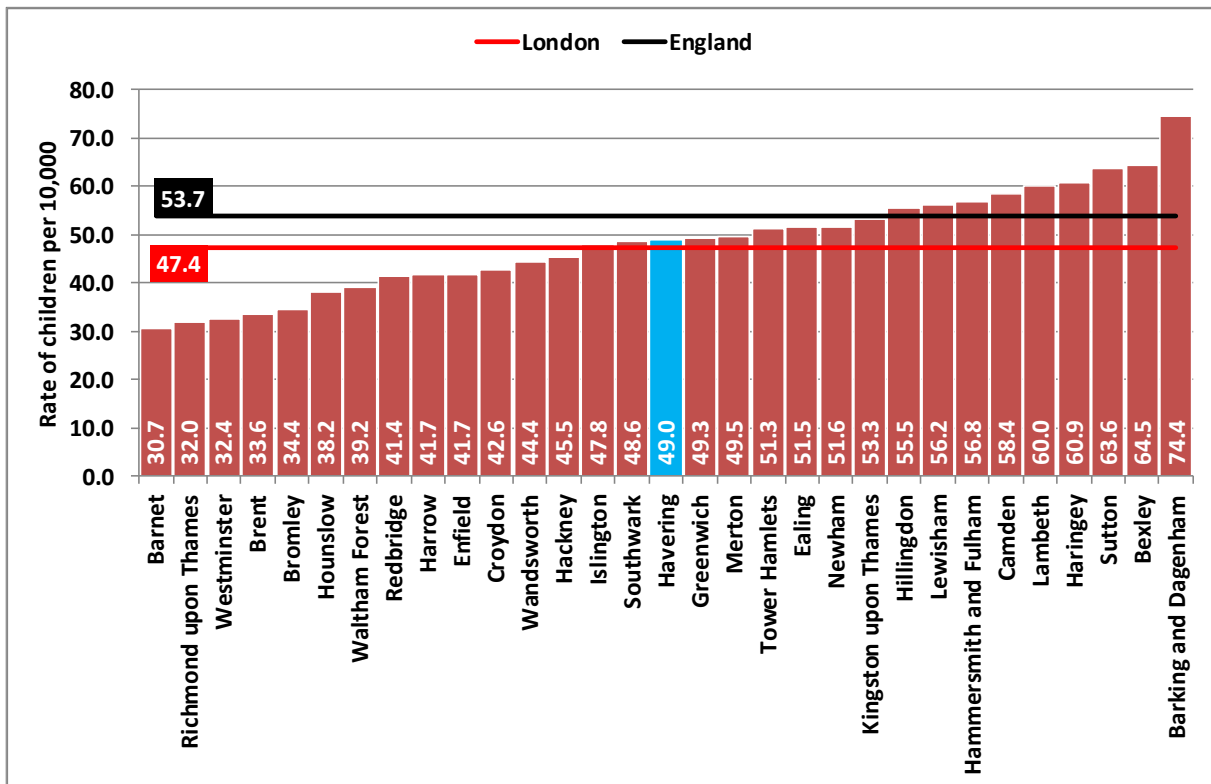
*Unaccompanied asylum seekers*

There were 17 recorded UAS as at 31<sup>st</sup> March 2015. This is a significant increase from 3 as at 31<sup>st</sup> March 2014. This has further increased in 2015/16 with 22 as at 31<sup>st</sup> December 2015.

**4.2.6 Children on a Child Protection Plan**

The number of children being injured in the family home is dropping and the category which is rising in Havering is neglect. Havering has a rate of 49 children per 10,000 who became the subject of a child protection plan; this is slightly higher than the London average at 47.4 per 10,000 but lower than the national average at 53.7 per 10,000. The number of children and young people on Child Protection Plans has increased by 24 cases (12.6%) in March, the highest amount this period. 2014-15's average of 173 plans is a 43.5% increase on 2013-14's average of 124 (see Figure 23)

**Figure 23: Number of children per 10,000 who became the subject of a child protection plan during the year ending 31 March 2014 in London boroughs.**



Source: NSPCC

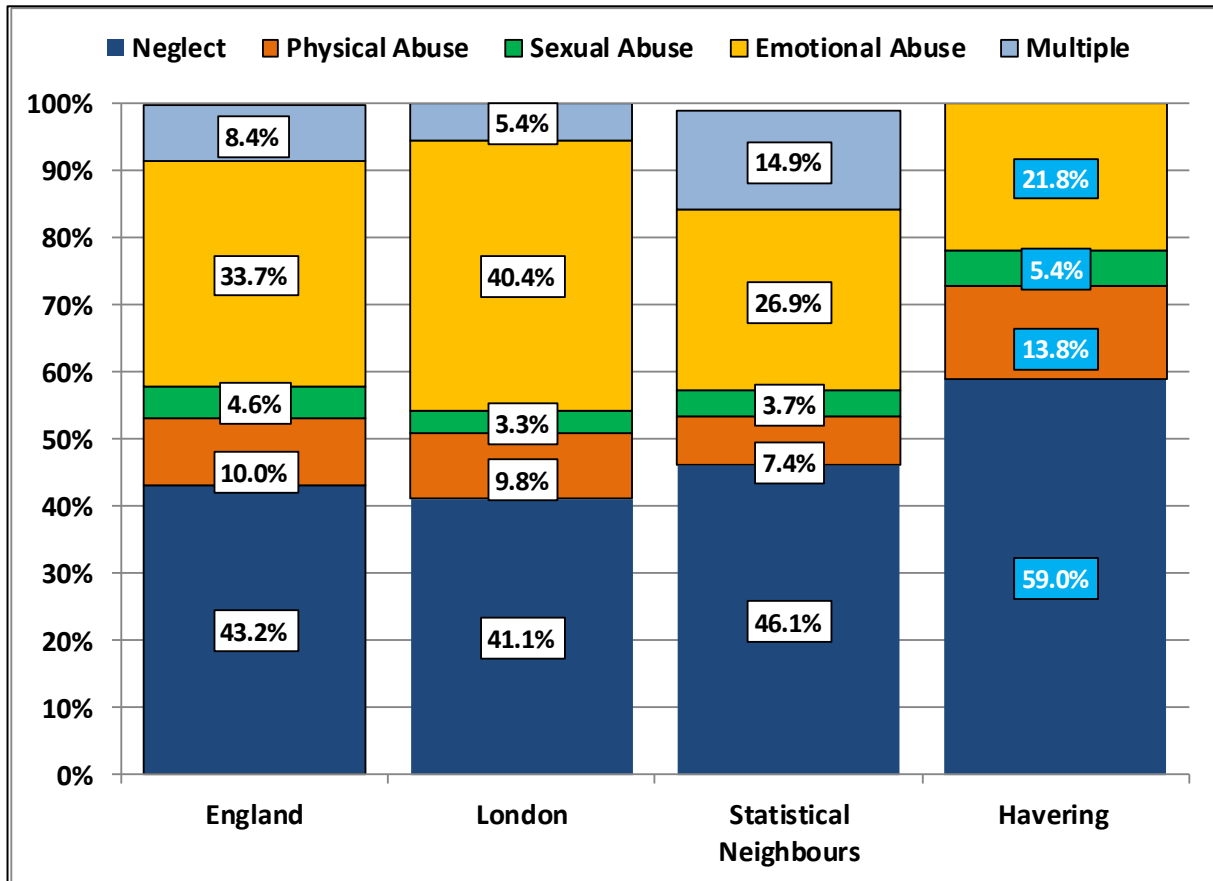


Colleagues in Social care work in partnership with families to reduce risks but, whilst families are increasingly understanding of the need to not physically chastise children they need further support and education for better parenting and the provision of stimulating environments.

*Neglect in early years*

Data shown in Figure 24 relates to the initial category of abuse for children on a Child Protection Plan during the year 2014/15. As can be seen, Havering have a 28% higher percentage of cases with Neglect recorded as the category of abuse when compared to our statistical neighbours (59.0% compared to 46.1%). Similarly, Havering have a 86.5% greater percentage of Physical Abuse cases compared to statistical neighbours (13.8% compared to 7.4%).

**Figure 24: Percentage of children on a child protection plan by category of abuse; comparing England, London, Havering and its statistical comparators**

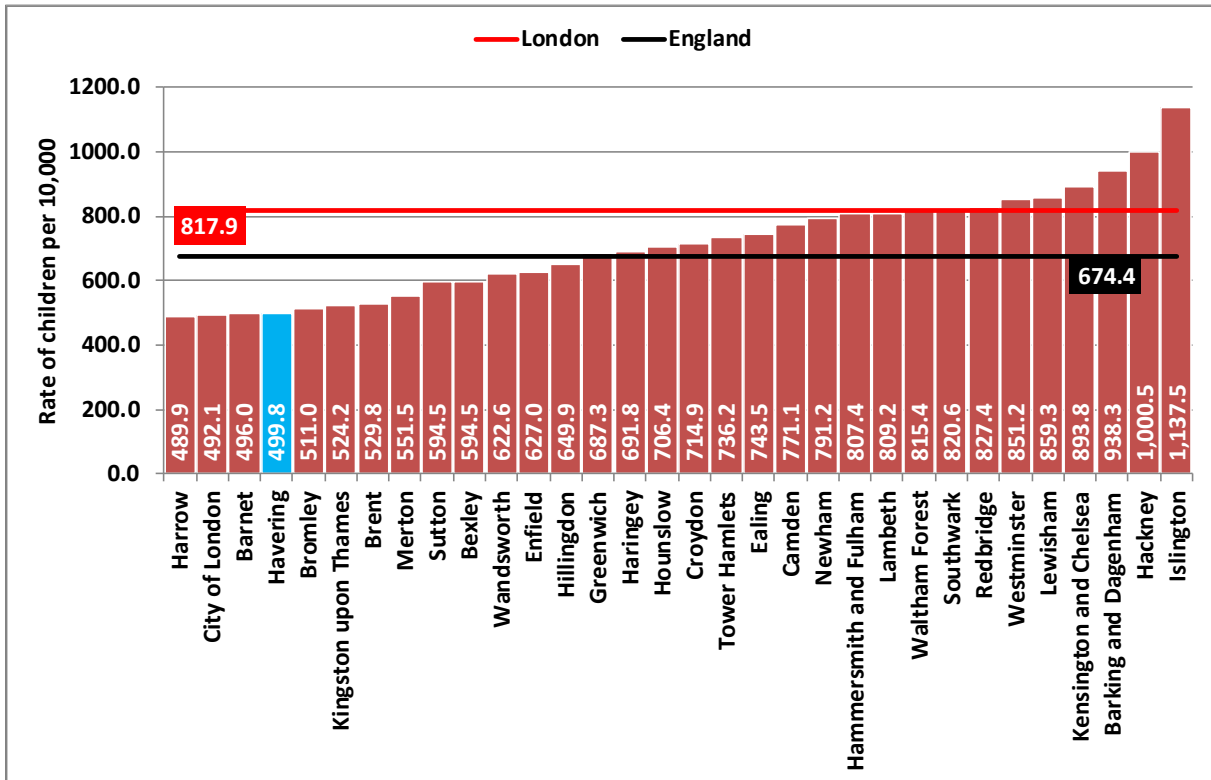


Source: Government Department of Education statistics

**4.2.7 Children in Need**

Havering has the fourth lowest rate of children in need compared to all London boroughs at 499.8 children per 10,000; both the London average and national rates are higher at 817.9 and 674.4 per 10,000 children respectively (see Figure 25).

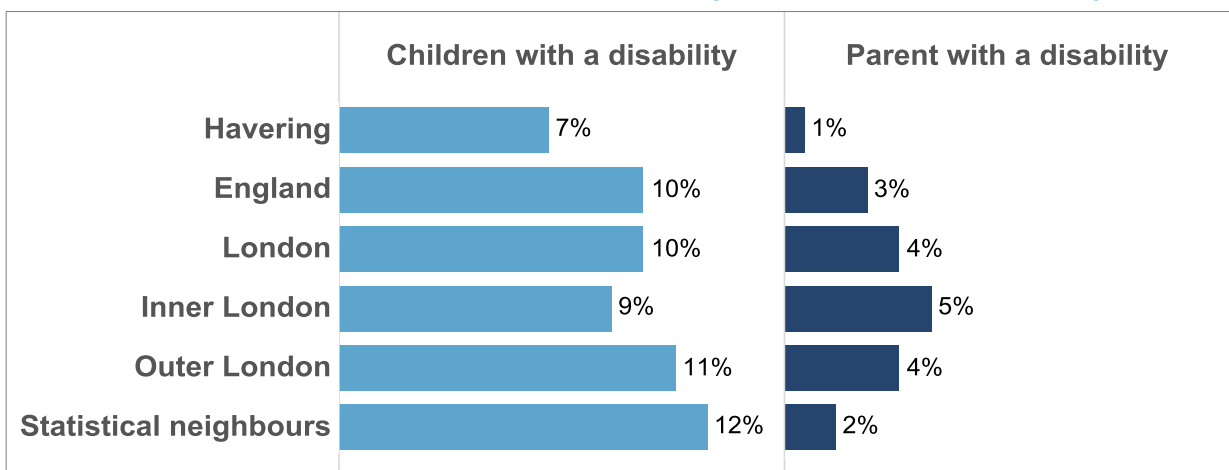
**Figure 25: Rate of children in need throughout 2014-15 per 10,000 children in London boroughs**



Source: NSPCC

A part of the statutory Children in Need Census looks at the primary need at the assessment stage of those children considered in need. Havering has a lower percentage of both children and parents with a disability of illness when compared to our statistical neighbours (see Figure 26).

**Figure 26: Proportion of those Children in Need whose primary need assessment is related to SEND (i.e. either 'Children with a disability' or 'Parent with a disability')**

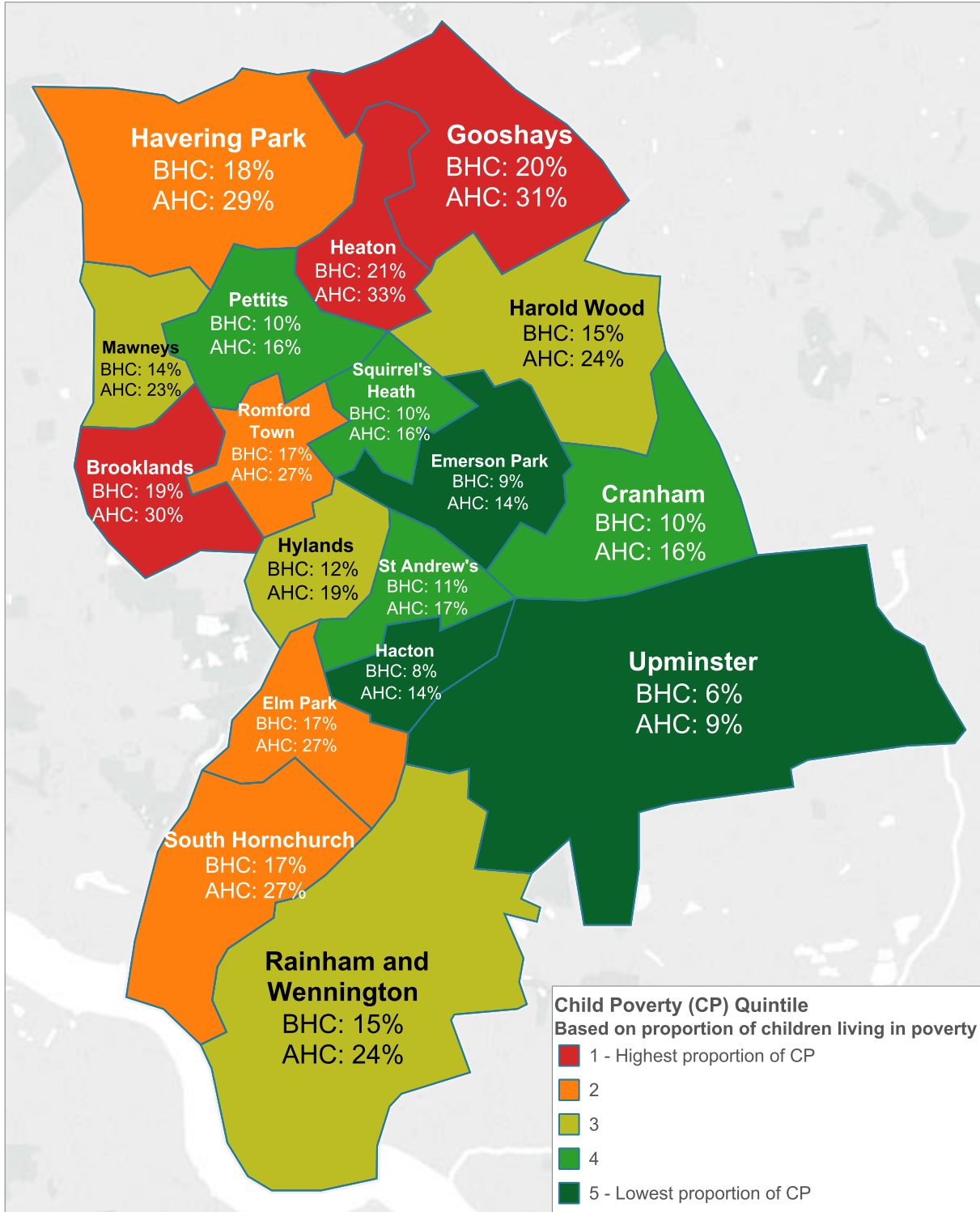


Source: Characteristics of children in need: 2014 to 2015

### 4.2.8 Children in Poverty

Figure 27 is a map of children poverty by Havering wards, and the areas of highest child poverty correlate with the areas of highest deprivation and SEND.

**Figure 27: Map showing percentage of children in poverty, before and after housing costs within Havering wards in 2015**



Source: End Child Poverty Commission, 2015; London's Poverty Profile using Her Majesty's Revenue and Customs (HMRC) measure; published October 2015

As expected the most deprived wards such as Gooshays and Heaton have the highest proportion of children in poverty whereas those wards that are more affluent e.g. Upminster have the lowest proportions. A report published this year by the Joseph Rowntree Foundation entitled Special educational needs and their links to poverty<sup>18</sup> explores why the links between special educational needs and disability (SEND) and poverty are so strong. This report shows that poverty is both a cause and an effect of SEND and makes a series of recommendations, including:

- Policy-makers and school and early years leaders should prioritise SEND.
- Staff in schools and early years settings should be trained to identify needs so that they can be spotted early and over-identification and under-identification are reduced.
- Targeted funding for pupils with SEND who are at risk of exclusion should be provided so that schools can support them before they are excluded.

### **Recommendation**

Ensure a continued focus on prevention and early intervention (universal services and targeted support) to address the risk factors for SEND

... including healthy lifestyle support for pregnant women / women considering pregnancy to address maternal obesity, smoking in pregnancy etc

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<sup>18</sup> [\*Joseph Rowntree Foundation, Special educational needs and their links to poverty, 2016\*](#)

## 5. PUPIL AND PARENT VOICE

### 5.1 Pupil Voice

One of the strongest themes running through the Children and Families Act and the SEND code of practice is that children and their families should be at the centre of our service delivery and development. This should be on an individual level though the assessment and EHC planning processes around a child and also at the strategic planning level.

We do this in a number of ways:

- Ensuring the child's voice is strong in each individual Assessment and EHC planning process.
- Ensuring that *ViewPoint* the councils tool for gaining feedback from all children, including those with SEND, involved in children's social care statutory processes is used and consideration given to feedback in future service delivery and development.
- The ongoing growth and effectiveness of the pupil forums being developed by our Advocacy for All contract.
- The successful use of POET, a nationally developed tool for capturing the views of children, young people, their parents and carers, was used successfully last year and will be used annually in future.

As part of the development of this JSNA we carried out three focus groups to enhance our understanding of the pupil SEND needs in Havering schools. We selected focus groups to run in a primary school, secondary school and special school to give us appropriate representation across the school settings. We worked with an Assistant Head at one of our Special School to design appropriate questions for the pupil group. These questions were adapted from questions that children in her school had already been consulted on as being appropriate for children with SENDs. See [Table 6](#) for a summary of questions asked by the focus groups within each school setting.

We have commissioned Advocacy for all to develop a group of champions that will help to raise the profile and voice of disabled children and young people. Advocacy for All will help young people to develop skills so that they are able to advocate for change on behalf of other disabled children and young people. The group will support local commissioning activities such as the re-commissioning of short breaks.

**Table 6: Summary of the focus groups by school and question asked**

Questions	Primary school	Secondary school	Special school
<b>Do you get help at school?</b>	All pupils agreed they received help at school.	All the pupils received help at school mainly through a learning mentor during lessons, one student had a scribe.	There was a resounding “yes” from all pupils.
<b>Do you want more help?</b>	The majority of pupils were happy with the level of help they receive. Some expressed pride in their ability to work independently and noted that they didn’t always need help.	Most of the pupils were very happy with their level of help. Some of the students wanted less help and wanted to be encouraged to be independent and supported when they asked for help. There was ‘covert reassurance’ that help was there should they need it.	Pupils were very happy with the level of help they receive. Discussion demonstrated that the support they most value is focused around the themes of 1:1 support, personal care, life skills and activities.
<b>What do you want more help with?</b>	Some pupils suggested they would like more subject-specific help. This primarily seemed to be borne from enjoyment of, and interest in, those subjects rather than particular needs. The subjects mentioned were History, Maths, RE and English (in particular ‘spellings’)	Maths, handwriting, improve handwriting ‘Money is really hard to understand’, they would like more help with understanding money ‘Would like more help with understanding how to fix a problem, rather than just being shown what the answer is’	Personal care and life skills (e.g. brushing hair, tying laces)  More 1:1 time with TAs in class
<b>What would make your school a better place?</b>	Suggestions were focused around the following themes: - sports (‘a swimming pool’, ‘better football pitch’, ‘trampoline’) - nature and animals (‘class pet’, ‘pond’, ‘building birds nests’) - technology (‘robots teaching us’ e.g. ‘to tie our laces’, ‘segways’, ‘vending machines’)	‘Pretty happy with what I’ve got’ ‘During tests people sitting too close to each other’ – perception of cheating ‘Get bullies out the way’ – exclude the bullies Most of the students seemed to really enjoy most aspects of school and had favourite subjects.	More reading Parents to visit schools more often/ more family days More whole school fun days More lunchtime clubs including art, girls’ ‘pamper’ club, iPad/ Xbox access, pool table More toys in class/ more play time Picnic benches

Questions	Primary school	Secondary school	Special school
<b>Do you do any learning outside of school? (What is it?)</b>	A variety of sports were mentioned including football, cricket and karate Others mentioned homework and a couple had tutors outside of school Cooking was also mentioned	The children did a variety of sporting activities including dodgeball, karate, judo, rugby and boxing 'I used to do karate, now I just play on my computer' 'I jog to my grandma's house'	A variety of sports were mentioned including horse riding, swimming, gym and karate Drama, acting, dancing and singing Practice crossing the road with parents Paper round
<b>What do you like doing for fun?</b>	Key themes were food, friends/ social activities, and pets/ animals. Travel and holidays were mentioned. 'Reading comics' 'Trying something new'	Boccia (a precision ball sport for people with disabilities) is very popular. Playing sports and watching sports. Most of the students spent their free time playing video games, watching YouTube and watching football and sports. Most of the students supported a football team.	Key themes were arts-based activities, sports and playing video games

Key emerging themes:

- The critically important role of the learning mentor in the school life for children with SEND.
- Would like more help with being independent and understanding how to fix a problem.
- Help with understanding money.
- Sports are an important part of school and recreational life.
- Reduction in sports activity from primary into secondary school – recommend finding ways for those with SEND to engage with appropriate sporting activities out of school time.
- Majority of freetime spent watching YouTube, sports or playing video games.
- For younger children, discussion focused around friends/ social activities, nurturing/ pets/ animals, and food (generally a love of sweets, chocolate etc).

## 5.2 Parent Voice

In Havering, we are fully committed to this principle and have involved parents in the development of all of our developments from the Local Offer, the EHC Plan and processes, Post 16 developments and reviewing of commissioned services, eg Short Breaks and Transport. Examples of parental involvement in a model of co-production is the work to build the local offer and also in establishing the EHC plan process. Havering has an established Parent Forum which we work with. We also use wider events and targeted consultations to reach as wide an audience as possible.

We have an established work programme which involves the continued development of our personal budget offer and also the re-commissioning of Short break provision. Work groups will consist of officers and parents. POET has given us and will continue to give, high quality data as we build and develop the use of this tool more widely. Over the last few years a working group has been established to create and then implement a new vision for children and young people's preparation for adulthood. The new vision is now in place, new provision opens in September 2016 and the new team is operational.

### Recommendation

- Establish a framework to collate and analyse service user and family feedback to better inform policy, practice and commissioning across health, education and social care services.
- Fully implement the personal budget policy in conjunction with health, where appropriate.



## 6. KEY SERVICES WITHIN THE LOCAL OFFER

### 6.1 Children and Disabilities (CAD) Support Team

#### 0-5 years old

The CAD 0-5 Early Support team have developed good links with the neonatal discharge team at Queens Hospital who refer to the service. Referrals are also received from the community paediatricians, therapy services and health visitors. Early years settings make referrals for Area SENCo input for children with SEN.

For children with a range of complex needs there is a single referral panel for six monthly multi-agency planning meetings to ensure a joint approach between education, health and social care. As multi-agency meetings are in place very few children 0-5 years of age have Education Health and Care plans (EHC). Requests for EHC assessments are usually made before a child is due to start a school placement.

Where families have been identified through an early help assessment requiring support for social needs, keyworkers jointly work with early help colleagues to offer support through home visits. Parent/carer's are offered groups at children's centres within the borough, jointly facilitated with colleagues from early help.

Referrals received from a range of agencies into the Children and Adults with Disabilities (CAD) Support team, 0-5 show an increase in the last 3 years, referrals received in 2015 have overall doubled for all areas of the service within the CAD support team, 0-5.

Significantly the number of children recorded as having a communication and interaction needs has tripled between 2014 and 2015. The majority of these children are supported by the Social Communication Team and the Area SENDCo.

#### 5-19 years old

The 5 -19 Support Team, CAD, offers support to children and young people with a range of difficulties, their schools, settings and families. The areas covered are Sensory (visual, hearing and multi- sensory difficulties), Medical and Physical, Speech, Language and Social Communication needs, complex needs, learning difficulties and Transitions KS 4 to KS 5. There are a range of disciplines within the Team covering Educational Psychologists, Social Workers, Family Support Workers, Specialist Advisory teachers, Specialist Assistants and a Mobility and Habilitation officer. All team members work flexibly and will visit children and families wherever they are; at home, out of borough, in school, nursery or clinic. Despite being a 5 – 19 Support team the Specialist teachers involved in sensory impairment work from point of diagnosis, often birth, onwards.

## Recommendation

Create a single database of children and young people with disabilities and /or complex health needs (0-25) across health, social care and education beginning with those with EHC plans CAD of new born babies and / or children newly resident in the borough likely to have SEND.

## 6.2 Health services for children and young people with SEND

The medical model determines the management or treatment of an individual based on a specific medical diagnosis. Due to the 'medical model' being used within health services, there is not a standardised system to record individual learning difficulties/disabilities. This poses a problem when trying to estimate both the size of this population and whether the current levels of resources are adequate. The alternative way of estimating the cohort is to look at the supply of support services within the health sector (Primary Care and Community Health Services).

### 6.2.1 Primary care

Analysis of primary care data provides us with some of our most comprehensive available health data for this population. General practices (GPs) are funded to provide enhanced care to people with learning disabilities aged 14 and over.

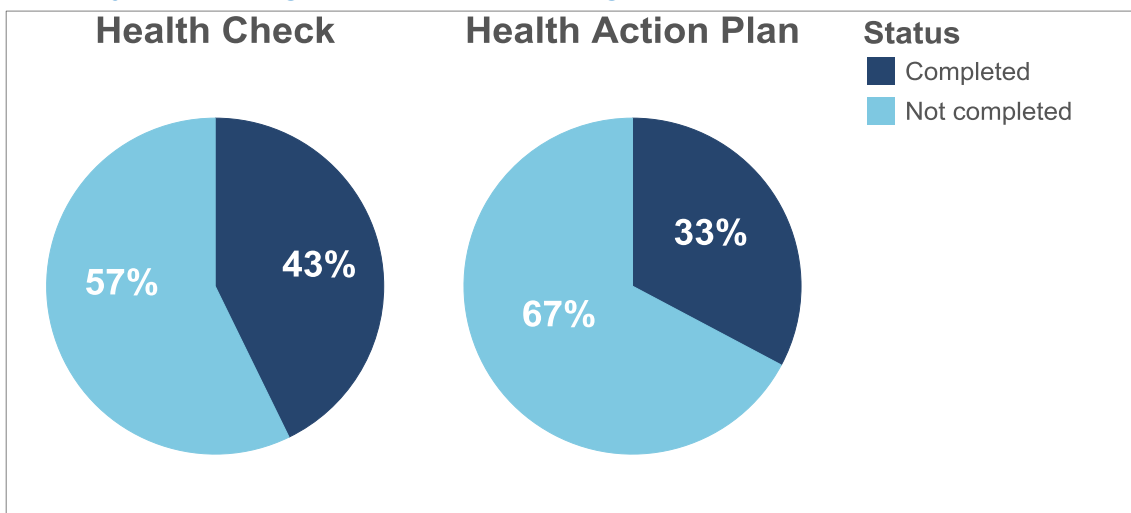
#### 6.2.1.1 Health Check and Health Action Plans

The enhanced care can comprise of completion of both an annual health check and/or a health action plan (see [Figure 28](#)).

As of June 2016, of those persons recorded with a learning disability:

- 57% of people had not had a health check completed
- 67% of people had not had a health action plan completed

**Figure 28: Completion of Health check and Health Action Plans amongst learning disability patients registered with a Havering GP**



Source: Health Analytics, June 2016

## Recommendation

Work with local GPs to improve uptake of health checks for (young) people with learning disabilities and the subsequent agreement of health action plans to address lifestyle issues and lower the risk of long term conditions

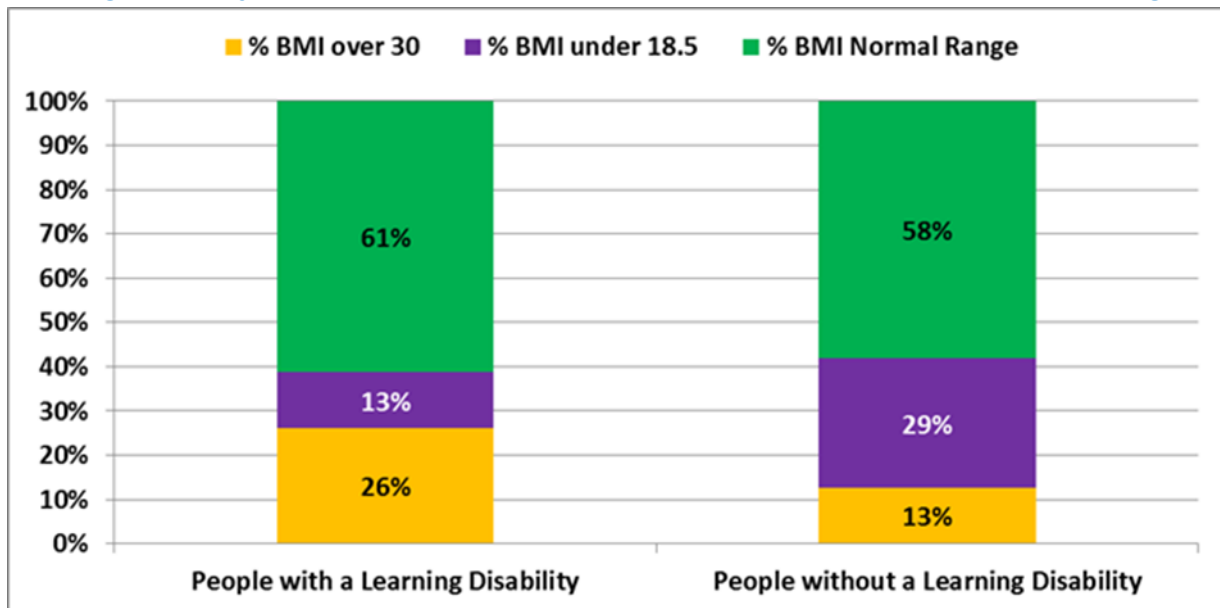
### 6.2.1.2 Long term conditions

People with a learning disability will experience greater health inequalities compared to people without a learning disability. They are at increased susceptibility to long-term health conditions (e.g. diabetes and obesity) which can contribute to health inequalities linked to vascular conditions, cancers and poorer mental health.

In Havering, people with a learning disability are:

- two and a half times more likely (8.7 per 1000 persons) to be recorded as having diabetes compared to those without a disability (3.4 per 1000 persons).<sup>19</sup>
- twice as likely (26% of people with a learning disability) to be recorded with a BMI over 30 compared to 13% of people without a learning disability. (see Figure 29)

**Figure 29: Stacked bar chart showing the proportion of pupils with and without a learning disability that had a BMI of over 30, under 18.5 and within the normal range.**



Source: Health Analytics, June 2016

- Engagement from practices is required to improve the completions of both health checks and health action plans for this population.
- Targeted support is required to support healthy weight management with this population.

<sup>19</sup> Health Analytics, June 2016

## 6.2.2 Community Health Services

North East London Foundation Trust (NELFT) currently provides therapy services to children aged 0-19 years registered with a Havering GP in a variety of settings including home, clinics, early years and education. NELFT are not currently commissioned to provide a 19-25 years' service though there are transition arrangements in place.

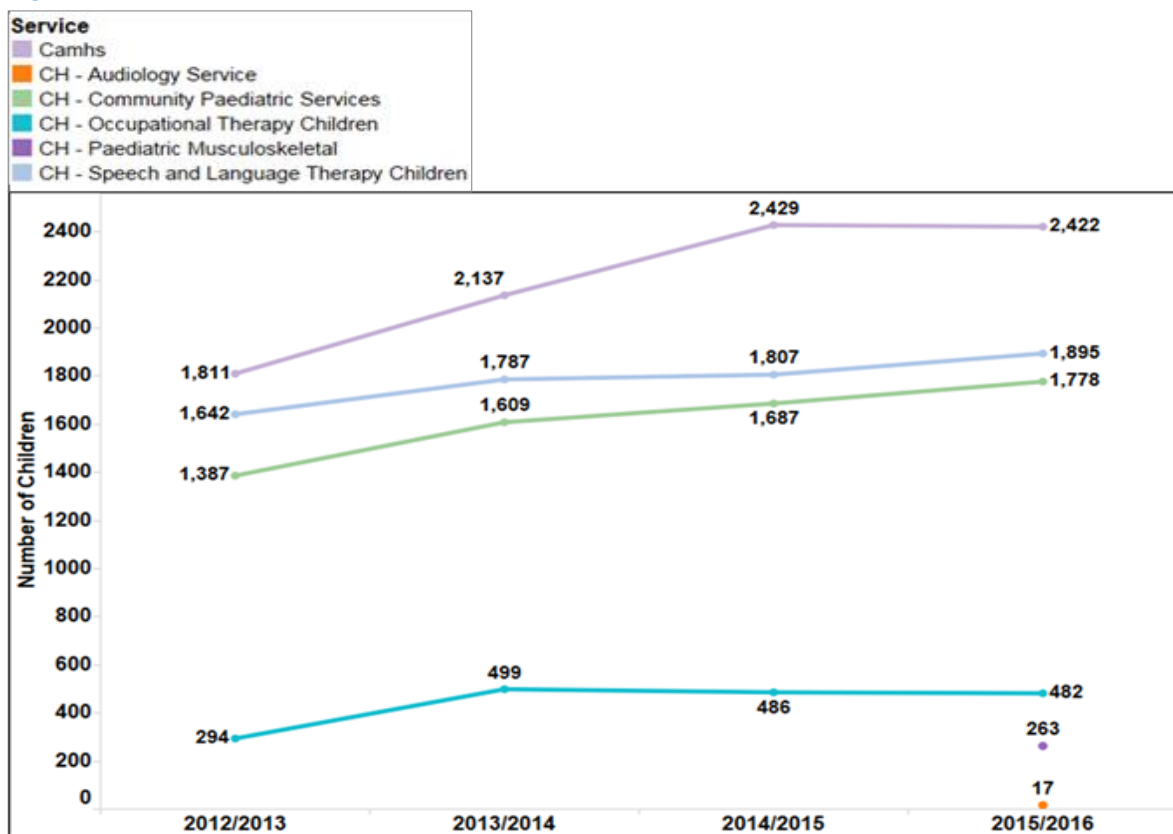
Therapies provided include:

- Community Paediatrics
- Physiotherapy divided into muscular–skeletal and neurology
- Speech and Language
- Occupational Therapy
- Child and Adolescent Mental Health Service (CAMHS)

### 6.2.2.1 Trend

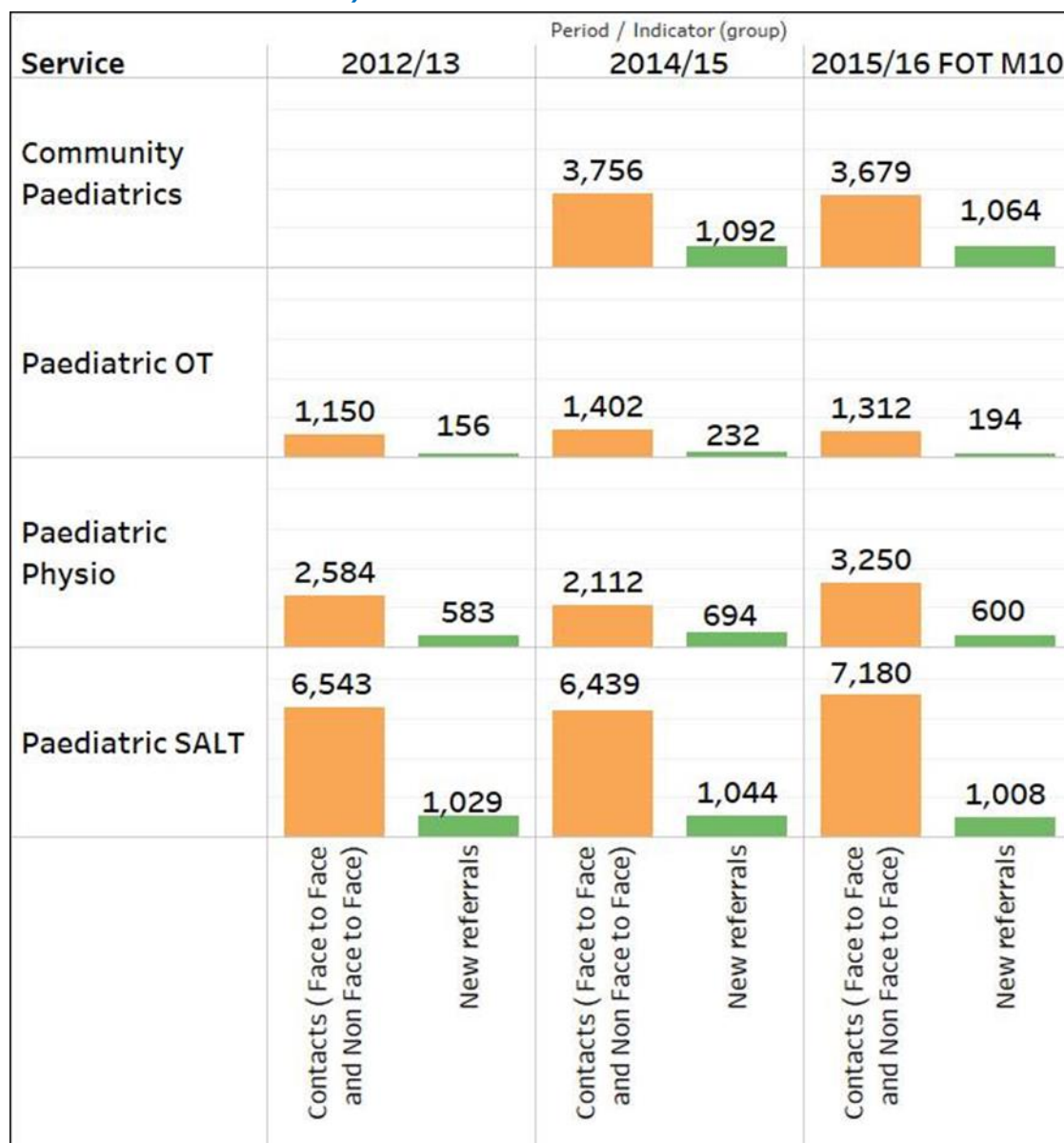
There has been an increase in service activity across all therapies in Havering over the past 3 years (see Figure 30 and Figure 1Figure 31 below).

**Figure 30: Number of children presented to each service from 2012/13 to 2015/16**



Source: North East London Foundation Trust, June 2016

**Figure 31: Community health services by service and year: Number of contacts (face to face and non- face to face) and new referrals**

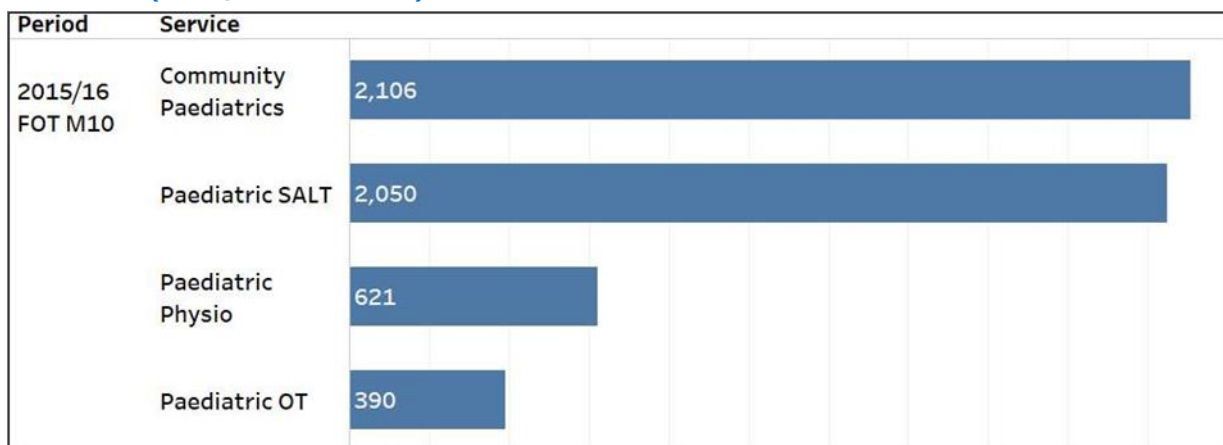


Source: North East London Foundation Trust, 2016

### 6.2.2.2 Average Caseload

Figure 32 shows average caseloads per month of service.

**Figure 32: Community health services by service and year: Average caseloads per month of service (2015/16 Month 10)**



Source: North East London Foundation Trust, 2016

### 6.2.2.3 Waiting Times and Did Not attend

Table 7 shows:

- Analysis of waiting times for access to community health services shows that Havering are mainly above national waiting time averages. Occupational Therapy nationally has high waiting times averaging at about 21 weeks, which are exceeded at present in Havering averaging 27 weeks due to increased referrals and 2.6 wte posts. Waiting time has reduced to 22 weeks at month 11. Similarly SALT Services average at one week above the national average. Referral to Treatment times for Consultant led services generally perform very well, meeting the 18 week target for those CYP registered with GP. For all CYP using the service the waits to 1st appointment are slightly better than the national average. (Nat. av 10.6 weeks).
- Analysis of data for Did Not Attend (DNA) at first appointment shows variation by service line. The national benchmark for DNA is 12.1% as used by Choose and Book. Using this measure Havering is an outlier for paediatric occupational therapy – significant given that Havering has a 27 week wait for first appointments for this service.

**Table 7: Referrals and appointment waiting times, 2015/16**

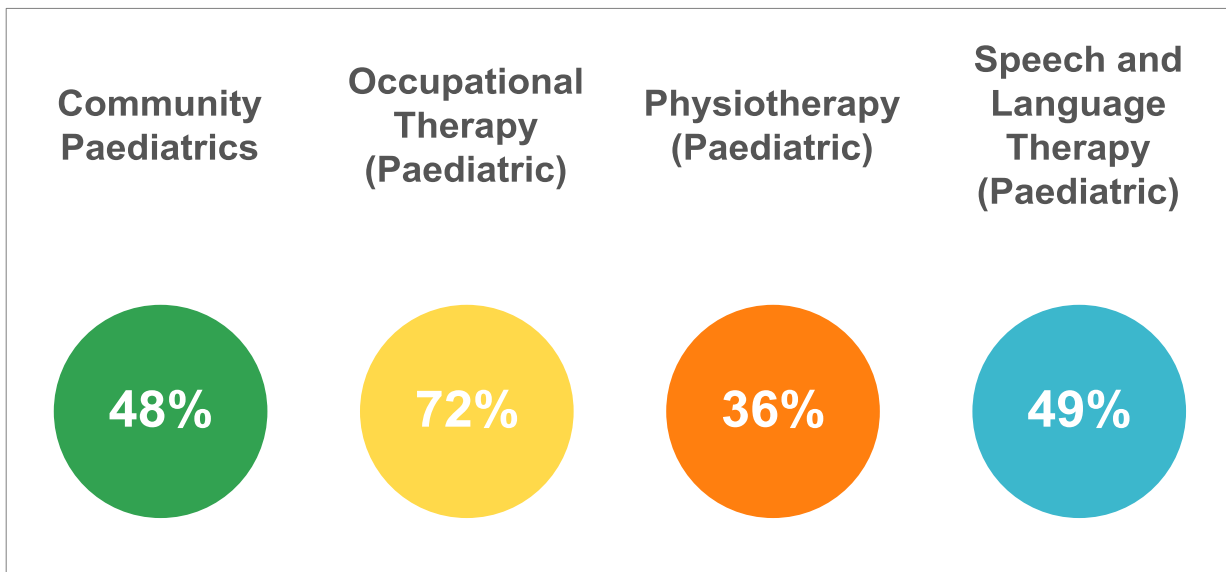
	Waiting to 1st Appt – weeks (Av. Q2-3 15/16)	DNA 1st Appt (Av. Q2-3 15/16)
<b>Paediatric OT</b>	27	19%
<b>Paediatric Physio</b>	9	15%
<b>Paediatric SALT</b>	14	12%
<b>Community Paediatrics</b>	below 18 weeks	13.5%
<b>All CYP</b>	8 weeks	

Source: North East London Foundation Trust

6.2.2.4 Source of Referrals

Figure 33 shows source of internal referrals as % of service.

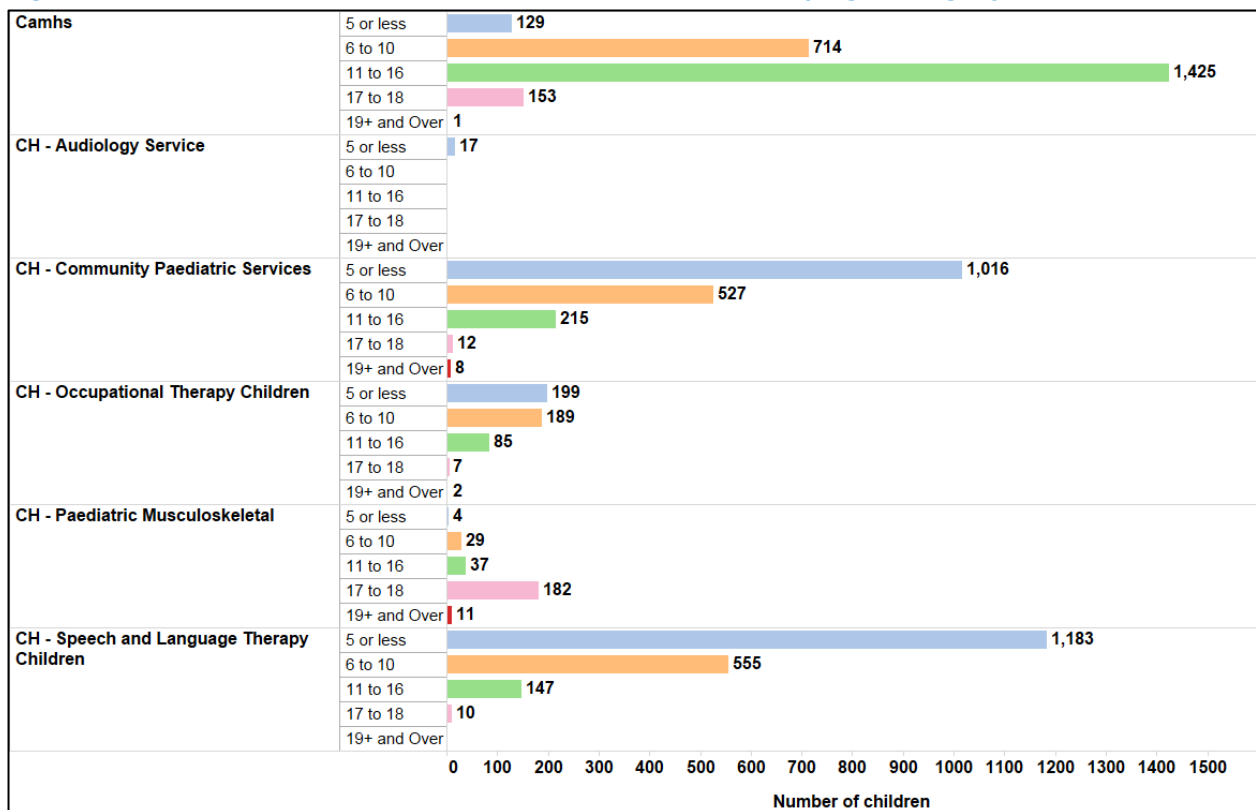
**Figure 33: Source of referrals that are internal as percentage of service**



Source: North East London Foundation Trust, June 2016

Internal Referrals Figure 34 demonstrates the high level of internal referrals, particularly with 72% of referrals into Occupational Therapy coming through internal referrals.

**Figure 34: Number of children presented to each service by age category in 2015/16**



Source: North East London Foundation Trust, June 2016

Note that high caseloads may mean children and young people are on the system, but may have not been closed. We also know that children and young people stay open on caseloads for longer periods.

### 6.2.2.5 Looked After Children

Looked After Children (LAC) are at increased risk of SEND and there is a specific LAC target of Referral to Treatment within 4 weeks for all community health services. Table 8 displays the variation in attainment by service line. There are increasing numbers of CYP with complex needs. OT and Physio vary considerably in performance, this will be due to pressures on the OT and Physio services in the community.

**Table 8: Looked After Children requiring services 2015/16 (Referral to Treatment in 4 weeks), average across Barking, Havering and Redbridge (Havering data not available)**

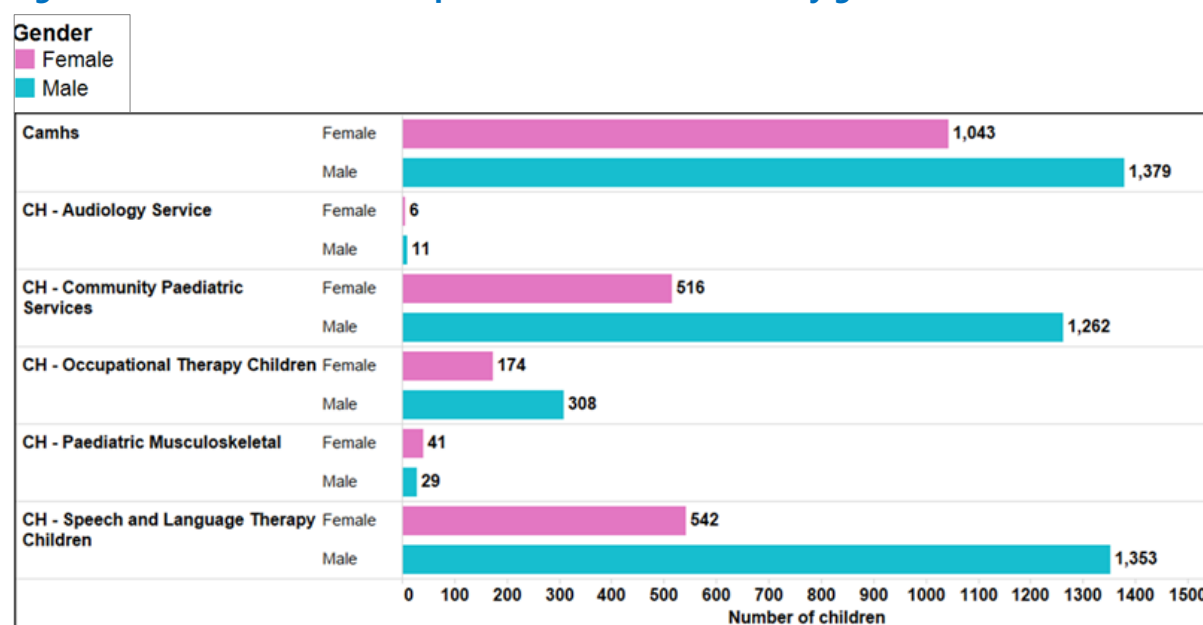
LAC requiring services (RTT withing 4 weeks)	Av. 2015/16 M11
<b>Paediatric OT</b>	14%
<b>Paediatric Physio</b>	14%
<b>Paediatric SALT</b>	18%
<b>Community Paediatrics</b>	80%

Source: North East London Foundation Trust, 2016

### 6.2.2.6 Gender

Regarding gender all but one service (paediatric musculoskeletal) had a noticeably higher proportion of male children presented compared to female. The CAMHS service which accounted for the highest majority of presented children consisted of 57% males and 43% females (see Figure 35).

**Figure 35: Number of children presented to each service by gender in 2015/16**



Source: North East London Foundation Trust, June 2016



## 6.2.2.7 Service Breakdown

### 6.2.2.7.1 Community Paediatrics

Paediatric NHS services have a higher level of internal referral, as clinicians hold on to cases for longer periods than with adult NHS services and may refer to allied health professionals.

This fits with Children and Young People using these services having Life long limiting illnesses and long term conditions and which are usually complicated and with co or multiple morbidities or other health needs ie physical and mental.

NELFT also operate a Single Point of Access (SPA), so children are referred in once and can then be referred to multiple services.

### 6.2.2.7.2 Physiotherapy

Physiotherapy saw an average increase in contacts of 15% and around a 10% increase in new referrals from 2012 to 2016.

### 6.2.2.7.3 Speech and Language Therapy

Speech and Language Therapy (SALT) saw an average increase in contacts of 6.4% and referrals have remained fairly steady at just over 1,000 per annum from 2012 to 2016. Community Paediatrics saw an average increase in contacts of 34% and referrals have remained steady at just over 1,000 per annum from 2013 to 2016.

### 6.2.2.7.4 Child and Adolescent Mental Health Services (CAMHS)

A total of 2423 children (36.4%) were presented to the CAMHS service which accounted for the highest number of children compared to all the services in 2015/16. Almost 59% of children referred to CAMHS were aged 11 to 16 but only 1 child was over 19. In contrast there were only 17 (0.3%) children presented to Audiology services.

The total number of children presented to CAMHS increased by 34% (611) from 2012/13 to 2015/16; whilst the number of children presented to occupational therapy services increased by 188 which accounted for the highest percentage increase of almost two thirds (64%) from 2012/13 to 2015/16. In general the total number of children presented increased for all services.

The government strategy for mental health<sup>20</sup> recognises that mental health problems contribute to perpetuating cycles of inequality through generations. Early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours

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<sup>20</sup> HM Government. (2011). [\*No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages\*](#)

such as smoking (over 40% of children who smoke have conduct and emotional disorders<sup>21</sup>) and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorders.

Stigma and experiences of discrimination continue to affect significant numbers of people with mental health problems. For all groups of people with mental health disorders, including children, this can:

- stop people from seeking help;
- keep people isolated, and therefore unable to engage in ordinary life, including activities that would improve their wellbeing;
- mean that support services have low expectations of people with mental health problems, for example their ability to do well at school; and
- stop people being educated, realising their potential and taking part in society

Risk factors for mental illness in childhood can be grouped as child, parental and household factors. Regarding parental factors, alcohol, tobacco and drug use during pregnancy increase the likelihood of a wide range of poor outcomes that include long-term neurological and cognitive–emotional development problems. Maternal stress during pregnancy is associated with increased risk of child behavioural problems, low birth weight is associated with impaired cognitive and language development, poor parental mental health with four- to five-fold increased risk of emotional/conduct disorder and parental unemployment with two- to three-fold increased risk of emotional/conduct disorder in childhood. Child abuse and adverse childhood experiences result in increased risk of mental illness and substance misuse/dependence later in life. Looked-after children, those with intellectual disability and young offenders are at particularly high risk<sup>22</sup>. In addition, teenage parents, young carers, children living in households affected by domestic violence those with a physical disability and those not in education, training or employment tend to have higher rates of mental ill-health than their peers.

**Conduct disorders** are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. They are associated with increased risk of personality disorder, with 40–70% of children with conduct disorder developing antisocial personality disorder as adults<sup>23</sup>. Overall, children who had conduct disorder or sub-threshold conduct problems in childhood and adolescence and whose problems are not treated contribute disproportionately to all criminal activity. Nearly half of children with early-onset conduct problems experience

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<sup>21</sup> Green, H., et al. (2005). *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Palgrave Macmillan

<sup>22</sup> Royal College of Psychiatrists. (2010). [\*No health without public mental health: the case for action\*](#). Position Statement PS4/2010

<sup>23</sup> National Institute for Health and Clinical Excellence (2009) [\*Antisocial Personality Disorder, Treatment, Management and Prevention\*](#)

persistent, serious, life-course problems including also crime, violence, drug misuse and unemployment<sup>24</sup>.

### **Pre-school children**

There is relatively little data about prevalence rates for mental health disorders in pre-school age children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger et al, 2006)<sup>25</sup>. According to the Child and Maternal Health Intelligence Network, in 2013, there are 2,230 children aged 2 to 5 years inclusive living in Havering who have a mental health disorder<sup>26</sup>.

### **School-age children**

Due to data limitations there is little data available on the types of mental health services and outcomes for children and young people in Havering.

## **6.2.3 Identification of SEN by health referring to Havering Council**

The initial identification of a potential disability or special educational need can happen in a number of different places but primarily the main areas are: within the home where a parent or carer identifies a difficulty; within health where a health professional identifies concerns; or within an educational establishment where a teacher may express concern with learning. Within SEND learner support, the majority of referrals for very young children come from health professions including health visitors, therapists, paediatricians, other consultants and specialists within the field of Hearing Impairment/Visual Impairment e.g. audiology professionals, although very few referrals are actually via GPs.

The health visiting team undertake an assessment of a child's growth and development at every contact either in a community setting or in the family home. Early identification of a delay in a child's growth and development is essential to ensure that relevant services are accessed in a timely way, a referral is made to the appropriate service with parental consent and families are supported through this process.

Children and Adults with Disabilities (CAD) Support Team, 0-5 hold a multi-agency planning meeting each month where children with complex medical needs are discussed with Early help service and health professionals that include community paediatrician, therapy services and health visitor lead, who contribute and feedback actions to the named health professional for that child.

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<sup>24</sup> Fergusson DM, Horwood LJ, Ridder EM (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology*, 46, 837–849

<sup>25</sup> Egger, H. L. and Angold, A. (2006) Common emotional and behavioural disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47 (3-4), 313–37

<sup>26</sup> [Child and maternal health intelligence network](#). Accessed 1<sup>st</sup> November 2013

The neonatal team at Queens Hospital send a discharge summary to the Acorn Centre of premature births and babies with health care needs. Paediatricians receiving the discharge summary take the information to the multi-agency planning meeting for appropriate services to be involved.

Paediatricians, the therapy service and wider CAD team that include advisory teachers for hearing and visual impairment take information of children with complex needs on their caseload to the multi-agency planning meeting for appropriate services to be involved. Health Visitors make referrals to the CAD support team in consultation with parent/carer's if there are concerns in any areas of the child's development.

#### 6.2.4 Palliative Care Services

Haven House whilst being commissioned as a hospice provides well over 90% of its support and care to children living life long limiting conditions. The budget is indicative for each year and as stated, there is over-performance year on year. End of life care tends to be short term and very small numbers, however as this is intensive and high cost support, one child can seriously affect performance and budgets within year.

The CCGs across BHR will be reviewing all the hospice support in 2016, with a view around developing hospice at home and other forms of care in partnership with providers.

#### Recommendation

Ensure key services e.g. community health services are commissioned for outcomes and reports on these outcomes are shared via the refreshed governance structure.

### 6.3 Schools and engagement in education

Havering seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are eight schools that have Additional Resourced Provisions (ARPs) or targeted additional funding to meet particular needs. For children with more complex needs, Havering has three special schools.

This change in populations in special schools is also reflected in Havering's mainstream schools where the pupil population is becoming more complex; pupils who would have previously been placed in special school are now remaining in mainstream school, this also reflects the drive of the new SEND Code of Practice, January, 2015, which encourages Mainstream Inclusion to be considered first in most instances.

This increase in complexity has led to a demand for additionally resourced provisions to provide specialist teaching for our more complex pupils with ASD and also those with challenging behaviour. Havering is now funding additional ARPs. Their role will not only be to allow pupils to stay in-borough and have a mainstream education but the specialist staff will also be able to support colleagues in other mainstream schools to grow expertise and confidence in their approach to pupils with additional, complex needs.

The Person Centred Approach is used to ensure schools are fully prepared for these children and a dedicated team of key workers from 0-5 and 5-19 CAD teams are allocated to the highest need children to further liaise and work with settings and schools in the Summer Term prior to transition into Reception and Year 7 in September.

### 6.3.1 Children aged 0-5 years old

#### **CAD Support Team**

The CAD Support team works in collaboration with agencies across education, health, social care, voluntary sector and with early years settings, schools and parent/carers to provide appropriate support packages and early intervention. The team provides coordinated access to specialist support, teaching, assessment and family support for children with special educational needs and disabilities (SEND) and their families. The team also works with children who require specialist early intervention and an integrated offer to support their learning within Early Years Settings and Schools. Staff within the team include: Area Special Educational Needs and Disabilities Coordinators, keyworkers, specialist teachers, educational psychologist and social worker.

#### **The CAD Support Team offers;**

- Home-based support
- Setting-based support
- Sleep service
- Groups

##### *6.3.1.1 Home-based Support*

#### **The home based support teams work with parents to:**

- Carry out an in-depth, ongoing assessment of their child's needs where targets will be set jointly to measure the child's progress.
- Help them understand their child's individual needs by jointly planning and modelling appropriate learning opportunities to promote their child's development.
- Provide information, advice and guidance on the best approach to support their child.

***Home Learning Support:*** A home teaching service to support young children twelve months to three years of age who have additional needs and their families, it is based on the principle that, parent/carers are key people in the care and development of their child. The aim is to support and enable parent/carers in this role, by building on their child's existing and emerging skills, through early play activities.

***Social Communication Support:*** Keyworkers work in partnership with parent/carers to support children where concerns are raised about social communication needs.

***Early Support:*** The specialist SEND early support team provides support to families whose children have complex needs and require significant multi-agency support from birth to five. Early support keyworkers are from a range of agencies. Families are offered coordination of services, keyworker support and multi-agency meetings.

### 6.3.1.2 *Setting-based Support*

**Area SEND Coordinators:** Advise and support early years educational providers to become fully inclusive and plan for children with additional needs in order to improve the outcomes for all children with SEND.

**Specialist Teacher:** Support teaching staff within maintained nursery and school with strategies and interventions to support children with social communication difficulties or a diagnosis of Autism to access all areas of the Early Years Foundation Stage curriculum.

### 6.3.1.3 *Sleep Service*

A weekly sleep advice drop-in session and sleep helpline support is available. For children with significant sleep issues, a full sleep assessment and an individual sleep programme is devised and support offered to implement the sleep programme.

### 6.3.1.4 *Groups*

A range of groups are offered to parent/carer's, these are structured to support parent/carer's to understand their child's needs and how to support them to achieve best outcomes. The range of activities offered include; weekly swimming group, regular block sessions of baby massage, developmental group, baby signing, messy play and stay and play sessions.

## Referrals

The CAD 0-5 Early Support team have developed good links with the neonatal discharge team at Queens Hospital who refer to the service. Referrals are also received from the community paediatricians, therapy services and health visitors. Early years settings make referrals for Area SENCo input for children with SEN.

The Barking, Havering, Redbridge United Trust have a KPI is to provide newborn hearing screening to 95% of babies before 3 weeks, and they can offer the Newborn Hearing Screen up to 3months. They commonly achieve screening rates of 98-99% of all babies born. In 2015/16, 3.7% (122) of babies screening for hearing were referred for further investigation. We do not specifics on how many of these 122 required subsequent treatment.

For children with a range of complex needs there is a single referral panel for six monthly multi-agency planning meetings to ensure a joint approach between education, health and social care. As these successful, early intervention, multi-agency meetings are in place very few children 0-5 years of age have Education Health and Care plans (EHC). Requests for EHC assessments are usually made before a child is due to start a school placement.

Where families have been identified through an early help assessment requiring support for social needs, keyworkers jointly work with early help colleagues to offer support through home visits. Parent/carer's are offered groups at children's centres within the borough, jointly facilitated with colleagues from early help and CAD (0-5).

## 0-5 years CAD Service

Referrals received from a range of agencies into the Children and Adults with Disabilities (CAD) Support team, 0-5 show an increase in the last 3 years, referrals received in 2015 have overall doubled for all areas of the service within the CAD support team, 0-5.

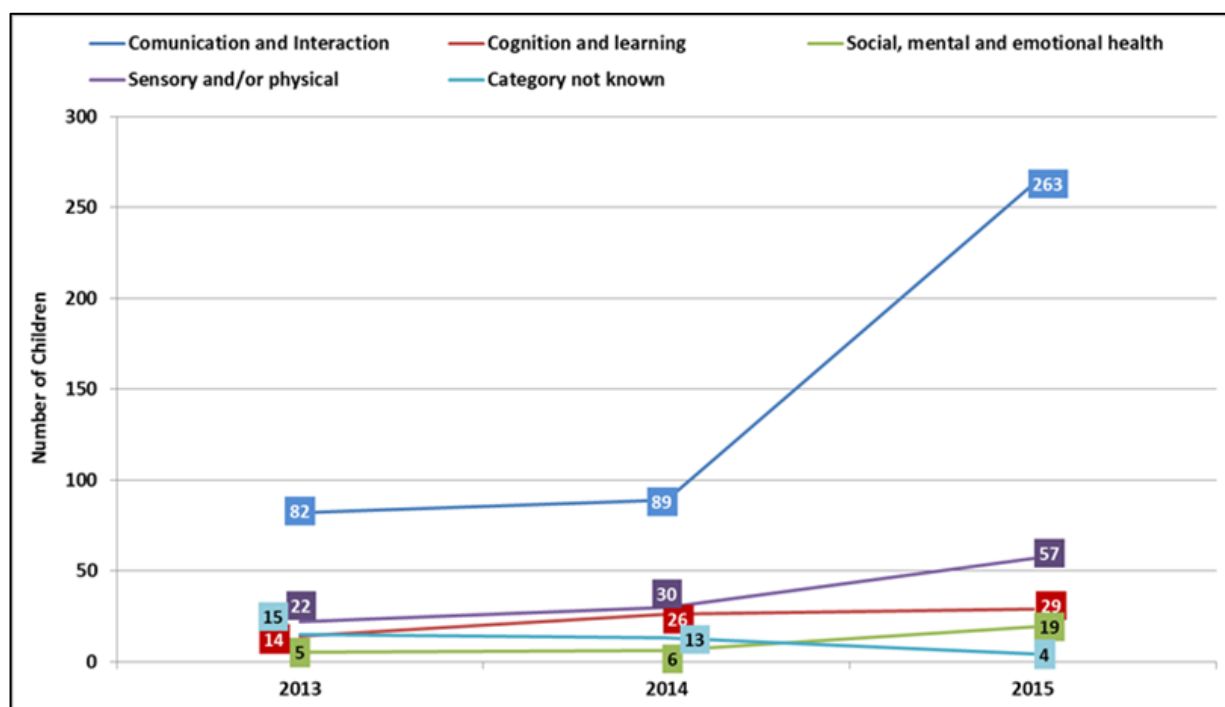
Referrals for the Early Support and Home learning teams have continued to increase each year showing twice as many requests for support in 2015. The category of SEN "Communication and Interaction" referrals for both team shows a significant increase in this area, where in 2013 and 2014 the highest category of need has been Sensory and/or Physical, although this has continued to steadily increase, figures show that in 2015 more children were referred for difficulties in the area of Communication and Interaction.

Referrals for the social communication team have almost trebled in 2015 compared to the previous year and four times as many from 2013, as expected the majority of the referrals are for children with social communication difficulties within the SEN category of Communication and Interaction.

As with the increase of referrals for the other teams, the referrals for the Area Special Educational Needs and Disability Coordinators (Area SENDCo) have doubled in 2015 compared to the previous year, although there is an increase in the all the categories of SEN, the most significant number of referrals have been received from early years settings has been for children within the SEN category of Communication and Interaction.

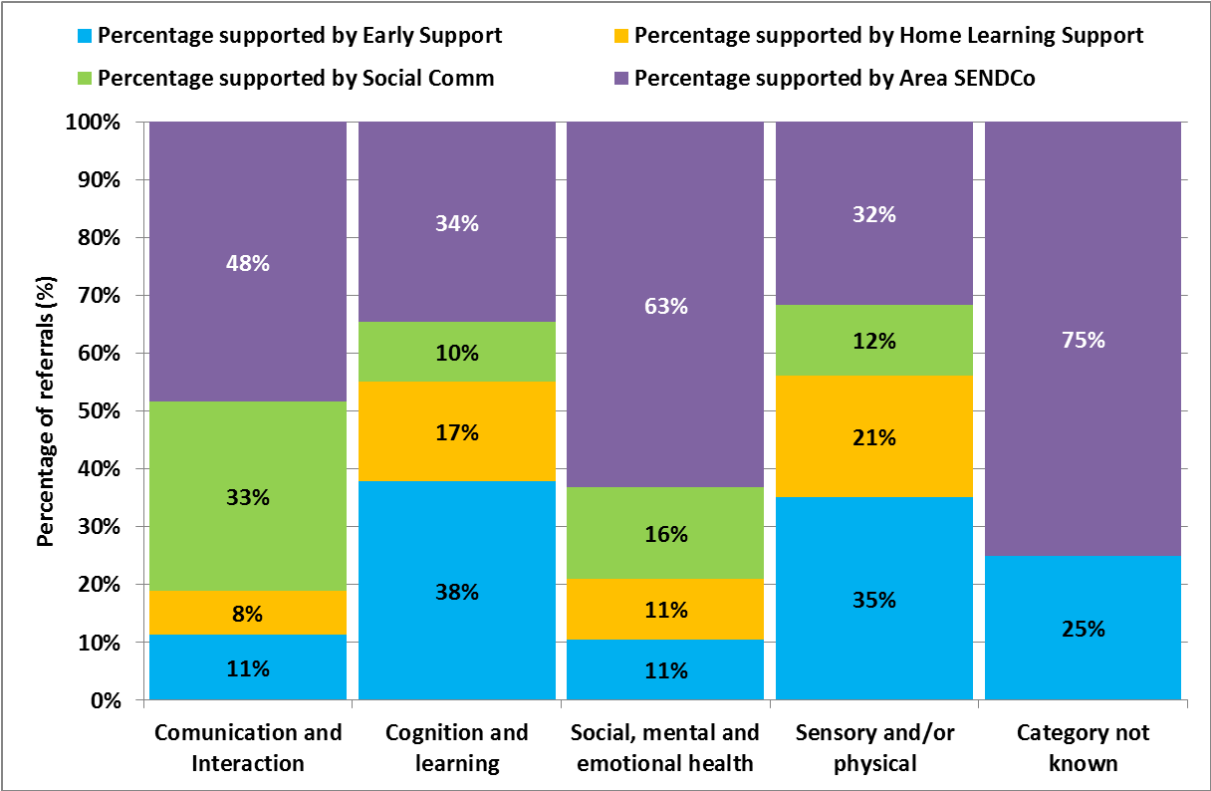
Figure 36 below shows the increase in referrals to support services across all the support categories. Significantly the number of children recorded as having a communication and interaction needs has tripled between 2014 and 2015. The majority of these children are supported by the Social Communication Team and the Area SENDCo (see Figure 37), this has declined in the past three years (see Figure 38).

**Figure 36: Time trend showing number of children within each category of need from 2013 to 2015**



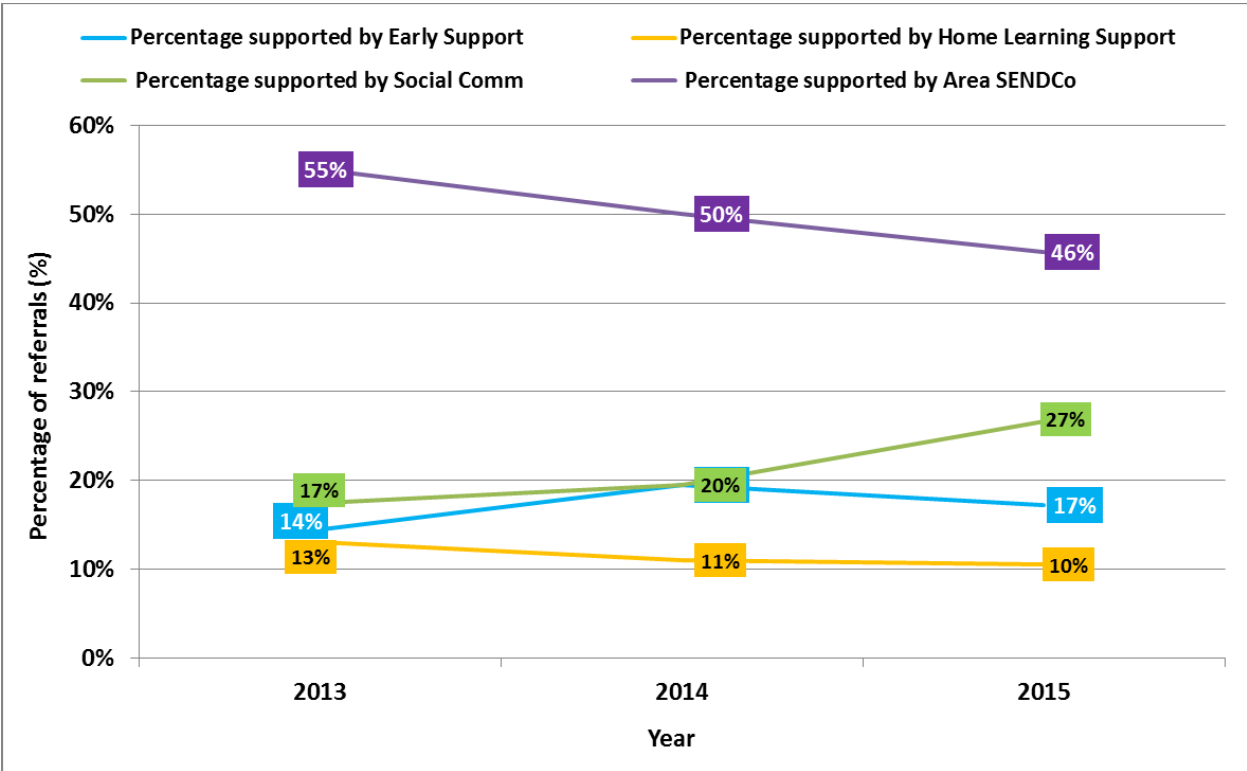
Source: LBH CAD Team ages 0-5

**Figure 37: Stacked bar chart showing percentage of children aged 0-5 by category of need and type of support service in 2015.**



Source: LBH CAD Team ages 0-5

**Figure 38: Time trend showing percentage of children supported by type of support service, 2013 to 2015**



Source: LBH CAD Team ages 0-5



## Transitioning from Early Years Settings to Primary School

The CAD team support children transitioning from Early Years settings into Primary School. Guidance is sent to both early years' settings and schools in planning and preparing children for transition. A person centred planning meeting takes place for all children who have been identified in their setting as on SEN support transferring to school, early years setting staff, parent/carers, relevant agencies working with the child and family and the staff from the school attend the meeting. An action plan is put into place for the school in preparation for the child's transition. School staff are encouraged to observe the child in the early years setting.

A transition team supports both the child identified with a high level of need and the teaching staff in the school during the transition period, this support is continued as required to ensure a successful transition. School staff are offered a training programme before transition. Not all children referred to the Area SENCo team continue to be on SEN support, some children make progress through early intervention and do not require a differentiated approach and are therefore no longer on SEN support.

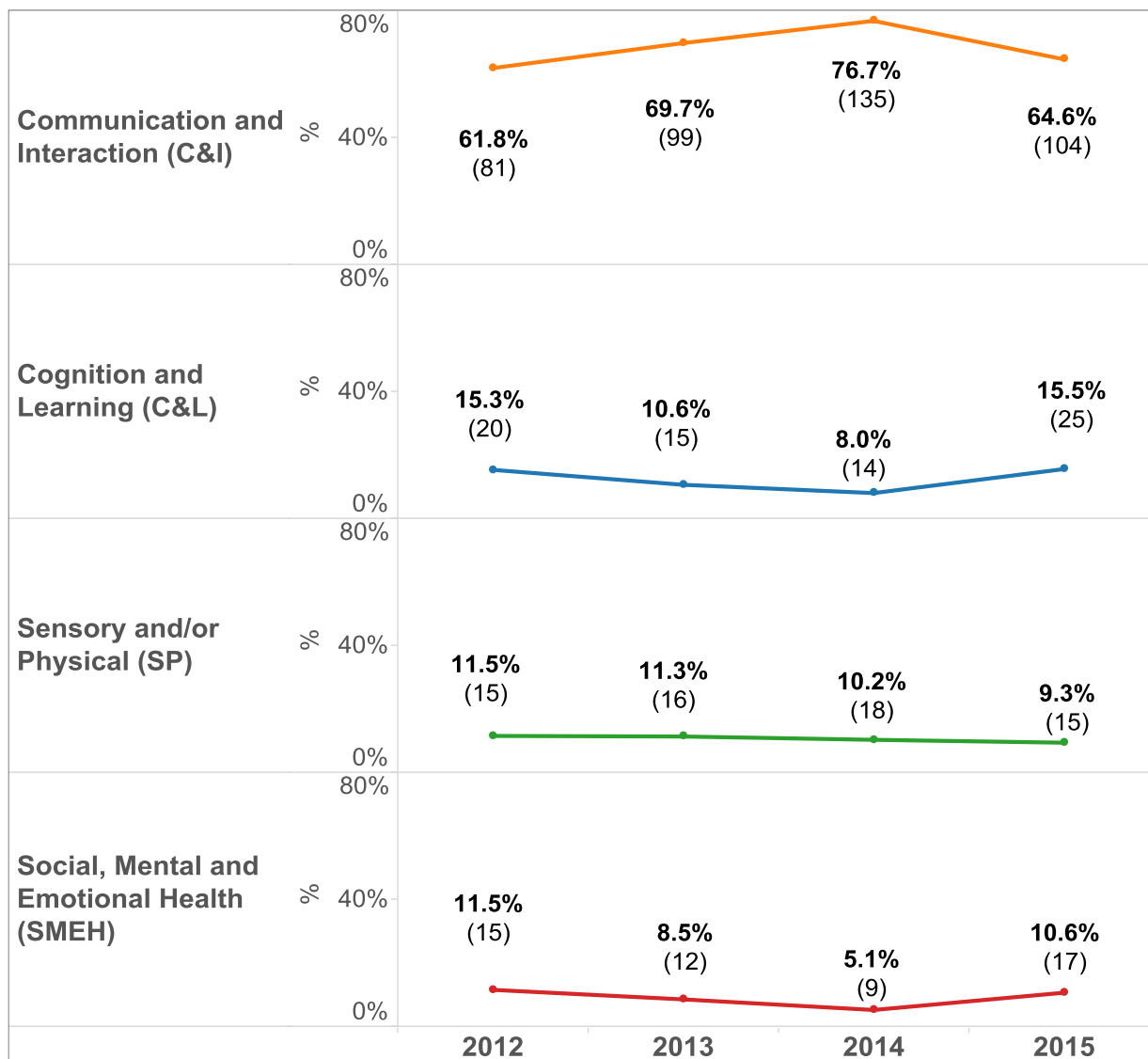
Early Support in CAD 0-5's has continued over the years to provide continuity to families through transitions and changes, supporting the families to build strength and resilience and, where possible, to help families to reach a point where they need less intensive key working support. As children have moved onto school some parents have become their own key worker and have been supported with this transition. Early identification of children with high needs is done through the Early Years Transition list which allows children to be tracked from pre-nursery into school.

The Person Centred Approach is used to ensure schools are fully prepared for these children and a dedicated team of key workers from 0-5 and 5-19 team (CAD) is allocated to the highest need children to further liaise and work with settings and schools in the Summer Term prior to transition into Reception in September.

Figure 39 shows the numbers of children transferring to school from Private, voluntary and Independent (PVI) early years settings. The data shows that the numbers of children transferring to school within the SEN category of Communication and Interaction remains consistently higher than children transferring within other SEN categories. The category of Communication and Interaction includes children with social communication difficulties and speech and language needs. In September 2015 there has been a small increase of children starting school within the SEN categories of cognition and learning and social, mental and emotional health. Within the last four years there is only small variation of the number of children starting school with a hearing impairment, visual impairment or physical disability covered by the SEN category of sensory and/or physical.

**Figure 39: Total children with recorded SEND transferred into primary school from Private and Voluntary Institutions (PVI) Early Years Settings only**

Type of SEND	Sep-12	Sep-13	Sep-14	Sep-15
<b>Total Children</b>	<b>131</b>	<b>142</b>	<b>176</b>	<b>161</b>



Source: LBH CAD Team ages 0-5, School census January 2016

There are sixteen school based nurseries, some of the nurseries offer places to two year olds. Figures are not available for the number of children attending with SEND.

There is a distinct spike in children identified as having Communication and Interaction (CI) difficulties on transfer to Primary school in 2014, there is also a drop in identification of children with Social, Emotional and mental Health (SEMh) difficulties. In September 2014 the new SEND Code of Practice began. The new Code of Practice used different categories to describe the special educational needs of children and children who would previously been seen as having social communication difficulties fell between the two categories of SEMh and

CI, it would appear that many practitioners chose to categorise children as having CI rather than SEMH difficulties, as it provides connotations with the SEMH category, discussion and familiarity led to colleagues being more comfortable with the usage of the term in the year after. Before the new Code of Practice the categories were Cognition and learning, behavioural, emotional and social needs, Communication and Interaction needs and Sensory and Physical Needs.

2014 was also the year when pupils with Social Communication Difficulties and ASD were first included in the SLCN caseload meetings in Primary schools, this may have highlighted pupils who previously would not have been categorised in the same way.

### 6.3.2 Children aged 5-19 years old

The 5 -19 Support Team , CAD, offers support to children and young people with a range of difficulties, their schools, settings and families The areas covered are Sensory (visual, hearing and multi- sensory difficulties), Medical and Physical, Speech, Language and Social Communication needs, complex needs, learning difficulties and Transitions KS 4 to KS 5. There are a range of disciplines within the Team covering Educational Psychologists, Social Workers, Family Support Workers, Specialist Advisory teachers, Specialist Assistants and a Mobility and Rehabilitation officer. All team members work flexibly and will visit children and families wherever they are; at home, out of borough, in school, nursery or clinic. Despite being a 5 – 19 Support team the Specialist teachers involved in sensory impairment work from point of diagnosis, often birth, onwards.

### 6.3.3 Schools

Havering seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are eight schools (see Table 9) who have Additional Resourced Provisions (ARPs) (2015) or targeted additional funding to meet particular needs, described below.

**Table 9: List of schools in Havering who have Additional Resourced Provisions (ARPs), 2015**

Special educational need specialism	Havering school
Hearing impairment	Hacton Primary School
Language difficulties	Mead Primary School
Social, emotional and mental health	Hilldene Primary School
Autism spectrum disorder	RJ Mitchell Primary School
Visual impairment	Previously Crownfield Junior School (VI friendly school)
Hearing impairment	Sanders Draper School
Autism spectrum disorder	Hall Mead Academy
Language difficulties	Redden Court Academy

The funding for the 'VI friendly' school is no longer based in one school but has been allocated to the post of 'Habilitation Officer'. Pupils with VI are based in their local schools and receive support from the Advisory Teacher for VI and the 'Habilitation Officer' as needed. Training for individual schools is given and borough-wide training is also offered regularly. Capital money has increased and improved the provision at 2 of the above ARPs and has been used to

develop a new Primary ARP, (Clockhouse Primary – online December 2016) and expand two secondary ARPS.

For children with more complex needs, Havering has three special schools (see [Table 10](#))

**Table 10: List of Special schools in Havering, 2015**

Special educational need specialism	Havering School	Number of 0-16 funded places
<b>Severe learning difficulties</b>	Ravensbourne	71
<b>Moderate learning difficulties</b>	Corbets Tey	110
<b>Moderate learning difficulties</b>	Dycorts	88

Although Corbets Tey and Dycorts are designated as MLD schools the intakes for both schools have changed year on year. Both schools are now reflecting 50% or more pupils with ASD, (complex or challenging behaviour), and run curriculae reflecting this change.

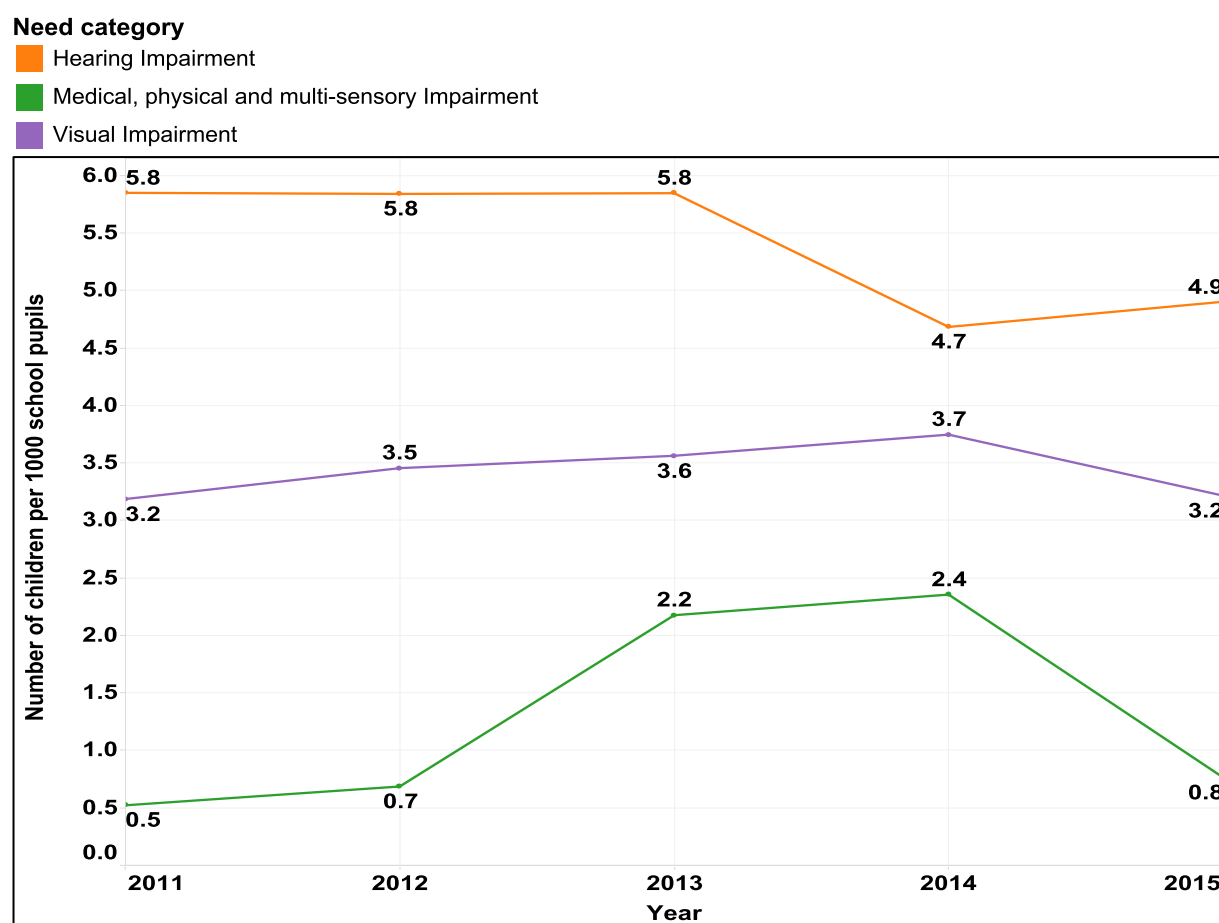
This change in populations in special schools is also reflected in Havering’s mainstream schools where the pupil population is becoming more complex; pupils who would have previously been placed in special school are now remaining in mainstream school, this also reflects the thrust of the new SEND Code of Practice, January, 2015, which encourages Mainstream Inclusion to be considered first in most instances. This increase in complexity has led to a demand for additionally resourced provisions to provide specialist teaching for our more complex pupils with ASD and also those with challenging behaviour. Havering is now funding additional ARPS. Their role will not only be to allow pupils to stay in-borough and have a mainstream education with their peers, and within their community, but the specialist staff will also be able to support colleagues in other mainstream schools to grow expertise and confidence in their approach to pupils with additional, complex needs.

This increasing complexity is challenging for colleagues in mainstream schools and they are calling on support services more regularly for advice. In order to prevent support services becoming purely “reactive”, training courses for Speech and Language skills, behavioural analysis of ASD, awareness raising for ADHD, ASD, Social Communication and a range of other areas are offered. Also, the early identification of children with high needs is done through the Early Years Transition list which allows children to be tracked from pre-nursery into school. The Person Centred Approach is used to ensure schools are fully prepared for these children and a dedicated team of key workers from 0-5 and 5-19 team (CAD) is allocated to the highest need children to further liaise and work with settings and schools in the Summer Term prior to transition into Reception and Year 7 in September.

Ravensbourne has an additional 23 places for post-16 students and at the other end of the age spectrum, accepts pupils from age two upwards. In addition, the R.J.Mitchell Nursery, previously known as the Bridge Nursery offers up to sixteen places (mornings or afternoons) for children in the year prior to Reception who have social communication difficulties. and /or a diagnosis of ASD. These would be the cohort of children identified as needing highly specialist support. Many of these pupils go on to the R.J. Mitchell additionally resourced provision or Special school, some will transfer into their local mainstream Primary school.

As can be seen by the data above and the time series below (see Figure 40) caseload numbers have not fluctuated hugely for any of the categories of caseload; visual impairment has remained steady, hearing impairment showed a marked drop in 2014 when the caseload was thoroughly overhauled and thresholds raised as numbers on the caseload had become unmanageable, training and awareness raising allowed for this drop in caseload to take place as schools and settings were more confident in their abilities to meet needs, physical and medical caseload shows a distinct rise in 2013 /2014, this is because children who didn't reach threshold were included on the caseload but didn't receive any input or intervention from the advisory teacher or specialist assistant.

**Figure 40: Time series showing the rate of pupils aged 5-19 by category of need from 2011 to 2015**



Source: LBH CAD caseloads for ages 5-19

### 6.3.3.1 Analysis of school-age Havering pupils with SEND

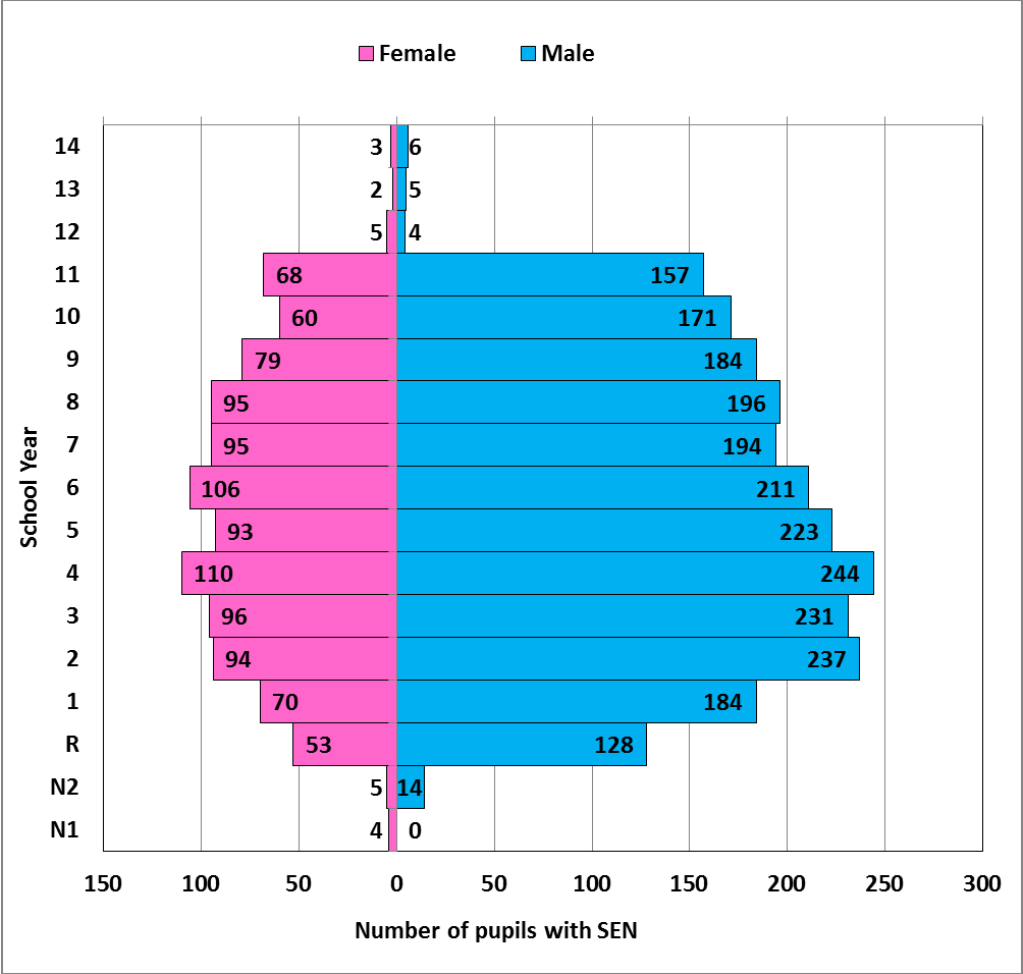
There are two different groups of children considered in this analysis.

- 1) **Children who are resident in Havering and for whom LB Havering is responsible for the provision of resources to meet the child's statement of special educational needs:** the responsible authority is dependent on the child's borough of residence, which may be different to where they attend school.
- 2) **Children whom attend Havering schools** (these children may reside in any borough)

The best source of evidence on the current prevalence of SEND amongst children in Havering is local data on special educational need derived from the School Census<sup>27</sup> and demand for children’s therapy services. GP records of children’s learning disabilities indicate substantial under-recording by GPs.

The School Census data below is for all pupils attending a Havering school whether they are a Havering resident or from another area. There is a wide difference in male children identified with SEN compared to female (see Figure 41). This is broadly in line with nationally available data.

**Figure 41: Number of Pupils by gender and academic year with identified all categories of SEND**



Source: School Census 2016

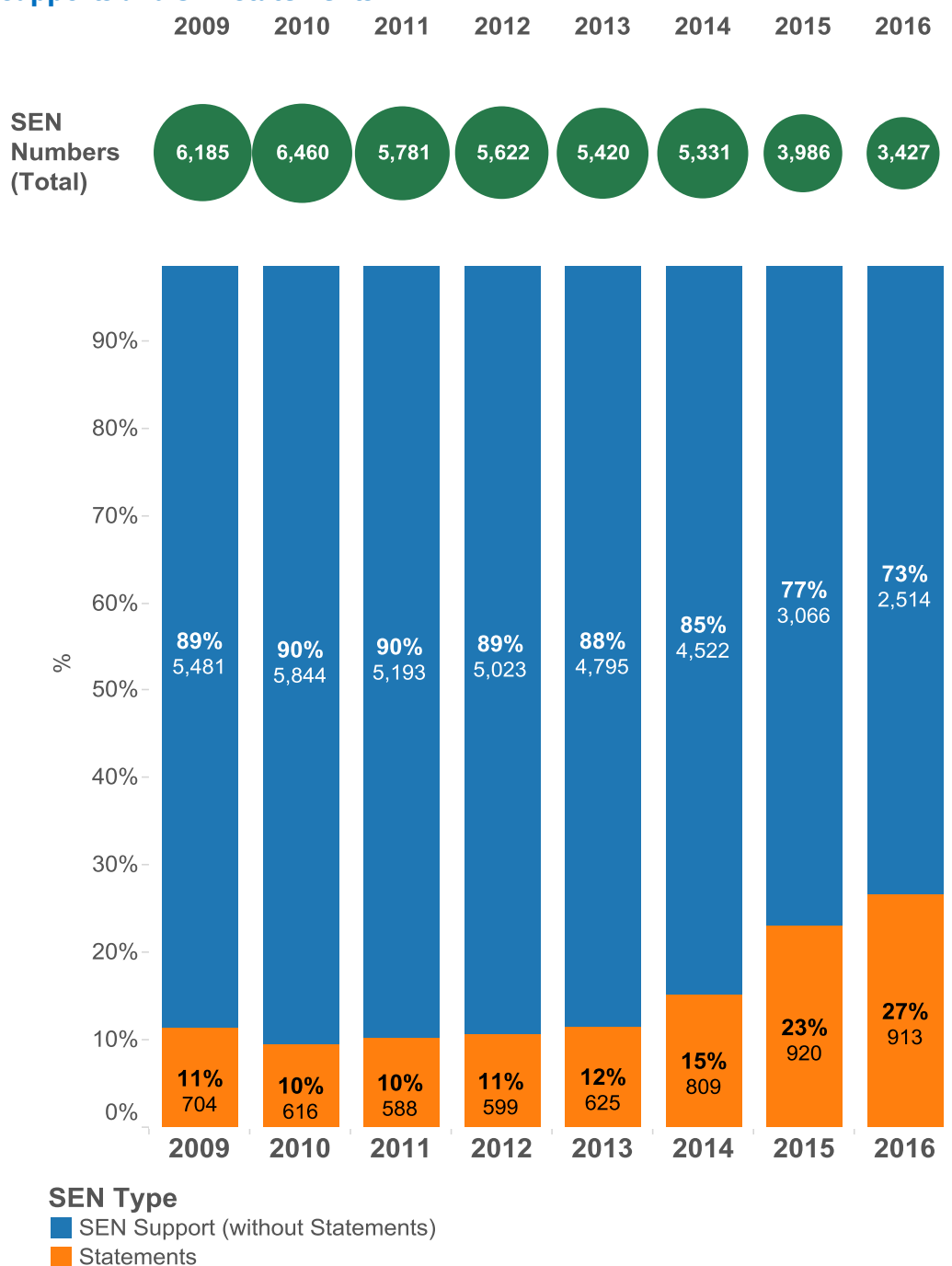
This data is broadly in line with nationally available figures, overall boys are more likely to be identified as needing SEN support. Research has indicated that male foetuses are more likely to suffer trauma, environmental assault etc. pre-birth and therefore have more congenital difficulties, boy babies are also more likely to suffer more from viruses etc and this again could account for the gender difference. Another body of research would point to an under identification of special educational needs in girls; girls needs can go undetected due to their

<sup>27</sup> The school census is a statutory return which takes place during the autumn, spring, and summer terms. The most recent data reported here is taken from the January 2016 school census

likelihood of exhibiting different and less intrusive behaviours in response to their difficulties. It is important that colleagues are aware of this possibility and be alert to the 'hidden' nature of girls' difficulties.

Due to Havering's policy of 'statementless' schools and the use of 'validated hours', instead of issuing statements, the drop in the number of children with statements can be seen between 2009 and 2012 (see Figure 42) and then the numbers rise again as statements begin to be issued as the 'validated hours' approach was dropped due to the changes in delegation of SEN funds to schools.

**Figure 42: Number of children and young people with SEN with distribution of SEN supports and SEN statements**



Source: School Census, January 2016

Conversely, the number of children receiving SEN support in school appears to have dropped steeply over the last seven years. In the past, there was a large over-identification of children with SEN in schools. The Support Services have worked with schools and settings to understand the definition of SEND and what it constitutes. Training and support has been aimed at giving colleagues in schools/settings the tools to identify and support pupils with SEN and place pupils appropriately on the following interventions: Wave 3, SEN, and Wave 2, (pupils in need of short-term intervention) interventions.

Support has been given to class/ subject teachers to improve differentiation in their planning and teaching which has led to pupils making better progress.

In the intervening period of statements converting to EHCPs (Sept 2014 – April 2018), a dual system is in place where we will see two separate Codes of Practice being applied and different terminology being used i.e. SEN Support, which is the COP January, 2015, and EHCP equivalent of School Action and School Action plus for the COP 2001(statements). Again we see a drop in pupils receiving School Support. As colleagues in schools/settings reviewed pupils using the new Code of Practice, (January, 2015), a drop in pupils identified as SEN has been seen (see [Table 11](#)).

**Table 11: Percentage of children and young people with SEN**

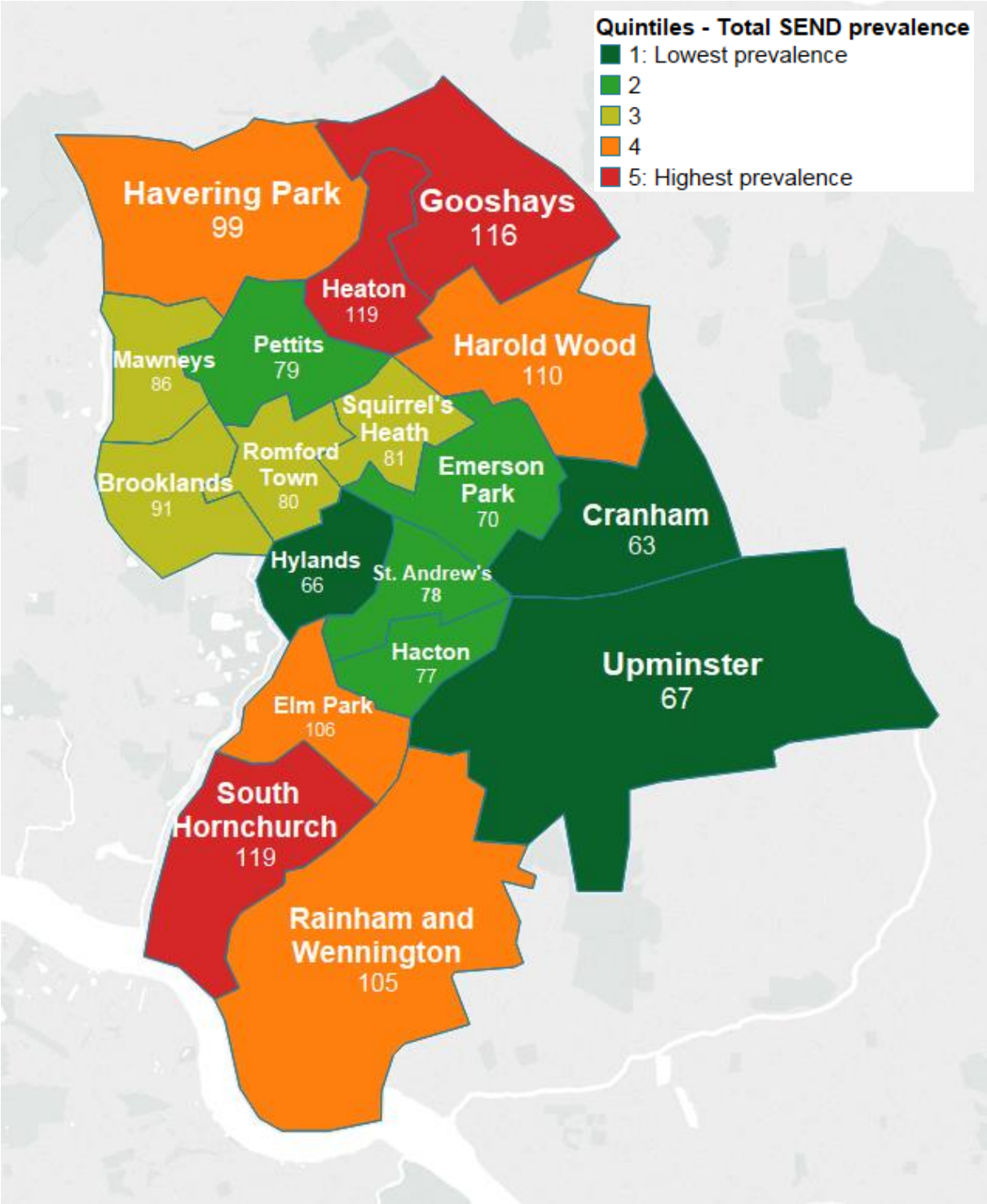
	2009	2010	2011	2012	2013	2014	2015	2016
<b>Statements   Pupils with statements or EHC plans</b>	1.9%	1.7%	1.6%	1.6%	1.7%	2.1%	2.4%	2.4%
<b>SEN Support (without Statements)</b>	14.8%	15.8%	14.0%	13.5%	12.8%	11.9%	7.9%	6.5%
<b>School Action Plus</b>	4.8%	4.8%	5.1%	5.4%	5.3%	4.7%	--	--
<b>School Action</b>	9.7%	10.8%	8.8%	8.0%	7.3%	7.0%	--	--
<b>SEN All</b>	16.7%	17.5%	15.6%	15.1%	14.5%	14.0%	10.3%	8.9%

Source: School Census, January 2016

[Figure 43](#) shows the prevalence of SEND across Havering at ward level. The areas of highest prevalence correlate to the areas of highest deprivation. [Table 12](#) shows distribution of children and young people with SEN across Havering.



**Figure 43: Map of Prevalence of SEND among Havering residents who attend Havering schools per 1000 pupils by Havering wards**



School census January 2016

**Table 12: Distribution of children and young people with SEN across Havering**

Ward	SEN support	Statement	Education, health and care plan	Pupils with statements or EHC plans	All SEN	Population in School
<b>Brooklands</b>	6.2%	2.3%	0.6%	2.9%	9.1%	2,194
<b>Cranham</b>	4.7%	1.2%	0.4%	1.5%	6.3%	1,808
<b>Elm Park</b>	7.2%	2.7%	0.7%	3.3%	10.6%	1,821
<b>Emerson Park</b>	4.3%	2.1%	0.6%	2.7%	7.0%	1,397
<b>Gooshays</b>	8.3%	2.0%	1.3%	3.2%	11.5%	2,757
<b>Hacton</b>	6.0%	1.5%	0.2%	1.7%	7.7%	1,475
<b>Harold Wood</b>	7.5%	2.3%	1.3%	3.5%	11.1%	1,753
<b>Havering Park</b>	7.4%	1.9%	0.6%	2.5%	9.9%	2,087
<b>Heaton</b>	8.9%	2.1%	0.9%	3.1%	12.0%	2,343
<b>Hylands</b>	4.1%	1.7%	0.8%	2.5%	6.6%	1,700
<b>Mawneys</b>	6.1%	1.6%	0.9%	2.5%	8.6%	1,899
<b>Pettits</b>	6.0%	1.4%	0.5%	2.0%	7.9%	1,691
<b>Rainham &amp; Wennington</b>	7.9%	1.9%	0.7%	2.6%	10.5%	1,846
<b>Romford Town</b>	5.7%	1.5%	0.7%	2.3%	8.0%	2,210
<b>South Hornchurch</b>	9.7%	1.6%	0.6%	2.1%	11.9%	2,283
<b>Squirrel's Heath</b>	6.4%	1.5%	0.2%	1.7%	8.1%	1,630
<b>St Andrew's</b>	5.7%	1.4%	0.7%	2.0%	7.8%	1,619
<b>Upminster</b>	4.8%	1.6%	0.3%	1.9%	6.6%	1,872
<b>Havering</b>	6.7%	1.8%	0.7%	2.5%	9.2%	34,385

Source: School Census, January 2016

Table 13 shows the type of SEN recorded as primary need. The figures for ASD and Social, Emotional and Mental Health (SEMH), may be confounded as it is likely that pupils identified with SEMH may well have identified ASD/ADHD. The figures for primary need MSI are also under-reported as the majority of these pupils would be in our Special Schools and therefore may have been given the primary need of SLD as PMLD.

**Table 13: Type of SEN recorded as primary need. SEN support or EHCs recorded as primary in Havering**

SEN Type	SEN support (K)		Pupils with statements or EHC plans (S or E)		All SEN	
	Count	%	Count	%	Count	%
<b>Moderate learning difficulty (MLD)</b>	946	37.7%	146	16.0%	1,092	31.9%
<b>Speech, language and communication needs (SLCN)</b>	656	26.2%	169	18.5%	825	24.1%
<b>Social, emotional and mental health (SEMH)</b>	307	12.2%	71	7.8%	378	11.0%

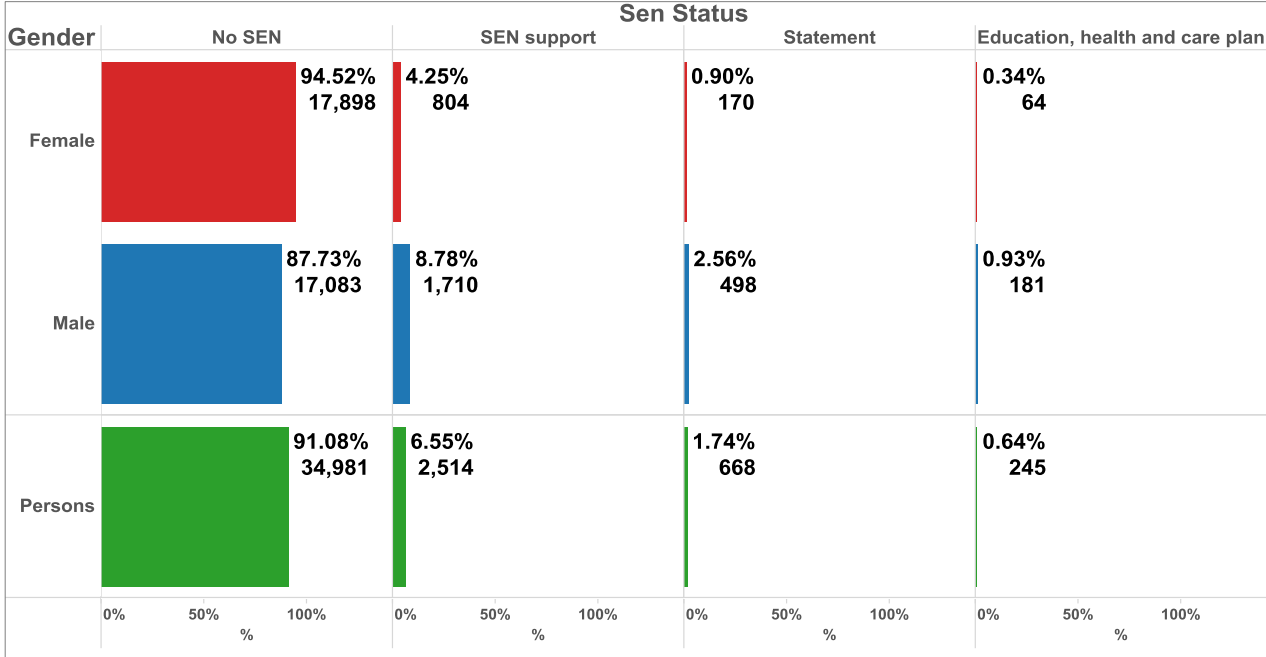
SEN Type	SEN support (K)		Pupils with statements or EHC plans (S or E)		All SEN	
<b>Autistic spectrum disorder (ASD)</b>	70	2.8%	195	21.4%	265	7.7%
<b>Specific learning difficulty (SPLD)</b>	149	5.9%	30	3.3%	179	5.2%
<b>SEN support but no specialist assessment of type of need (NSA)</b>	164	6.5%	13	1.4%	177	5.2%
<b>Severe learning difficulty (SLD)</b>	12	0.5%	117	12.8%	129	3.8%
<b>Other Difficulty/Disability (OTH)</b>	94	3.7%	16	1.8%	110	3.2%
<b>Physical Disability (PD)</b>	54	2.2%	52	5.7%	106	3.1%
<b>Hearing impairment (HI)</b>	29	1.2%	39	4.3%	68	2.0%
<b>Profound &amp; multiple learning difficulty (PMLD)</b>	3	0.1%	51	5.6%	54	1.6%
<b>Visual impairment (VI)</b>	23	0.9%	13	1.4%	36	1.1%
<b>Multi-sensory impairment (MSI)</b>	Less than 5	0.0%	Less than 5	0.1%	Less than 5	0.1%
<b>All SEN Types</b>	2,508	--	913	--	3,421	--

Source: School Census, January 2016

### Gender

The split of a greater percentage of boys with SEN support or statement/EHCP reflects the national trend. There is also research available which highlights the under identification of female pupils with SEN due to certain types of gender-specific characteristics which we ought to be aware of and make colleagues in school aware (see [Figure 44](#)).

**Figure 44: Prevalence of SEN within genders in Havering**

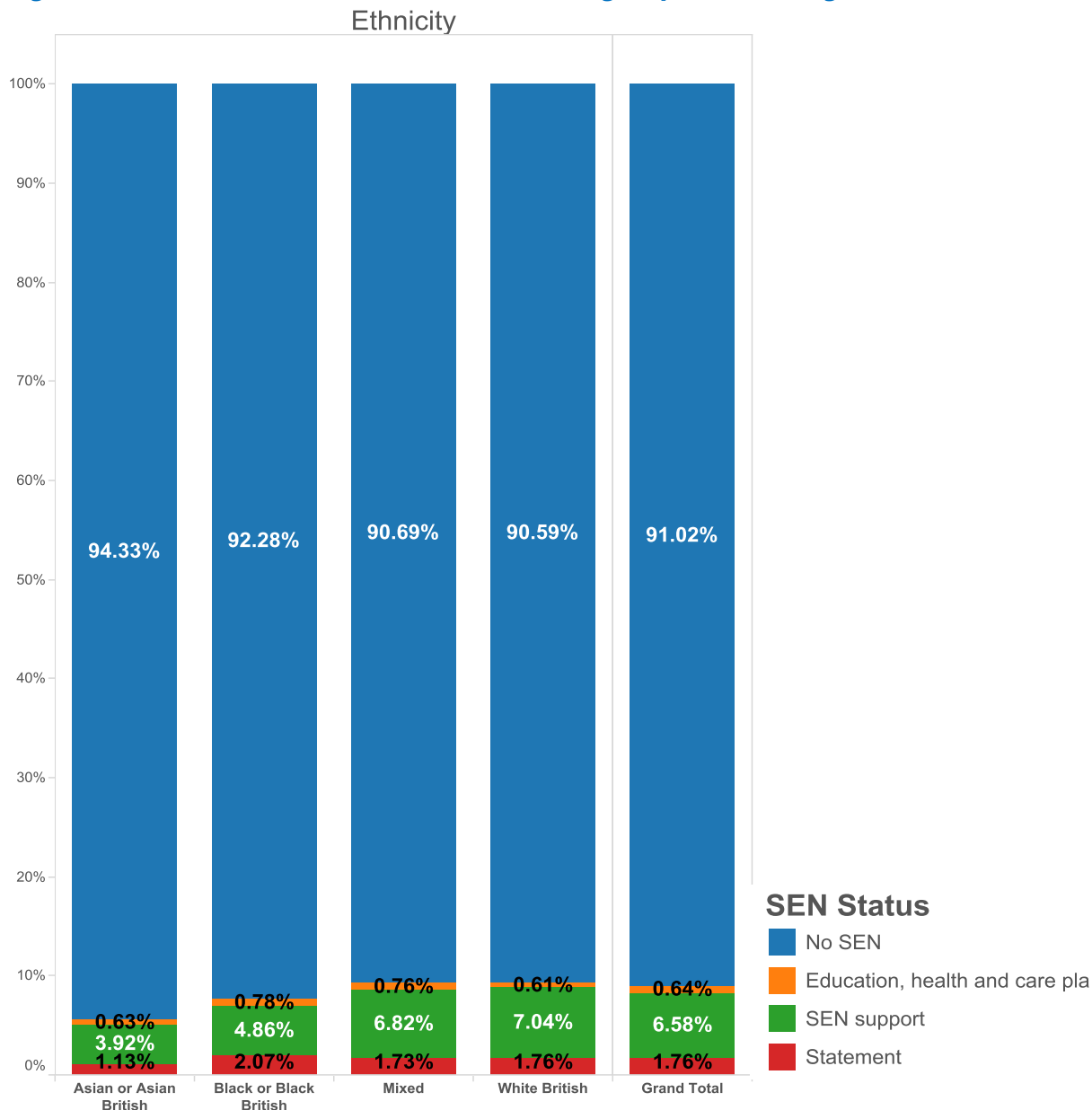


Source: School census in January 2016

**Ethnicity**

The growing number of Asian/Black/Mixed pupils holding statements reflects the changing ethnic diversity of the Borough (see Figure 45). However, when you compare the data of Asian/Black or Black British children receiving SEN support, the percentages are very low in comparison to pupils in mixed or white British ethnic groups. This may be a cultural artefact because Asian/ Black families are unwilling to have their children ‘labelled’ as having special educational needs. Interestingly, Black or Black British children who have been identified as having special educational needs are more likely to have been issued a Statement historically. The data showing the awarding of an Education, Health and care Plan shows no significant difference so far. This is an interesting phenomenon and colleagues should be aware of this previous discrepancy.

**Figure 45: Prevalence of SEN in different ethnic groups in Havering**



Source: School census in January 2016

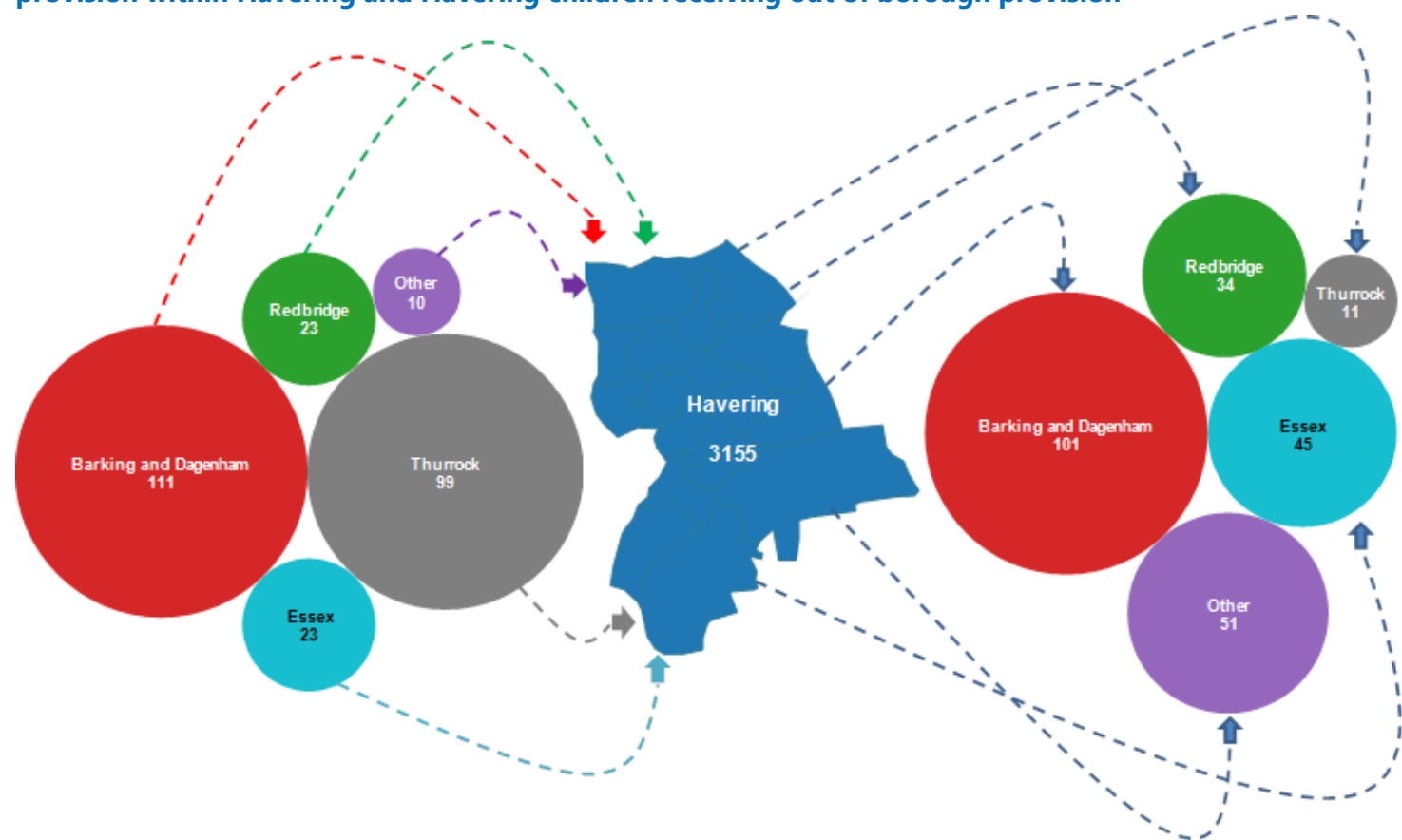
**6.3.3.2 Education Health and Social Care Plans**

EHC plans are in place for newly assessed children and young people, and the “conversion” processes are on-going for those with a statement. Further work has been agreed to extrapolate the individual outcomes to assist in the planning of support across education, health and social care. This links to our key recommendation to develop a single data base between health providers, commissioners and the local authority. This will greatly increase the capability of analysing and reporting on the type of support provided within EHC plans. The Havering EHC assessment process is attached in the Appendix.

### 6.3.3.3 Out of borough

Havering has the highest net importer of children attending its schools. As of January 2016 there were 4032 pupils attending Havering schools who are resident in other areas. Havering is surrounded by three other boroughs and one county, due to the nature of the boundaries many pupils find travelling easier if they 'step' over a borough or county border. Figure 46 shows areas of where pupils attend Havering Schools.

**Figure 46: Overall summary of numbers of pupils coming in from outer boroughs into Havering, having residents receiving SEN provision within Havering and Havering children receiving out of borough provision**



Source: School census Jan 2016 for outside boroughs receiving SEND provision in Havering and CAD 5-19 data for period 2015/16 for numbers of Havering residents receiving SEND provision out of borough

At the time of writing this section, there were 242 children and young people attending out of borough placements. This is a combination of placing young people out of borough due to the fact that needs could not be met locally as well as maintaining existing placements for young people that have moved into the local area.

#### Alternate provision

Current data for financial year 2016/17 shows that there are 13 young people in alternative provision; these young people remain on their school roll.

Home Educated: There are 8 pupils with a Statement/EHCP who are home schooled

### 6.3.3.4 Exclusions and Persistent Absenteeism

#### 6.3.3.4.1 Permanent Exclusion

In Havering, there were 140 permanent exclusions from Academies and Free Schools during the academic year 2013/14. 59% of permanent exclusions were with children with special educational needs. Every effort should be made to avoid a permanent exclusion for a child/young person with SEN/D. Awareness training of the guidance for permanent exclusion is offered to schools now as a case by case basis.

Government data show that children with special educational needs are far more likely to be excluded than their peers. Havering employs two vulnerable children's officers to support pupils and parents where there is the threat of a permanent exclusion. Parents of pupils with SEND can also receive impartial information and advice from Havering's Parents in Partnership (PIPs) service. Where necessary, officers will challenge schools to employ alternative strategies such as managed moves or alternative provision. There is also a team of behaviour support specialists that can advise and support schools where they experience challenging behaviour from pupils, including those with special educational needs. A secondary school 'exclusions concordat' is being developed which includes the following reference:

*'Before considering fixed term or permanent exclusion, schools should consider whether continuing disruptive behaviour might be the result of unmet educational or other needs. At this point, the school should consider a multi-agency assessment and the possible use of alternative provision'*

A Fair Access Panel (FYFAP) meets monthly to consider cases of pupils at risk of exclusion from school. In the case of pupils/young people with a statement of SEN/EHC plan, the Panel will seek advice and support from SEND (CAD) team.

Comparison data for permanent exclusions for pupils with SEN support and for pupils with statements or EHC plans shows that the Havering numbers are so low they have been suppressed by the Department for Education. This demonstrates the excellent work being done locally to support these groups to remain in education (see [Table 14](#)).

**Table 14: Percentage of permanent exclusions 2013/14**

Area	No Identified SEN	Pupils with SEN support	Pupils with statements or EHC plans
<b>National</b>	3%	43%	15%
<b>Outer London</b>	3%	38%	12%
<b>Statistical neighbours</b>	4%	60%	19%
<b>Havering</b>	5%	x	x

Source: School Census Data 2016

#### 6.3.3.4.2 Fixed Term Exclusion

In Havering, there were 1,053 fixed term exclusions days from Academies and Free schools during the academic year 2013/14 (Note: children can have multiple fixed term exclusions). Table 15 shows there were more than double the number of fixed term exclusions for pupils with a SEN compared to pupils with no recorded SEN. This level of fixed term exclusions reflects the challenges presented by pupils in schools. Work continues to support colleagues to develop strategies to maintain pupils successfully, as well as the very high levels of inclusion with Havering mainstream schools. Work is ongoing to help mainstream schools in particular to meet the behavioural challenges of their pupils, especially in the area of challenging behaviours linked to pupils with ASD and ADHD.

**Table 15: Fixed term exclusions in 2013/14 in Havering**

	SEN				No SEN	All
	Statement	School Action Plus	School Action	Total all SEN		
<b>Numbers</b>	51	136	113	<b>300</b>	<b>753</b>	<b>1053</b>
<b>%</b>	6.30%	7.71%	4.25%	5.74%	2.35%	

Source: School Census, January 2016

Comparison data for fixed term exclusions for pupils with SEN support shows that 5.6% of pupils in Havering have fixed term exclusions, compared to 8.2% for Outer London and 10.8% for England (see Table 16). The Havering picture is further improved for pupils with statements of EHC plans with 6.3% having fixed term exclusions compared to 14.8% for our statistical neighbours and 15.2% for England (see Table 16)



**Table 16: Percentage of fixed term exclusions in 2013/14**

Area	No Identified SEN	Pupils with SEN support	Pupils with statements or EHC plans
<b>National</b>	1.7%	10.8%	15.2%
<b>Outer London</b>	1.5%	8.2%	11.9%
<b>Statistical neighbours</b>	2.1%	12.1%	14.8%
<b>Havering</b>	2.4%	5.6%	6.3%

Source: School Census, January 2016

#### 6.3.3.4.3 Persistent Absenteeism

Persistent absenteeism is recorded as being absent for more than 15% of sessions at school. 7.7% of children with SEND support (without statement) were persistently absent in 2013/14 compared to 3.3% of children with no identified SEN needs (see Table 17). This is higher than Outer London (6.2%) and England (7%). Analysis over the past 3 years sees an improving picture compared to 8.9% of persistent absenteeism for children with SEND support in 2012.

**Table 17: Persistent absenteeism 2013/14 for all Havering Schools**

Area	No Identified SEN	Pupils with SEN support	Pupils with statements or EHC plans
<b>National</b>	2.6%	7.0%	11.0%
<b>Outer London</b>	2.2%	6.2%	10.5%
<b>Statistical neighbours</b>	2.5%	6.7%	10.1%
<b>Havering</b>	3.3%	7.7%	12.1%

Source: School Census, January 2016

## 6.4 Housing

We currently only collect housing data for people with learning disabilities aged 18 and over unless they are LAC. When looking at the statutory performance indicator for adult's with learning disabilities in settled accommodation, Havering's 2014/15 outturn was 63%. Of those aged 18-25, the performance was 92% of young adults with learning disabilities in settled accommodation.

## 6.5 Equipment

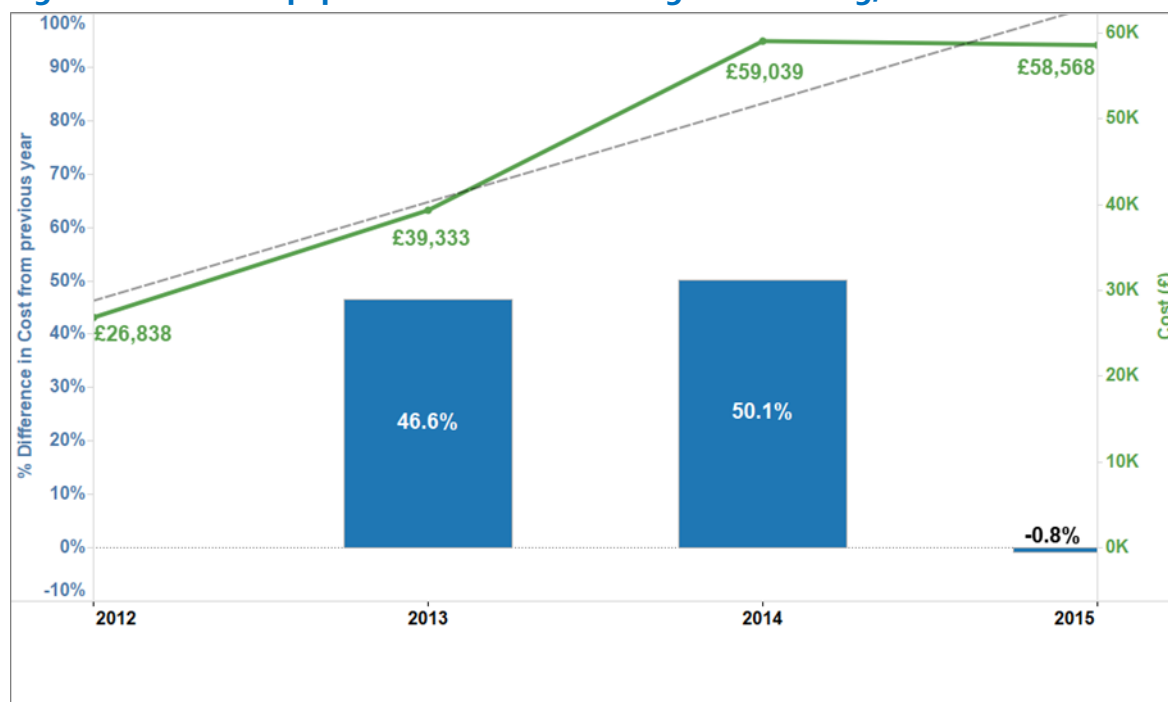
Equipment can assist in prompting the independence of a child and also in assisting carers and enabling access to education and the promotion of health. All agencies have a responsibility to provide equipment but there is a level of confusion around who provides what and in what circumstances. Work is underway to write guidance and eligibility criteria to cover the provision across education, health, social care, and schools. The aim will then be

to explore the possibility of centralised equipment purchase and recycling to achieve more timely provision and greater efficiency across partners.

At present, equipment used in Nursery settings and mainstream schools i.e. changing tables, hoists, slings, specialist seating is purchased by the LA. Equipment is stored centrally and when quotes are received a search is done to ensure equipment is fully recycled before a new purchase is made. Special schools have, historically, purchased and re-used their own equipment out of delegated funds. However, exceptionally, loans from the mainstream stock can be made. Consideration is being given to putting mainstream/special equipment stock together as special schools are having to purchase more and more equipment as the complexity of their populations increase.

Figure 47 shows spend has increased from £26,838 in 2012 to £58,568 in 2016. This reflects the changing population in mainstream schools and the greater need for equipment, at the same time as items are being moved, serviced and re-used as the stock in store improves. In the last year £8,022.39 of equipment has been recycled in this way. This saving has prevented an exponential raise in equipment spend but this has been masked in the last two years of spend as we have also had a rolling programme of renewing and upgrading Radio Aids in our Resourced Provisions for pupils with Hearing Impairment (HI)– a cost of £21,036.

**Figure 47: Cost of equipment for London Borough of Havering, 2012-2015**



Source: Havering Children and Adults with Disabilities 5-19 Support Team, (2016)

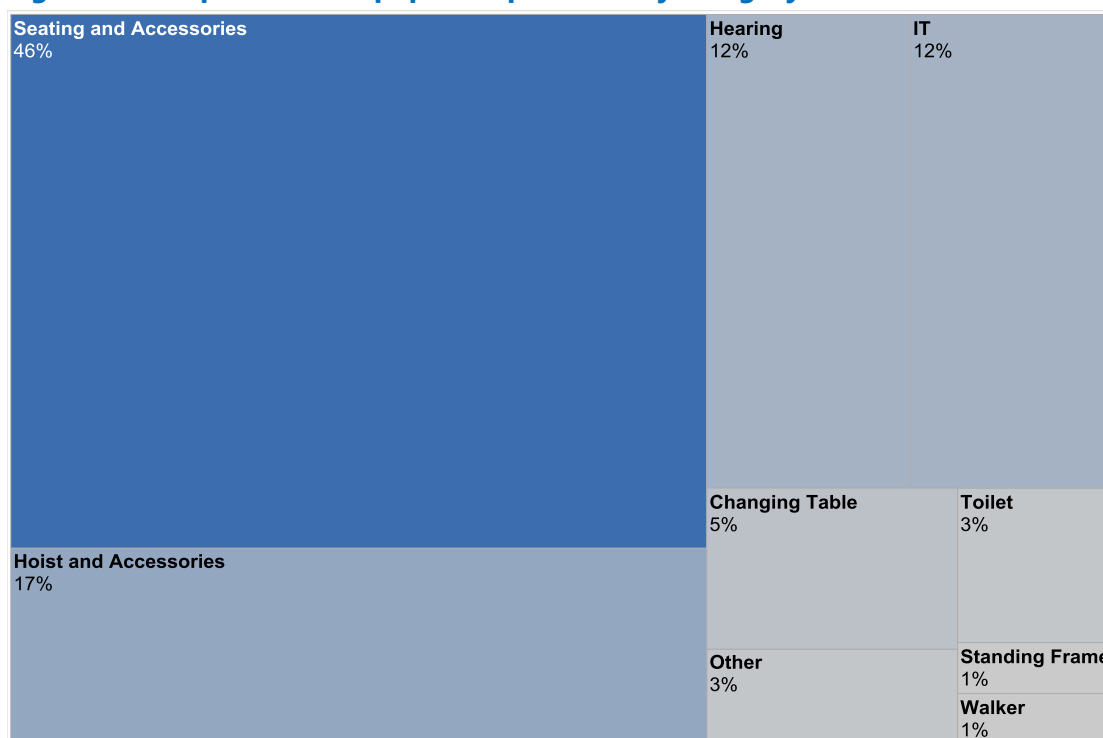
Note: increase in cost maybe due to improvement in data quality.

Another difficulty is the upgrading of children’s hearing aids by Paediatric Audiology resulting in the need for upgrading or changing of type of Radio Aid, (Radio Aids are regarded as an Educational provision and not funded by Health). However, Radio Aids are recycled as much as possible and education colleagues work closely with health colleagues to co-ordinate these upgrades and changes. Pupils with HI are often given technological

support aids rather than Teaching Assistant support if they are in Mainstream provision and so provision and maintenance of equipment is key for access to the curriculum.

Figure 48 shows the type of equipment provided by the Local Authority to children with SEND. Nearly half (46%) of equipment provided is for seating and accessories with the next major groups being Hoist and accessories, Hearing and IT equipment.

**Figure 48: Proportion of equipment provided by category, 2014-15**



Source: Havering Children and Adults with Disabilities 5-19 Support Team, London Borough of Havering, 2016

### Recommendation

Give greater transparency regarding the eligibility criteria for health, education and social care services to aid partnership working and give clarity to children and families.

## 6.6 Youth Justice

### 6.6.1 First Time Entrants

Over the past five financial years Havering has had 440 first time entrants. Only 3 of the cases over the past five years had a SEND status when open to the Youth Offending Service.

First Time Entrants (FTE) refers to young people who have been arrested, charged for the first time and been given a community order that **is not** a triage. Triage is the only community order given prior to Court or after a Court sentence that does not count as FTE as it is a voluntary engagement due to the nature or circumstance of the offence (low level, mitigating circumstances). All other youth community orders count towards FTE statistics (if

a young person commits an offence for the first time and receives any other Youth Order, either before Court or after Court). The severity of the offence depends which order a young person gets if it is their first offence.

The Youth Offending Service (YOS) is specifically designed under the Crime and Disorder Act 1998 to address the offending of all entrants, first time or not, into the Criminal Justice System. We are a multi-agency team (CAMHS, Prospects, Police, Social Work, Drugs and Alcohol, Probation) and our assessments highlight specific areas that lead to offending, which the multi-agency will then address. The idea is that going forward they would reduce re-offending significantly.

The YOS is also based in Early Help in order to support with addressing young people who have key indicators relating to their propensity to offend before they do. Targeted Youth Support (TYS) also sits under the Group Manager of the YOS to look at this aspect of prevention. Triage is a part of the service that is delivered by TYS which is for young people who have committed very low level offences with mitigating circumstances to avoid them going through into FTE into the CJS.

### 6.6.2 Young People Sentenced to Custody

Over the past 5 financial years Havering has had 52 custodial sentences (see Table 18). None of the cases had any SEND status when open to the Youth Offending Service. The number of young people recorded in Havering Youth Offending Service who are First Time Entrants (FTE) or sentenced to custody is very low. Just 3 young people in 5 years have had diagnosed SEN according to our system. The YOS has the ability to record SEN on their system but local knowledge determines that this represents a large under-reporting issue.

The YOS often receives young people who have been excluded multiple times from multiple schools and so miss out on any formal diagnosis before being excluded. This could in part explain the under-representation of young people with SEN known to YOS and the custody service. There needs to be a greater relationship between YOS and SaLT and new funding from the Local CAMHS Transformation Plan will help to address this issue by providing SaLT support to those young people in the YOS. Recording of SaLT needs to increase within YOS.

**Table 18: First Time Entrants and young people with custodial sentences over past 5 years**

	2010/11	2011/12	2012/13	2013/14	2014/15
<b>Total first time entrants</b>	147	126	72	62	33
<b>Numbers of Young People in custody</b>	6	16	16	9	5

Source: YOS database

## 6.7 Transport and assistance for travelling to facilities

Recently there has been a refresh of our transport policy and we are working with parents/carers to develop a range of flexible travel options. 402 young people were provided with travel assistance in the 2015/16 academic year, of which 327 are on buses and 75 pupils are in taxis. The Passenger Travel Service operates 34 buses on a daily basis.

## 6.8 Leisure services

London Borough of Havering are committed to providing leisure services that are appealing and supportive to children with disabilities. We held our first Havering Disability Group in December 2015 where local partners including YMCA, Positive Parents, Havering SENCO, Youth Service, Havering School Sports Collective, Havering College FE and local club coaches attended. Feedback was gathered on what activities children and families would like to see, when, times, facilities, etc.

- From this we held our first Para Active Open Session Event at the YMCA during Feb 2016 Half Term. We had 13 children attend with a mixed variety of disabilities and age ranges. Following the success of this event and feedback provided we continued to run these open Para Active afternoon sessions every half term/holiday. They have continued to succeed with 26 attending our last session during May Half Term (10 returners and 16 new). Feedback showed 100% of the participants enjoyed the day and would come back again stating they felt the event was "good 10/10" and "Great Event - More often please".
- We secured Sportivate funding to help deliver physical activity / sport sessions for SEND students at Havering Further Education College. SEND students are able to access the college sports hall during their non-teaching period on a Tuesday morning to participate in a variety of sports and physical activity delivered by Havering Sport Leader and the Sports Team at the college. The Last session saw over 20 participants from all types of physical, sensory and learning disabilities.

**Para Active:** YMCA staff, Havering Sport Coaches and coaches from local clubs (including from the Local Havering Tennis Club) help to deliver the different sessions offered at the Para Active events. We had a demonstration from Shinjiru Martial Arts Academy the local Karate club for Autism at our last event. We are calling out for other local clubs who deliver all-inclusive sessions to come along to the event to promote their sessions as well as provide us details to advertise via our webpage [www.havering.gov.uk/paraactive](http://www.havering.gov.uk/paraactive). We launched this new webpage to help promote local session which is also linked to Havering Local Offer. Furthermore we have made adaptations to support people using Havering leisure services.

**Central Park Leisure Centre:** disabled parking bays, full access into the facility, accessible toilets and changing areas, pool hoist for accessing the swimming pool, CPLC has IFI status with accessible equipment in the gym area.

**Hornchurch Sports Centre:** disabled parking bays, full access into the facility, accessible toilets and changing areas, pool hoist for accessing the swimming pool, accessible equipment in the gym area, lift for accessing the first floor of the building.

**Chafford SC:** limited disabled parking, full access into the facility, accessible toilets and changing areas, pool hoist for accessing the swimming pool. Facilities will be improved once the new leisure contract is awarded.

## 7. EDUCATIONAL ATTAINMENT FOR CHILDREN WITH SEND

Figure 49 shows percentage of attainment for different year groups compared between those with no SEN, SEN support and SEN statements

### 7.1 Primary school

#### **Reception Year (5 years old) with identified SEND with a good level of development**

There are very small numbers of children holding Statements in the Reception cohort, these children have identifiable and severe/complex needs on entry into school and therefore, whilst progress would be expected to be seen it would be on an individual basis rather than in comparison to the entire cohort.

- 22% of children in Reception Year with identified SEN support (without a statement) achieved a good level of development under the Foundation Stage Profile (FSP) in 2015 compared to 73% of children with no identified SEN. This is one of the lowest attainment levels compared to London (30 out of 32) and our statistical neighbours (8 out of 11).
- 0% of Havering children with statements or EHC plans attained good development at FSP

The data points to the need for Havering to review the type and quality of support given to pre- schoolers/ Reception pupils identified as requiring SEN support.

#### **Year 2 (8 year olds) with identified SEND attaining KS1**

The data suggests that Havering's interventions with Statemented pupils in the area of writing work well. Support for schools in meeting the needs of children receiving SEN support, sharing the successful interventions and support and training on evidence based interventions for colleagues in schools, and early years settings, and parents takes place, provided by the Education Quality and Effectiveness Team. Again when comparing with national data it must be borne in mind there are smaller numbers of children identified as in need of SEN support. This set of data shows that the interventions available to children receiving SEN support in KS 1 work well in reading and allow a significant proportion of pupils with SEN to attain an average level at KS 1. Havering is still not attaining as highly as other London Boroughs or statistical neighbours but it must be borne in mind that less children are identified as having SEN in Havering and therefore would have a different, more complex profile to those they are being compared. However, the Statemented pupils attainment levels are in line with national averages, perhaps a more similar cohort in terms of complexity and needs.

- 64% of children with SEN support (without statements) attained Level 2 or above in Reading in 2015, compared with 97% of children with no identified SEN needs in 2015. This is one of the lowest attainment levels compared to London (30 out of 32) and our statistical neighbours (7 out of 11).
- 26% of Havering children with statements or EHC plans attained Key Stage 1, comparable to London (28%) and England (27%).
- 54% of children in Year 2 with SEN support (without statements) attained Key Stage 1 in writing compared to 96% of children with no identified SEN in 2015. This is lower than

63% in Outer London and comparable to 55% nationally. 23% of children with statements or EHC plans attained Key stage 1 in writing in Havering compared to 22% in Outer London and 21% nationally.

- 71% of children with SEN support (without statements) attained Key stage 1 in maths, compared to 98% of children with no identified SEN needs in 2015. This is lower compared to London (79%) and England (73%). 33% of children with a statement or EHC plan attained Key Stage 1 in maths, compared to London (30%) and England (29%). Again pupils with a Statement attain well compared to national averages. For children receiving SEN support, work undertaken by the Education Quality and Effectiveness Team, with settings and schools, provide support across the Borough. The identification of good quality maths interventions is an area of development.

## 7.2 Secondary school

### **Year 6 (11 year olds) with identified SEND attaining KS2**

- 43% of children with SEN support (without statements) attained Key Stage 2 in reading, writing and maths compared to 93% with no identified SEN needs in 2015. This is lower compared to outer London (52%) though comparable to England (43%). 11% of children with statements or EHC plans attained Key Stage 2, lower compared to Outer London (21%) and England (16%).

Although this data has grouped all reported areas together it can be seen that nearly half of children receiving SEN support attain national average results by the end of KS2, compared to the starting point of roughly a fifth of children doing so at the beginning of their Primary career. Interventions and support have allowed these children to leave Primary with the skills to cope with Secondary school. Pupils with Statements do less well at KS 2 and further analysis is required to discover why they fall back at this stage.

### **Year 11 (15 year olds) with identified SEND attaining KS4**

- 20% of SEN support (without statement) attained Key Stage 4 in reading, writing and maths compared to 62% of children with no identified SEN needs in 2015. Havering has one of the lowest attainments in this Key Stage compared to Outer London (28%) and England (23%). 7% of children with statements or EHC plans attained Key Stage 4, compared to Outer London (10%) and England (9%). This percentage of pupils receiving SEN support attaining average results in KS 4 is low but reflects the complexity of those pupils in Secondary school who still require SEN support.
- The percentage of pupils receiving SEN support attaining average results in KS 4 is low but reflects the complexity of those pupils in Secondary school who still require SEN support. Further work is needed to look at methods of support used by Secondary colleagues and raise awareness of strategies and ways of differentiation which bring about success. This also applies to the Statemented cohort.

Further work is needed to look at methods of support used by Secondary colleagues and raise awareness of strategies and ways of differentiation which bring about success. This also applies to the Statemented cohort.



All schools, academies and Early Years providers are allocated to a member of the Quality Assurance and Effectiveness team; the Strategic Lead. The Quality Assurance team monitor the progress of all groups including those with SEND, within their allocated schools and settings. The Quality Assurance Strategic Lead undertakes an annual quality assurance review which looks at a wide range of areas commonly covered during Ofsted inspections, including elements of provision, policy, curriculum and compliance with regards to SEN.

The team monitors all Ofsted reports against specific areas which need to be addressed within individual provision or more widely where themes emerge and we note that since this activity has been in place, over the last two years, there have been no adverse references to SEND provision or achievement within any Ofsted report.

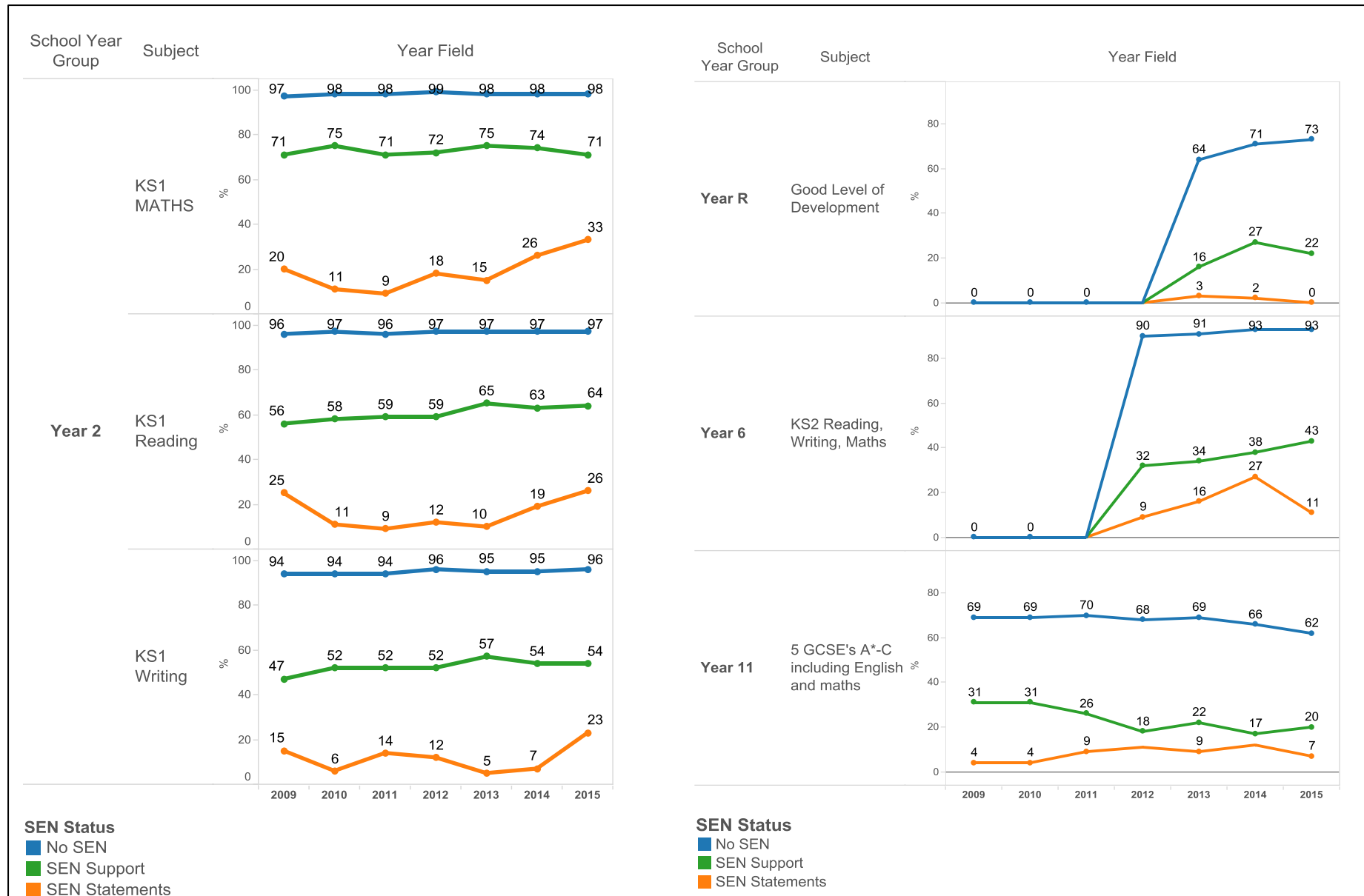
While we do not have a specialist permanent team member for SEND currently, there has been a specific SEND Senior Advisor in place until December 2016. This is now commissioned as needed through a consultancy model. Where significant issues are identified, the provider is monitored regularly and support is brokered through Havering Education Providers Monitoring Group, as set out in the Havering Education Providers Quality Assurance Framework.

*Our Education Providers Monitoring Group* meets monthly and includes information and representation from all relevant council services, including the SEND team. Any concerns are discussed at the meeting and will in turn be relayed back to the strategic lead for the provider; actions will be agreed and taken forward. Where there are concerns regarding provision for SEND pupils generally, we have commissioned specific detailed SEND reviews which in turn will make specific improvement recommendations to the leadership team and governors. Where we undertake whole school reviews, we will include a SEND specialist within the reviewing team if data suggests possible underachievement or poor provision. Support would then be brokered generally through a school to school support partnership or through specific support from officers. Where there are areas of non-compliance identified this is followed up directly by the Assistant Director, such is the priority attached. Strategic Leads regularly review school websites for compliance, quality and ease of access. Where there are issues, for example with published SEN information this is brought to the attention of the school's leadership team.

We work closely with governor services that support the development of governors, including training and advice on SEND issues for governors generally and those with specific responsibility. We have regular briefing and training sessions for head teachers and leaders. This includes as relevant regular input from the specialist SEND team. Additionally, we hold school-led network meetings for inclusion leads and a SENDCos development network which aim to keep practice current and compliant and to share ideas and strategies. We have invested in the NAHT/Eddison, "Aspire" programme for the past three years for a substantial cohort of schools, and a key driver of this programme is focused on systematic development of inclusion and support for SEND and vulnerable pupils, placing this at the centre of school improvement.



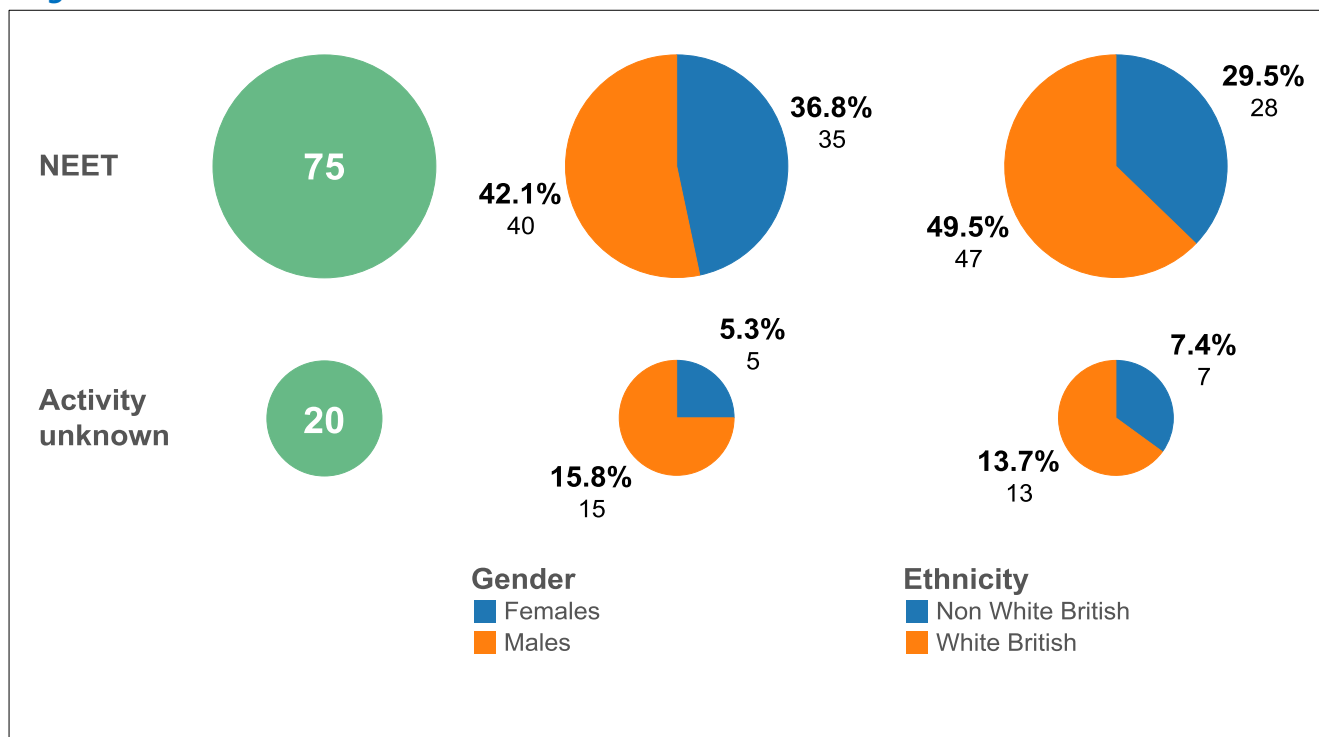
**Figure 49: Percentage of attainment for different year groups compared between those with no SEN, SEN support (Pupils without statements) and SEN statements (Pupils with statements or EHC plans)**



### 7.2.1 Not in Education, Employment of Training (NEET)

We currently have 75 young people whom are either Not in Education, Employment or Training or whose activity is currently unknown as of June 2016 (see Figure 50).

Figure 50: NEET Breakdown as of June 2016



Source: CAD 5-18 team, June 2016

### 7.2.2 Short Breaks

Approximately 244 young people currently access commissioned Short Breaks from 6 providers. The provision of Short breaks often prevents families reaching crisis points. Commissioned services include a range of activities: holiday club, weekend residential trips, pre-school sessions. In addition to the commissioned services approximately 146 families are in receipt of Direct Payments. Services are due to be re-commissioned in 2016/17 to reflect the change in needs locally. A number of these families receive this support as a personal budget.

### 7.2.3 Transitions

Children can experience transition at different points across health, education and social care. Transitions include moving from **early years setting into school** and then as **children moving into adult services** (for instance, Children’s to Adults in social care; Children’s to Adults in health services; Children leaving care; and, CAMHS to Adult MH services). Transition from adolescence to adulthood should be an exciting time for young people but it can bring particular challenges for those young people who have disabilities and statements of special educational needs or education, health and care plans.

### **Recommendation**

Continue to provide appropriate challenge to any educational provision not achieving good outcomes for children and young people with SEND and other vulnerable groups including LAC and children in need.

#### *7.2.3.1 Early years to school*

Children transitioning from Early Years settings into Primary School are supported by The 0-5 CAD team. Guidance is sent to both early years settings and schools in planning and preparing children for transition. A person-centred planning meeting takes place for all SEN supported children transferring to school. This meeting is attended by early years setting staff; parent/carers; relevant agencies working with the child and family; and the staff from the school. An action plan is put into place for the school in preparation for the child's transition. School staff are encouraged to observe the child in the early years setting.

#### *7.2.3.2 Child to Adult Transitions*

Havering has developed a multi-agency protocol to ensure effective transition from child to adult support. The protocol sets out how the transition process for children to adult social care and support will work. The purpose of the protocol is to make clear the transition planning, regulations and processes, agreed by the relevant agencies in Havering, that support the move from childhood to adulthood for young people aged 13- 25 years.

This protocol does not replace internal processes within individual agencies, but is intended to support multi-agency working. The overarching aim of the protocol is to provide excellent transition support in Havering to ensure that every young person with disabilities and special educational needs aged of 13-25 years and their parents/carers have a smooth and positive transition. A Preparation for Adulthood Team within CAD has specific responsibility for this area.

The protocol seeks to ensure that:

- Every young person with a disability coming into Adult Services will receive services and support according to need and eligibility.
- The need for services of young people is identified at an early stage and planned for accordingly and inform future need.
- Young people and their families are well supported, informed and fully involved in the process to make their own choices.
- The transition process is coordinated, systematic and consistent with close partnership working between all professionals and agencies
- Post 16 services and opportunities are commissioned effectively, based on early identification of likely need for support.

### **Recommendation**

Monitor the delivery of the recently implemented Transitions Plan

### 7.2.3.3 Outcomes we want to achieve

#### *Young people*

- ✓ Make decisions and take the lead or are supported by people that can advocate for them.
- ✓ Are supported so they can plan for what they want to achieve.
- ✓ Are able to access the same opportunities as other young people.
- ✓ Have access to services
- ✓ Can try things out beforehand
- ✓ Can change their mind
- ✓ Young people subject to a protection plan should experience a service that is a seamless and ensures they remain safe as they move into adulthood

#### *Their parents/carers*

- ✓ Are listened to and fully involved
- ✓ Have a single point of contact
- ✓ Feel supported
- ✓ Receive consistent messages
- ✓ Have easy access to understandable information
- ✓ See agencies working together and pursuing agreed plans but remaining flexible to accommodate change

## 8. RECOMMENDATIONS

The SEND Needs Assessment Steering Group made a series of recommendations under 3 broad headings:

- Strategic – about how key partners work together to develop and implement relevant strategy
- Services - in terms of what is available and how services work together to better meet the needs of children and their families
- Technical – to assist service delivery and improve our understanding of the needs of children and young people as presented in future iterations of the JSNA

<b>STRATEGIC</b>	1	Undertake a review of the groups responsible for local strategy, commissioning and planning of education, health and social care services relevant to children and young people (0-25) with SEND to eliminate duplication; reaffirm terms of reference and membership and confirm governance with the Health and Wellbeing Board
	2	Use the SEND JSNA to develop strategic commissioning intentions and service development priorities across education, health and social care
	3	Give greater transparency regarding the eligibility criteria for health, education and social care services to aid partnership working and give clarity to children and families.
	4	Ensure key services e.g. community health services are commissioned for outcomes and reports on these outcomes are shared via the refreshed governance structure.
	5	Fully implement the personal budget policy in conjunction with health, where appropriate
	6	Ensure a continued focus on prevention and early intervention (universal services and targeted support) to address the risk factors for SEND
	7	... including healthy lifestyle support for pregnant women / women considering pregnancy to address maternal obesity, smoking in pregnancy etc
<b>SERVICE</b>	8	Review the joint EHC planning and resource allocation meetings to ensure the process and membership enables timely sign off of plans
	9	Implement the findings of the review of equipment services across education, health and social care to further improve user experience and outcomes
	10	Ensure the planned re-commissioning of short breaks includes input from health so that a joint approach can be developed and implemented.
	11	Ensure the data presented in the JSNA regarding community health services informs the on-going review(s) of therapy services
	12	The resulting improvement plans for therapy services should reflect recent / predicted increases in demand and rapid implementation should be a priority
	13	Continue to provide appropriate challenge to any educational provision not achieving good outcomes for children and young people with SEND and other vulnerable groups including LAC and children in need
	14	Monitor the delivery of the recently implemented Transitions Plan
	15	Establish a framework to collate and analyse service user and family feedback to better inform policy, practice and commissioning across health, education and social care services

	16	Work with local GPs to improve uptake of health checks for (young) people with learning disabilities and the subsequent agreement of health action plans to address lifestyle issues and lower the risk of long term conditions
TECHNICAL	17	Create a single database of children and young people with disabilities and /or complex health needs (0-25) across health, social care and education beginning with those with EHC plans
	18	Ensure the new child health information system (CHIS) records children and young people with a EHC plan
	19	The Youth Offending Service should review its processes to identify and record children and young people with SEND so they can better target support as required
	20	Formalise a systematic approach whereby midwives, health visitors and school nurses alert CAD of new born babies and / or children newly resident in the borough likely to have SEND.

## 9. APPENDIX

### 9.1 Key documents for further information

Below is a list of useful documents and resources for further information. Except otherwise stated, these are locally produced documents which can provide more detailed information on various sections of this document. Any of the documents noted as being in draft will be available online when published:

- ❖ This is Havering: a Demographic and Socioeconomic Profile (updated quarterly)
- ❖ Health and Wellbeing Strategy 2015-2018
- ❖ Children and Young People JSNA 2014

### 9.2 SEN projections

**Primary:** The historical trend of Havering statemented pupils in mainstream primary schools is calculated as a proportion of total primary school population. This trend is applied to future projected total primary school rolls to produce the projected number of statemented pupils expected in mainstream schools for future years (using a 1 year average). This total is then split out by type of need based on the historical trend of how the number of statemented pupils on roll was made up of different types of SEN need for previous years. The projections are produced separately for those Havering statemented pupils who attend Havering schools and out borough schools.

**Secondary:** The historical trend of Havering statemented pupils in mainstream secondary schools is calculated as a proportion of total secondary school population. This trend is then applied to future projected total secondary school rolls to produce the projected number of statemented pupils expected in mainstream schools for future years (using a 1 year average). This total is then split out by type of need based on the historical trend of how the number of statemented pupils on roll was made up of different types of SEN need for previous years. The projections are produced for those Havering statemented pupils who attend Havering schools and out borough schools separately.

**Special schools:** The historical trend of Havering statemented pupils in Havering special schools is calculated as a proportion of the 5-16 Havering population projection. This trend is then applied to the future projected 5-16 population to produce the projected number of statemented pupils expected in Havering special schools (using a 1 year average). This is then split out by type of need based on the historical trend of how the number of pupils on roll was made up of different types of SEN need for previous years. The projections are produced for those Havering statemented pupils who attend Havering schools and out borough schools separately

## Appendix 1: Projections for children with a statement of Special Educational Need who attend Primary School in Havering

		Number of statemented pupils in Havering primary schools by type of need													
Year	Total primary NOR	Total	ASD	BESD	HI	MLD	MSI	OTH	PD	PMLD	SLCN	SLD	SPLD	VI	
2012/13	19072	137	44	14	8	21	0	1	7	0	34	1	5	2	
2013/14	19834	280	75	33	19	49	0	3	13	0	74	3	8	3	
2014/15F	20721	310	82	38	19	52	0	3	13	0	87	3	10	3	
2015/16	21381	320	85	39	20	54	0	3	13	0	90	3	10	3	
2016/17	22028	330	87	40	20	55	0	3	14	0	92	3	11	3	
2017/18	22708	340	90	42	21	57	0	3	14	0	95	3	11	3	
2018/19	23333	349	92	43	21	59	0	3	15	0	98	3	11	3	
2019/20	23670	354	94	43	22	59	0	3	15	0	99	3	11	3	
2020/21	24037	360	95	44	22	60	0	3	15	0	101	3	12	3	
2021/22	24440	366	97	45	22	61	0	4	15	0	103	4	12	4	
2022/23	24842	372	98	46	23	62	0	4	16	0	104	4	12	4	
2023/24	25008	374	99	46	23	63	0	4	16	0	105	4	12	4	
		<b>Total</b>	<b>ASD</b>	<b>BESD</b>	<b>HI</b>	<b>MLD</b>	<b>MSI</b>	<b>OTH</b>	<b>PD</b>	<b>PMLD</b>	<b>SLCN</b>	<b>SLD</b>	<b>SPLD</b>	<b>VI</b>	
	2012/13	0.7%	32.1%	10.2%	5.8%	15.3%	0.0%	0.7%	5.1%	0.0%	24.8%	0.7%	3.6%	1.5%	
	2013/14	1.4%	26.8%	11.8%	6.8%	17.5%	0.0%	1.1%	4.6%	0.0%	26.4%	1.1%	2.9%	1.1%	
	2014/15	1.5%	26.5%	12.3%	6.1%	16.8%	0.0%	1.0%	4.2%	0.0%	28.1%	1.0%	3.2%	1.0%	
	1 year average	1.5%	26.5%	12.3%	6.1%	16.8%	0.0%	1.0%	4.2%	0.0%	28.1%	1.0%	3.2%	1.0%	



## Appendix 2: Projections for children with a statement of Special Educational Need who attend Secondary School in Havering

Year	Total secondary NOR	Total	ASD	BESD	HI	MLD	MSI	OTH	PD	PMLD	SLCN	SLD	SPLD	VI
2012/13	15028	291	64	42	15	54	0	3	26	1	47	2	30	7
2013/14	14837	348	75	54	18	66	0	4	32	1	57	2	32	7
2014/15	15038	353	77	57	18	81	0	4	32	0	61	2	14	7
2015/16	15075	354	77	57	18	81	0	4	32	0	61	2	14	7
2016/17	15366	361	79	58	18	83	0	4	33	0	62	2	14	7
2017/18	15622	367	80	59	19	84	0	4	33	0	63	2	15	7
2018/19	16226	381	83	62	19	87	0	4	35	0	66	2	15	8
2019/20	16642	391	85	63	20	90	0	4	35	0	68	2	15	8
2020/21	17070	401	87	65	20	92	0	5	36	0	69	2	16	8
2021/22	17359	407	89	66	21	93	0	5	37	0	70	2	16	8
2022/23	17812	418	91	68	21	96	0	5	38	0	72	2	17	8
2023/24	18051	424	92	68	22	97	0	5	38	0	73	2	17	8
		<b>Total</b>	<b>ASD</b>	<b>BESD</b>	<b>HI</b>	<b>MLD</b>	<b>MSI</b>	<b>OTH</b>	<b>PD</b>	<b>PMLD</b>	<b>SLCN</b>	<b>SLD</b>	<b>SPLD</b>	<b>VI</b>
	2012/13	1.9%	22.0%	14.4%	5.2%	18.6%	0.0%	1.0%	8.9%	0.3%	16.2%	0.7%	10.3%	2.4%
	2013/14	2.3%	21.6%	15.5%	5.2%	19.0%	0.0%	1.1%	9.2%	0.3%	16.4%	0.6%	9.2%	2.0%
	2014/15	2.3%	21.8%	16.1%	5.1%	22.9%	0.0%	1.1%	9.1%	0.0%	17.3%	0.6%	4.0%	2.0%
	1 year average	2.3%	21.8%	16.1%	5.1%	22.9%	0.0%	1.1%	9.1%	0.0%	17.3%	0.6%	4.0%	2.0%

### Appendix 3: Projections for children with a statement of Special Educational Need who attend Special School in Havering

Year	5-16 year old population	Total	ASD	BESD	HI	MLD	MSI	OTH	PD	PMLD	SLCN	SLD	SPLD	VI
2012/13	33851	242	64	8	2	54	0	3	7	20	32	48	2	2
2013/14	34037	274	78	13	2	57	0	3	7	21	35	52	3	3
2014/15	34378	294	81	14	2	58	0	4	7	27	34	62	3	2
2015/16	34733	297	82	14	2	59	0	4	7	27	34	63	3	2
2016/17	35339	302	83	14	2	60	0	4	7	28	35	64	3	2
2017/18	36047	308	85	15	2	61	0	4	7	28	36	65	3	2
2018/19	36899	316	87	15	2	62	0	4	8	29	36	67	3	2
2019/20	37762	323	89	15	2	64	0	4	8	30	37	68	3	2
2020/21	38578	330	91	16	2	65	0	4	8	30	38	70	3	2
2012/22	39348	337	93	16	2	66	0	5	8	31	39	71	3	2
2022/23	40093	343	94	16	2	68	0	5	8	31	40	72	3	2
2023/24	40759	349	96	17	2	69	0	5	8	32	40	74	4	2
		<b>Total</b>	<b>ASD</b>	<b>BESD</b>	<b>HI</b>	<b>MLD</b>	<b>MSI</b>	<b>OTH</b>	<b>PD</b>	<b>PMLD</b>	<b>SLCN</b>	<b>SLD</b>	<b>SPLD</b>	<b>VI</b>
	2012/13	0.7%	26.4%	3.3%	0.8%	22.3%	0.0%	1.2%	2.9%	8.3%	13.2%	19.8%	0.8%	0.8%
	2013/14	0.8%	28.5%	4.7%	0.7%	20.8%	0.0%	1.1%	2.6%	7.7%	12.8%	19.0%	1.1%	1.1%
	2014/15	0.9%	27.6%	4.8%	0.7%	19.7%	0.0%	1.4%	2.4%	9.2%	11.6%	21.1%	1.0%	0.7%
	1 year average	0.9%	27.6%	4.8%	0.7%	19.7%	0.0%	1.4%	2.4%	9.2%	11.6%	21.1%	1.0%	0.7%

**Appendix 4: Projections for Havering residents with a statement of Special Educational Need who attend an out of borough special school**

Year	5-16 year old population	Total	ASD	BESD	HI	MLD	MSI	OTH	PD	PMLD	SLCN	SLD	SPLD	VI
2012/13	33851	61	15	20	2	4	0	0	2	3	6	5	3	1
2013/14	34037	77	19	28	2	5	0	0	4	3	7	5	3	1
2014/15	34378	77	19	28	2	5	0	0	4	3	7	5	3	1
2015/16	34733	78	19	28	2	5	0	0	4	3	7	5	3	1
2016/17	35339	79	20	29	2	5	0	0	4	3	7	5	3	1
2017/18	36047	81	20	29	2	5	0	0	4	3	7	5	3	1
2018/19	36899	83	20	30	2	5	0	0	4	3	8	5	3	1
2019/20	37762	85	21	31	2	5	0	0	4	3	8	5	3	1
2020/21	38578	86	21	31	2	6	0	0	4	3	8	6	3	1
2012/22	39348	88	22	32	2	6	0	0	5	3	8	6	3	1
2022/23	40093	90	22	33	2	6	0	0	5	3	8	6	3	1
2023/24	40759	91	23	33	2	6	0	0	5	4	8	6	4	1
		<b>Total</b>	<b>ASD</b>	<b>BESD</b>	<b>HI</b>	<b>MLD</b>	<b>MSI</b>	<b>OTH</b>	<b>PD</b>	<b>PMLD</b>	<b>SLCN</b>	<b>SLD</b>	<b>SPLD</b>	<b>VI</b>
	2012/13	0.2%	24.6%	32.8%	3.3%	6.6%	0.0%	0.0%	3.3%	4.9%	9.8%	8.2%	4.9%	1.6%
	2013/14	0.2%	24.7%	36.4%	2.6%	6.5%	0.0%	0.0%	5.2%	3.9%	9.1%	6.5%	3.9%	1.3%
	2014/15	0.2%	24.7%	36.4%	2.6%	6.5%	0.0%	0.0%	5.2%	3.9%	9.1%	6.5%	3.9%	1.3%
	1 year average	0.2%	24.6%	35.2%	2.8%	6.5%	0.0%	0.0%	4.6%	4.2%	9.3%	7.1%	4.2%	1.4%

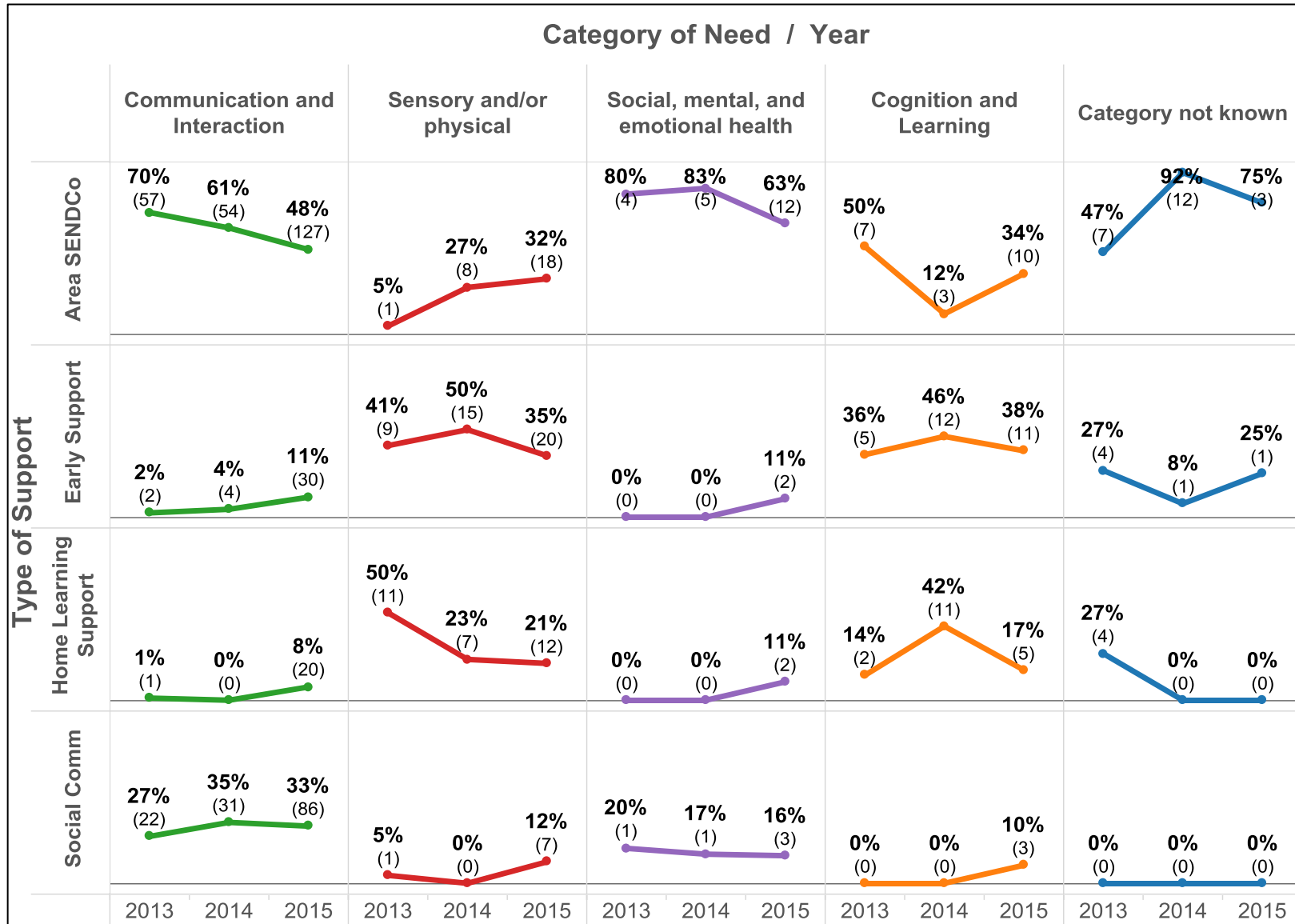
### 9.3 Children and Disabilities Support Team

**Appendix 5: Number of children aged 0-5 years known to CAD by category of need by year (2013 to 2015) and supported by a service to service**

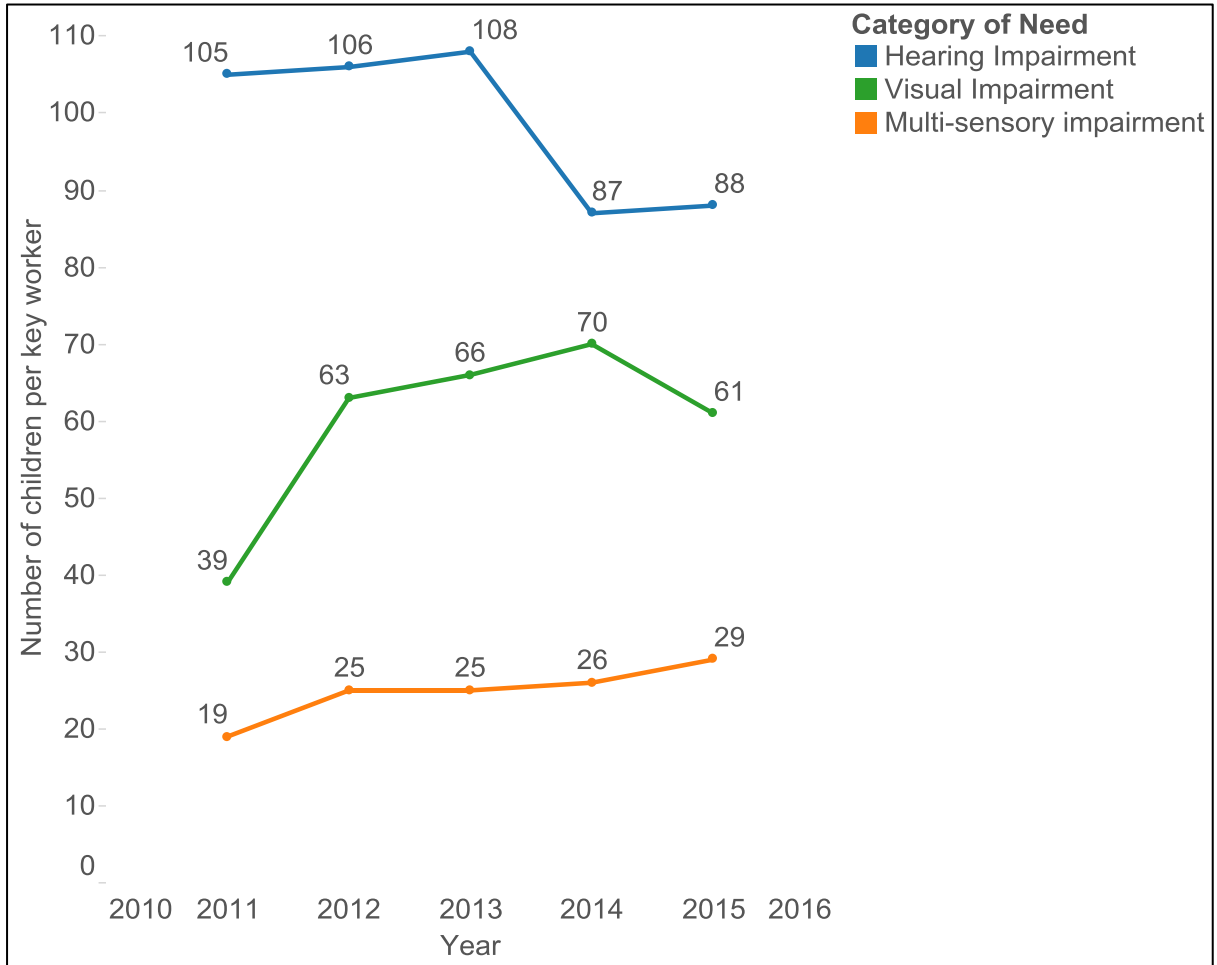
Type of Support	Category of Need / Year														
	Communication and Interaction			Sensory and/or physical			Social, mental, and emotional health			Cognition and Learning			Category not known		
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
Area SENDCo	57	54	127	1	8	18	4	5	12	7	3	10	7	12	3
Early Support	2	4	30	9	15	20	0	0	2	5	12	11	4	1	1
Home Learning Support	1	0	20	11	7	12	0	0	2	2	11	5	4	0	0
Social Comm	22	31	86	1	0	7	1	1	3	0	0	3	0	0	0
<b>Grand Total</b>	<b>82</b>	<b>89</b>	<b>263</b>	<b>22</b>	<b>30</b>	<b>57</b>	<b>5</b>	<b>6</b>	<b>19</b>	<b>14</b>	<b>26</b>	<b>29</b>	<b>15</b>	<b>13</b>	<b>4</b>

Source: LBH CAD Team ages 0-5

Appendix 6: Percentage of children 0-5 years known to CAD by category of need by year (2013 to 2015) and type of support service



## Appendix 7: Number of children per key worker by category of SEND need, 2011-2015



Source: LBH CAD Team ages 5-19 caseloads

## 9.4 SEND Pathway

