This JSNA considers the needs of children or young people aged from 0 – 25 years with a learning difficulty or disability which calls for special educational provision to be made. There are four main areas of need - communication and interaction needs, cognition and learning difficulties, social, emotional and mental health difficulties and sensory and/or physical needs.

What are the key stats?

- 2,226 pupils in school in Tower Hamlets with an Education, Health or Care (EHC) Plan and 6,000 with SEN support (Jan 2019)
- Percentage of pupils with a statement/EHC plan is higher than London and England and is increasing, the percentage with SEN support is similar to London and England but decreases have levelled off locally, regionally and nationally
- Speech, Language and Communication and Social, Emotional and Mental Health are the most prevalent needs for pupils in Tower Hamlets

Who is affected?

- All ages, but greatest need identified at 7-10 years for SEN support and at 13 years + for EHC plan
- Double the levels of identified need are found amongst boys
- Children in need and looked after are significantly more likely to have a special educational need as are those eligible for free school meals

What is currently in place?

- Significant SEND improvement journey undertaken by local partners through the Tower Hamlets Together (THT) partnership
- SEND Strategy (2018-2023) in place
- Significant and sustained system focus

How can we further tackle the issue?

- Strengthen primary prevention approach
- Strengthen and embed community provision (identification and early intervention service offer, particularly around SLCN)
- Further develop data collection and accessibility to build granularity of understanding
- Develop shared outcomes
Setting the scene: Special Educational Need & Disability (SEND)

**Definition**
A child or young person has special education needs (SEN) if they have a learning difficulty or disability which calls for special educational provision to be made.

Special educational needs and disability code of practice sets out the 4 broad areas of need: communication and interaction, cognition and learning, social, emotional and mental health and sensory and/or physical needs.

**Trends**
Overall the percentage of children with identified SEN is increasing (for second year nationally, by .2%) although there is some variability depending on primary area of need

**Age**
Across all ages (<2 to 19+) identified need for SEN support (nationally) is highest between 7 and 10 years old, for statement/EHC plan is highest (nationally) from 13 years old upwards (at secondary school age)

**Gender**
Higher levels of identified need amongst boys and highest prevalence of need identified 1 year earlier than for girls

**Ethnicity**
Profound multiple learning difficulties more common among Pakistani and Bangladeshi children, but this may be combination of any/all of material and social deprivation, inequalities in access to maternal health care, misclassification and higher rates of environmental or genetic risk factors

**Disability models**
*Medical model* - people are disabled by their impairments or differences. *Social model* - disability is caused by the way society is organised. It identifies systemic barriers, negative attitudes and exclusion by society (purposely or inadvertently) that mean society is the main contributory factor in disabling people.
Setting the scene: Special Educational Need & Disability (SEND)

Risk factors

1. **Poverty** *(Joseph Rowntree Foundation, 2016)*
   - *Intergenerational disability*
     - Some evidence that this plays a role in the link between poverty and SEND (a high prevalence of disabled children living with disabled parents)
     - The relationship between adult disability and poverty and the hereditary nature of a small number of disabilities and learning difficulties (such as dyslexia and autism) suggests a link to child poverty
     - Strong evidence that parental disability is a driver of poverty – certain disabilities lead to a ‘decline in income and employment rates...following disability onset’. In addition inheriting a disorder is also likely to impact on a child’s future employment and earning potential.
   - *Co-occurring causal factors*
     - Low levels of maternal education frequently co-occur with poverty, and mothers without qualifications are 2.3 x more likely to have children identified as having SEND compared with children whose mothers have a degree/higher degree
     - Behavioural factors associated with poverty (for example, smoking and consuming alcohol during pregnancy, low birth weight, parental stress and family breakdown) can also contribute to the likelihood of a child developing certain types of SEND
   - *The identification of SEND in some schools*
     - Poverty and SEND can be conflated with some children identified as having forms of SEND due to under-achievement attributable to cultural and social factors associated with living in poverty (such as a poorer home learning environment or more challenging behaviour) rather than because of an underlying disorder

2. **Gender** - The prevalence of all-cause childhood disability is higher among boys than girls in the early years, by late teens the prevalence among girls is similar to that of boys. Neurodevelopmental conditions appear to be more common among boys than girls. Why this is the case remains unclear but may be associated with genetic differences between sexes, under identification in females due to diagnostic criteria based on male characteristics or the fact that different social expectations for girls allow them to adopt compensatory behaviours ('social camouflage') allowing them to mask their social challenges, thereby making it harder to spot *(Dean et al, 2017)*

3. **Genetic** – multiple genetic factors (interacting between themselves and with environmental factors) often underlie SEND
4. **Infections** – for post neonatal acquired cerebral palsy for example, 20% is caused by meningitis and 30% by other infections. Viral infections in pregnancy such as rubella, herpes and cytomegalovirus can result in babies born with disabilities including sight and hearing loss, motor difficulties and learning disabilities. Some disabilities are associated with vaccine preventable diseases such as birth defects due to congenital rubella syndrome or encephalitis following measles.

5. **Factors with the strongest association with any mental disorder** in primary school children include:
   - Poor parental mental health (odds ration 2.59)
   - In receipt of benefits low-income and disability (odds ratio 2.37)
   - Lone parent - previously married (odds ration 1.80)
   - Unhealthy family functioning (odds ratio 1.89) (*NHS Digital, 2017*)

   It should be noted that these are associations, and not necessarily risk factors.

5. **Pregnancy outcomes** - **Low birth weight** and **prematurity** are both associated with an increased risk of development of SEND.
   - In one study 22% of premature births had a severe disability (e.g. cerebral palsy + not walking, low cognitive scores, blindness, profound deafness), 24% had a moderate disability (e.g. cerebral palsy + walking, IQ/cognitive scores in the special needs range, lesser degree of visual or hearing impairment) and 34% had a mild disability (defined as low IQ/cognitive score, squint, requiring glasses)
   - Risk of prematurity increases with multiple pregnancy from 7% to 57% and there is variation by ethnicity - highest for Black Caribbean women (10%) and lowest for White British (7%). Bangladeshi women have an 8% risk of a premature birth. Major long term consequence of prematurity is neurodevelopmental disability.
   - 14 risk factors account for 60% of low birth weight births including tobacco smoke (active smoking and ETS exposure), substance misuse (drug and alcohol), infections, nutritional factors (low BMI, anaemia), intimate partner violence and an inter-pregnancy interval less than 18 months

7. **Behavioural** – factors impacting upon pregnancy outcomes, including smoking in pregnancy, maternal excess weight, pregnancy at ends of age spectrum
8. Alcohol use in pregnancy is linked to risk of developing Foetal Alcohol Syndrome (FAS) - restricted growth, a distinct pattern of facial features and physical characteristics and central nervous system dysfunction) and Foetal Alcohol Spectrum Disorders (FASD) – develops at lower levels of alcohol consumption, children do not show the full characteristics of FAS and less likely to be correctly diagnosed

9. Untreated or inadequately treated depression in pregnancy – risks include poorer pregnancy outcomes (low birth weight and preterm delivery) and adverse child development outcomes (such as emotional problems, attention deficit hyperactivity disorder, and conduct disorder) independent of confounding factors such as maternal smoking, alcohol use, and postnatal depression or anxiety. The risk of postnatal depression (with potential effects on mother-infant interactions and child development) is also increased (Kirby et al, 2019)

10. Increased genetic risk linked to consanguinity increases risk of disability - increased incidence of syndromic and non-syndromic deafness, visual impairment. Mild and severe intellectual and developmental disability is more prevalent in children born from consanguineous union. 15 x risk of recessive disorders and 2 x risk of all congenital disorders among first cousins.

11. Unintentional Injuries - increasingly important cause of disability as children get older. Infants and toddlers are most at risk of injuries in the home while road traffic accidents dominate as children get older. At all ages, children and young people in poorer households and neighbourhoods are at greater risk of injury (in part due to living near busy roads and in poor quality housing)

12. Air pollution - Maternal exposure to ambient air pollution is associated with adverse birth outcomes, such as low birth weight and pre-term births. Emerging evidence also suggests ambient air pollution may affect diabetes and neurological development in children (WHO, 2019). Recent research suggests an association between exposure to two main air pollutants and facets of childhood and adolescent mental health (clinically diagnosable depression and conduct disorder at age 18) (Roberts, 2019), and that air pollution is significantly associated with increased risk of psychiatric disorders (Khan et al, 2019)
Setting the scene: Key SEND characteristics 2019

Identified need
- Pupils with SEN for England and Tower Hamlets – 15% for England and London, 17% for Tower Hamlets, 3rd year of increases, driven by increases in the number of pupils with an Education, Health and Care (EHC) plan and with SEN support; similar picture of change locally, regionally and nationally, but greater magnitude in Tower Hamlets (see slide 21)
- 3% of pupils had a statement or EHC plan in England and in London, for Tower Hamlets the figure is 5% and a similar percentage are on SEN support locally, regionally and nationally (12%)

Primary need
- Across all pupils with SEN, Speech, Language and Communications Needs (SLCN) is the most common primary type of need (22% of pupils)
- SEN support - 23% of pupils had SLCN
- EHC Plans – 29% of pupils had Autistic Spectrum Disorder (ASD)

Primary school
- SLCN is the most common type of need in Tower Hamlets (47%), London (40%) and England (31%); second most common need at this age is Moderate Learning Difficulty (MLD) for England (21%) but Social, Emotional and Mental Health (SEMH) needs for London (16%) and Tower Hamlets (17%)

Secondary school
- MLD is the most common type of need for England (22%), for London it is SEMH (21%) and for Tower Hamlets it is again SLCN (29%); second most common need at this age is Specific Learning Disability for England (21%), SLCN for London (19%) and SEMH for Tower Hamlets (21%)

Special schools
- ASD is the predominant primary need for England (30%), for London (39%) and for Tower Hamlets (51%)
**Setting the scene: Key SEND characteristics 2019**

**Gender**
- More prevalent in boys than girls, 4% of boys and 2% of girls have an EHC plan and 15% of boys were on SEN support compared to 8% of girls
- ASD is the most prevalent primary type of need for both boys (33%) and girls (18%) with an EHC plan
- SLCN was the most prevalent primary type of need among boys with SEN support at 25%, compared with 20% of girls
- MLD was the most prevalent primary type of need among girls with SEN support at 26%, compared with 21% of boys

**Poverty**
- Pupils with SEN more likely to be eligible for free school meals – 28% compared to 13% of pupils without SEN. Pupils with EHC plans are more likely to be eligible for free school meals than pupils on SEN support (33% compared to 27%)
- Half (47%) of people in poverty live in a family that includes a disabled person, compared to one in three (35%) people who are not in poverty *(Social Metrics Commission, 2019)*

**Age**
- SEN support is most prevalent among primary age pupils, before decreasing as age increases through secondary ages
- For EHC plans however, as age increases the percentage of pupils with EHC plans also increases, up to age 16 when 4% of pupils have an EHC plan
- The primary type of need for children on SEN support varies according to the age of the child:
  i. 59% of 4 year-olds on SEN support have a primary type of need of SLCN. This reduces to 9% of 15 year-olds
  ii. At age 10, the most prevalent type of need is MLD (28%). This type of need is most prevalent at this age
  iii. By age 15 the most prevalent type of need is Specific Learning Difficulty at 25%, compared with 17% at age 10 and 4% at age 5
- Age differences are less distinct for pupils with an **EHC plan**, but MLD and SEMH are more prevalent in older pupils; SLCN decreases with age increases, but to a lesser extent than among pupils with SEN support
- ASD is the most prevalent primary type of need across ages 4 to 17 for those pupils with an EHC plan. Prevalence is highest at age 4 at 37%
Setting the scene: Key SEND characteristics 2019

Looked After Children
- 4 x more likely to have a special educational need (SEN) than all children, and over 9 x more likely to have an EHC plan than all children
- 56% of looked after children had a special educational need (2018), compared to 46% of children in need and 15% of all children
- SEMH was the most common primary type of special educational need for looked after children, for 39% of those with an EHC plan and 46% of those with SEN support (for whole pupil population this is the primary need of only 13% of those with an EHC plan and 18% of those with SEN support)
- Looked after children with an EHC plan are much less likely to have hearing impairment, visual impairment, autistic spectrum disorder, physical disability, or speech, language and communication needs as their primary type of special educational need than all children

Ethnicity
- SEN most prevalent in travellers of Irish heritage and Gypsy/Roma pupils (30% and 26% respectively)
- Travellers of Irish heritage and black Caribbean pupils had highest percentage of pupils EHC plans (4.5%). 3% of Bangladeshi pupils had EHC plans, similar to ‘all pupils’ nationally. Indian pupils had the lowest percentage of pupils with EHC plans at 2%, compared with 3% of all pupils nationally
Setting the scene: The four broad areas of need

**Communication and interaction (Law et al, 2017)**

**Speech, language and communication needs**

- *Children and young people with speech, language and communication needs (SLCN) have difficulty in communicating with others. This may be because they have difficulty saying what they want to, understanding what is being said to them, or they do not understand or use social rules of communication. The profile for every child with SLCN is different and their needs may change over time. They may have difficulty with one, some or all of the different aspects of speech, language or social communication at different times of their lives.*

- Amongst the most common developmental difficulties in childhood and can occur in childhood as primary difficulties with speech, language and communication or secondary to other developmental conditions such as autism

- More than 10% of children and young people (7% at age 5) have long-term SLCN creating barriers to communication or learning in everyday life:
  - 8% have developmental language disorder
  - 2% have language disorders associated with another condition such as autism or hearing impairment.
  - SLCN also include conditions such as speech difficulties, stammering and many others

- Children from areas of social disadvantage are at higher risk, around 50% of children may start school with delayed language /other SLCN

- Developmental conditions of childhood, such as stammering or speech impairment disorders, often cause SLCN in children and young people. Some conditions are present from birth and individuals may need support throughout their lives. For example, children with cerebral palsy often experience difficulty articulating particular speech sounds, while some cannot make themselves understood at all

- Up to 60% of young offenders and 88% of long-term unemployed young men have been found to have SLCN, with 35% of offenders having speaking and listening skills at a basic level *(Public Health England, 2016)*

**Autistic spectrum disorder (ASD)**

- *Children and young people with ASD, including Asperger’s Syndrome and Autism, are likely to have particular difficulties with social interaction. They may also experience difficulties with language, communication and imagination, which can impact on how they relate to others.*

- Autistic spectrum disorder (ASD) is defined by the NHS as ‘a condition that affects social interaction, communication, interests and behaviour’.

- Usually symptomatic before age of three, occurs in about 1% of the population, more often in boys (but under-diagnosis in girls)

- Children and young people with ASD, including Asperger’s Syndrome and Autism, are likely to have particular difficulties with social interaction. They may also experience difficulties with language, communication and imagination, which can impact on how they relate to others
Setting the scene: The four broad areas of need

Cognition and learning needs
Cover a wide range of needs, including moderate learning difficulties (MLD), severe learning difficulties (SLD), where children are likely to need support in all areas of the curriculum and associated difficulties with mobility and communication, through to profound and multiple learning difficulties (PMLD), where children are likely to have severe and complex learning difficulties as well as a physical disability or sensory impairment. Specific learning difficulties (SpLD) affect one or more specific aspects of learning including a range of conditions such as dyslexia, dyscalculia and dyspraxia.

- A third of people with a learning disability also have ASD (Emerson & Baines, 2010) (Brugha, et al, 2012).

Social, emotional and mental health
There are a wide range of social and emotional difficulties which manifest themselves in many ways, including becoming withdrawn or isolated, as well as displaying challenging, disruptive or disturbing behaviour. These behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children and young people may have disorders such as attention deficit disorder, attention deficit hyperactive disorder or attachment disorder.

- 81% of children with emotional and behavioural disorders have unidentified language difficulties, and young people referred to mental health services are 3 x more likely to have SLCN than those who have not been referred (I CAN/RCSLT, 2017)
- 36% of 5-19 year olds with a diagnosed mental disorder were recognised as having special educational needs (NHS Digital, 2019)

Sensory and/or Physical needs
Some children and young people require special educational provision because they have a disability which prevents or hinders them from making use of the educational facilities generally provided. These difficulties can be age related and may fluctuate over time. Many children and young people with vision impairment (VI), hearing impairment (HI) or a multi-sensory impairment (MSI) will require specialist support and/or equipment to access their learning, or habilitation support. Children and young people with an MSI have a combination of vision and hearing difficulties.

Physical and sensory needs cover a wide range of medical conditions in addition to those mentioned above. Some children with physical disabilities may be very cognitively able.
Setting the scene: Mental health disorders in childhood

Mental Health of Children & Young People Survey of 5 – 19 year olds (NHS Digital, 2017)

Headlines

- One in twelve (13%) had at least 1 mental disorder, one in twenty (5%) had 2 or more individual mental disorders
- Four broad types:
  - Emotional disorders (anxiety disorders, depressive disorders, mania and bipolar affective disorders). One in twelve (8.1%) had an emotional disorder, with rates higher in girls (10.0%) than boys (6.2%)
  - Behavioural or conduct disorders (repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or values are violated). One in twenty (5%) had a behavioural disorder, with rates higher in boys (6%) than girls (3%)
  - Hyperactivity disorders (characterised by inattention, impulsivity and hyperactivity; likely to be lower than ADHD by DSM-5 definition); 2% had a hyperactivity disorder, with rates higher in boys (3%) than girls (1%)
  - Less common disorders (including autism spectrum disorders (ASD), eating disorders). 2% were identified with one or more of these other types of disorder: 1% with ASD, .5% with an eating disorder and 1% with tics or another less common disorder

By stage of lifecourse

- Pre-school children: 6% of 2-4 year olds had a disorder, 3% behavioural, mostly oppositional defiant disorder (2%); ASD identified in 1.5%
- Primary school: at least one disorder - 9.5%, 3% had two – behavioural disorders (5%) and emotional disorders (4%) most common; rates of emotional disorder were similar in boys and girls, but other types were more than twice as common in boys
- Secondary school: 14% identified with a mental disorder, 6% met criteria for two – emotional disorders were most common (9%) followed by behavioural disorders (6%); boys and girls equally likely to have a disorder, but different types – emotional disorders predominate in girls (11% compared to 7%) while behavioural disorders (7% compared to 5%) or hyperactivity disorders (3% compared to 1%) predominate for boys
- Transitioning to adulthood: 17% of 17-19 year olds had one mental disorder, 6% had criteria for two. Emotional disorders most common (15%), 13% identified with an anxiety disorder and 5% with depression. For girls rate of disorder highest in this group (partly due to differences in type of disorder)

Trends

- Slight increase in prevalence of mental disorder in 5 – 15 year olds from 9.7% in 1999 to 10.1% in 2004 and 11.2% in 2017 driven by an increase in emotional disorder which have become more common in 5-15 year old boys and girls, up from 4.3% in 1999, to 3.9% in 2004 to 5.8% in 2017
- All other types of disorder – behavioural, hyperactivity and other less common disorders have remained broadly stable in prevalence over time
Policy context: current guidelines

Special Educational Needs and Disability (SEND) Reforms

The Special Educational Needs and Disability (SEND) provisions in the Children and Families Act 2014 were introduced on 1 September 2014. From September 2014, children or young people who are newly referred to a local authority for assessment are considered under the new Education, Health and Care (EHC) plan assessment process.

Children and Families Act Part 3 (2014)

- Sets out local authority functions and requirement for co-operation between it and its partners in delivering those
- Sets out responsibilities for:
  - Identification and assessment of education, health and care needs, provision and review of education, health and care (EHC) plans and the duties around provision of services identified within the EHC plan
  - Health professionals to inform local authority and discuss with parents if child under school age has/is likely to have SEND (Section 23 notification)
  - Integration and joint commissioning of education, health and care provision by local authority and its partners
  - Information and advice – local authorities must publish information on provision both within and outside its area (including travel) for CYP with SEND for whom it is responsible – the Local Offer

SEND code of practice 0 – 25 years (DfE, DoH 2015)

- Sets out duties of local authorities, health bodies, schools and colleges to provide for those with special educational needs for 0 to 25 year olds under Part 3 of the Children and Families Act 2014 with scales for attainment targets, and guidance and support for parents and carers.
- Sets out how statutory services should help children with SEND to achieve well in their early years, at school and in college, to find employment, to lead happy and fulfilled lives and to have choice and control over their support
- Key duties for statutory organisations providing services to children and young people with SEND include:
  - Providing EHC plans based on a single assessment process to support children, young people and their families from birth to 25. Statutory organisations must provide impartial advice, support and mediation services to families and children relating to care and education
  - Commissioning and planning of services for children, young people and families should be run jointly by health services and local authorities. Information about services must be set out clearly and be easy to read and personal budgets should be more widely available to children, young people and families.
- Expects outcomes to be a central feature of a child or young person’s EHC plan.
Policy context: current guidelines

**The NHS Long Term Plan** (DoH 2019)

- Sets out ambitions to improve care over the next 10 years by:
  
  i. Bringing down waiting times for autism assessments - joint (with LA CSC and education services) development of packages to support children with autism or other neurodevelopmental disorders (including ADHD) and their families, through diagnosis by 2022
  
  ii. Providing the right care for children with a learning disability – designated keyworker for children and young people with a learning disability, autism or both with the most complex needs by 2023/24, initially to inpatients or children at risk of admission, then for the most vulnerable children with a learning disability and/or autism, including those who face multiple vulnerabilities such as looked after and adopted children, and children and young people in transition between services. Expanding STOMP-STAMP programmes to stop overmedication
  
  iii. Tackling causes of morbidity and preventable deaths in people with a learning disability and for autistic people by increasing annual health checks in primary care for people aged 14+ to 75%
  
  iv. Enabling local providers to take control of budgets to reduce avoidable admissions, enable shorter lengths of stay and end out of area placements and where possible, people with a learning disability, autism or both will be enabled to have a personal health budget
  
  v. Improving the pregnancy outcomes by taking action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and a focus on risk factors for developing SEND - preventing pre-term birth, implementing continuity of carer and serious brain injury by 2025.

**Transition Care Act (2014)**

- Requires local authorities to assess the needs of children approaching adulthood likely to need care and support after turning 18

**SEND Code of Practice (0-25)** (DfE, DoH 2015)

- Preparation for transition should start early
  
  Families need to know that the great majority of children and young people with SEN or disabilities, with the right support, can find work, be supported to live independently, and participate in their community. This ambition should be encouraged by all parties right from the start
  
  When a young person is under the care of a paediatrician, health professionals must work with the young person to develop a transition plan, identifying the lead in co-ordinating care and referrals and the young person must know who the lead is and how to contact them
  
  If the young person has an EHC plan, the CCG and local authority must cooperate to meet the outcomes in the EHC plan.

**Transition from children’s to adults’ services for young people using health or social care services** (NICE guideline [NG43] 2016)

- Provides guidance on the transition from children’s to adults’ services for young people using health or social care services
Policy context: current guidelines

Local policy

**Tower Hamlets SEND Strategy 2018-2023** (Tower Hamlets CCG and LA, 2018)

• Implementation led by London Borough of Tower Hamlets (LBTH) and Tower Hamlets Clinical Commissioning Group (THCCG) through the Tower Hamlets Together (THT) partnership arrangements. The strategy sets out commitments on changes that will be made by 1 and 5 years

• Sets out shared vision, strategic principles, proposes that commitment demonstrated through new SEND charter (with subsequent extension to commercial and leisure organisations); proposes shared outcomes framework.

• Sets out five priorities for developing the local SEND system for the next five years:
  1. Leading SEND – strong strategic leadership, shared vision across the partnership, data and evidence led
  2. Timely identification and assessment - across, education, health and social care that leads to earlier intervention
  3. Better outcomes and pathways - mapping education and care pathways for children and young people with SEND
  4. Clear information and involvement – increasing participation and better communication with parents and carers and children and young people with SEND
  5. Moving on - helping children and young people to start and leave school and services well

**Tower Hamlets Transformation Plan for Children and Young People’s Mental Health and Wellbeing** (Refreshed 2018 - 2019)

Sets out vision and priorities for 2018-2021 in line with *Future in Mind, Implementing the Five Years Forward View plan, Transforming Care* and Transforming Children and Young People’s Mental Health Provision (green paper 2018); adopts i-Thrive framework approach (i) getting advice and signposting, (ii) getting help (iii) getting more help (iv) getting risk support (i-Thrive model including Tower Hamlets projects and achievements within each domain of the Framework is in Appendix); sets out levels of need within Tower Hamlets and the services that are in place in order to meet that need.

**Tower Hamlets Children and Families Strategy (2019 - 2024)** (LBTH 2018)

5 year strategic direction set out by Tower Hamlets Children and Families Partnership Board; identifies 3 priority areas: 1) Aspiration to action (education and workplace skills experience) 2) Healthy families (building resilience, supporting mental health and healthy relationships, childhood obesity and improving outcomes for children in the early years with a focus on speech, language and communication skills) 3) Safe and secure (stronger voice for young people in developing youth services and in response to community safety, reducing the exposure to and perpetuation of violence by children and young people)
What works: effective interventions

Implementation review
• House of Commons Select Committee - Education (2019 – current) Special educational needs and disabilities inquiry: to review the success of recent reforms, how they have been implemented, and what impact they are having in meeting the challenges faced by children and young people with special educational needs and disabilities

System-level guidance
• Local area SEND inspection framework (Ofsted and Care Quality Commission, 2016) sets out the inspection principles for local area inspections under section 20 of the Children Act 2004

Service-level guidance
• The Cochrane Library is a set of summarised evidence to help people make informed decisions about health. It contains numerous systemic reviews on SEND, including, for example, 32 on autism and 12 on learning disabilities

• The Campbell Library produces systematic reviews and other evidence syntheses for evidence-based policy and practice. It also contains systematic reviews on SEND, including, for example, six on autism

• The Communication Trust contains a ‘What Works’ section, where practitioners can access up-to-date information on types of universal strategies and their efficacy

Clinical guidelines
• The National Institute for Health and Care Excellence (NICE) is a source of evidence-based guidance on health and social care.

• NICE has published two clinical guidelines on autism in children and young people: Autism spectrum disorder in under 19s: recognition, referral and diagnosis (CG 128) and Autism spectrum disorder in under 19s: support and management (CG 170).

• There are also two guidelines relevant to learning disabilities: Mental health problems in people with learning disabilities: prevention, assessment and management (NG 54) and Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NG 11).

• Other relevant guidance includes Attention deficit hyperactivity disorder: diagnosis and management (CG72) and conditions of relevance to people with SEND, such as for those aged under 5 years, aged 14 to 25 years, with hearing impairment or with other conditions more commonly affecting SEND.
What works: effective interventions

Primary prevention
Reducing the incidence of preventable impairments/conditions is important because, for children and young people, these may be associated with pain and restriction. While gene markers and gene therapies may offer a way forward for a small number of conditions, for most common childhood conditions, in most cases, primary prevention is likely to be best achieved through public policies to reduce exposure to social and environmental risks (Chief Medical Officer, 2012)

Key elements of a primary preventive approach
Strategic interventions at national and local level to:
- **Reduce socio-economic disadvantage** across the life course through ‘living wages’ and employment, and adequate welfare benefits.
- **Improve material environments** such as safe and healthy housing, schools and workplaces.
- **Reduce exposure to environmental hazards** including air pollutants, and environmental and industrial pollutants, especially lead.
- **Reduce exposure to parental and other sources of environmental tobacco smoke** in utero, infancy and childhood.
- **Promote safe alcohol consumption** in pregnancy.
- **Ensure adequate dietary intake of key nutrients, including folic acid and other vitamins and minerals**, among women of childbearing age, to protect against neural tube conditions and other consequences of vitamin deficiencies. Vulnerable groups may require supplementation around the time of conception.
- **Achieve population coverage of immunisation against common communicable diseases**, notably rubella, sufficient to ensure herd immunity to protect both the foetus from pregnancy-acquired infection and children from complications of these diseases.

And...
- **Improve pregnancy outcomes** - there are recognised risk factors for prematurity and so strategies for prevention are important; there are prevention strategies and treatment interventions for the 14 risk factors accounting for 60% of low birth weight births
- **Appropriate treatment of depression in pregnancy** - high intensity psychological interventions (e.g. cognitive behavioural therapy or interpersonal therapy) with antidepressant medication for moderate-severe depression. NICE recommend that referrals for women with perinatal mental health difficulties are fast-tracked to begin within one month of initial assessment (NICE, 2018)
- **Increased genetic risk** to children born within consanguineous unions - 1) Family-centred approach to provision of genetic services which a) identifies families with an affected member, and b) strengthens access and appropriateness of services; 2) Raise genetic literacy at community level; 3) Educate professionals at the interface with the community. Focus on ‘empowering informed reproductive decision making’ and not reducing consanguineous unions (WHO, 1997)
Past trends
- The % of pupils with any SEN needs has fallen over the last decade, this decrease has levelled off in Tower Hamlets (and London and England); this fall has been driven by decreasing numbers of children with SEN support (no EHC plan or statement)
- However, the decrease in the proportion of children requiring SEN support has levelled off since 2017
- Additionally, there has been a sharp increase in the % of children with EHC plans/statements in Tower Hamlets (in contrast to more modest rises across London and England) - Tower Hamlets is the 2nd highest local authority area for % of pupils with statements or EHC plans (5% compared to 3% for England and London)
- Taken together these two factors have led to small year on year increases in the total percentage of children with any SEN since 2017

Projecting trends and future needs is challenging
- By 2034, around 54,000 new homes are expected to be built in the borough, largely concentrated in the Isle of Dogs; residents are likely to be of child-bearing age, with sufficient resources to move out of borough on the birth of their child (for larger houses), which they are conceivably more likely to do. Future impact on SEND numbers is therefore difficult to quantify
- By 2024 the total population is projected to reach 342,600, a 7% increase (GLA 2017), with subsequent lower levels of increase (5%) to 360,100 in 2029
- While levels of deprivation across the borough may be falling as current residents are priced out, significant numbers are likely to remain and in more entrenched poverty
- One analysis suggests that by 2020/21 total number of pupils with a statement/EHCP is projected to reach around 2,870 (confidence intervals 2,770 to 2,980) (Bennet F, 2019a); at September 2019 this has already been exceeded
- More detailed projections of future need are set out in slide 24
The rate of increase in the number of pupils with EHC plans/statements has increased over the last ten years. The rate of decrease in the number of children with SEN support reached a high point in 2014 at 10% and moved to 4% growth in 2019.

- Differences in magnitudes of change in pupil numbers with EHC plan:
  - greater increase in number of pupils with EHC plans in primary school from 2016-19 across London and England
  - Greater increase in number of pupils with EHC plans in secondary school from 2016-19 in Tower Hamlets

- Significantly greater increase in numbers of pupils with SEN support in Tower Hamlets primary schools between 2017-2018 (7% or 229 pupil increase) and secondary schools between 2018-2019 (14% or 258 pupils)

- Increase in numbers of pupils with SEND support drives increase in total pupils with SEND
### The local picture: Communication and interaction needs – SLCN

#### Key messages

- Nearly half (47%) of state funded primary school pupils and a third (29%) of secondary school pupils with SEN have SLCN as their primary need.
- SLCN are the highest need for children with SEN in primary and secondary schools in Tower Hamlets and in primary schools in London and England.
- Significantly higher proportion of SLCN in Tower Hamlets than London and England (3 x as much in Tower Hamlets secondary schools than London).
- The proportion of pupils with SLCN has remained broadly stable over three years but the number of children with SEN with SLCN has increased by 200 over this period.
- Department of Health guidance to Health & Wellbeing Boards (*Department of Health, 2014*) suggests that as many as 10% of children may have some form of SLCN – bringing into sharp relief the size of the levels of identified need in Tower Hamlets.

#### Diagram

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary need SLCN in England</th>
<th>Primary need SLCN in London</th>
<th>Primary need SLCN in Tower Hamlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>40%</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>2018</td>
<td>47%</td>
<td>19%</td>
<td>40%</td>
</tr>
<tr>
<td>2019</td>
<td>54%</td>
<td>29%</td>
<td>47%</td>
</tr>
</tbody>
</table>

### Key facts

- Setting the scene
- Policy context
- What works?
- Local picture
- Local actions
- Impact on indicators
- Public perspective
- Knowledge gaps
- Priorities
- Key contacts & Appendices
The local picture: Communication and interaction needs – Autistic Spectrum Disorder

Key messages

- A broadly similar proportion of pupils are identified with ASD in Tower Hamlets and London but pupils in Tower Hamlets are more likely to attend special schools than mainstream schools.
- There has been a 4% increase in the proportion of pupils in special schools with ASD over three years with a 1% increase in primary and secondary schools which represents an increase of 200 children with SEN with ASD needs over this period.
- The high quality of Tower Hamlets special school provision is likely to be a key factor in the presentation of children with ASD in Tower Hamlets.

The local picture: Social, emotional and mental health needs (SEMH)

Key messages:
- SEMH needs account for the second largest proportion of primary need for pupils with SEN in primary school in both Tower Hamlets and London and second highest proportion of need in secondary school in Tower Hamlets (it is the highest proportion of need for secondary schools in London).
- A similar proportion of children with SEN in Tower Hamlets have SEMH as their primary need in primary and secondary school as in London and England, but there is twice the proportion of children with SEMH needs in special schools in Tower Hamlets than London.
- The proportion of pupils with SEMH has remained broadly stable over three years in primary and secondary school (has fallen by 2% in special schools) but the number of children with SEN with SEMH has increased by 100 over this period.
- The higher proportions of SEMH need in secondary school is in line with national data indicative of development of SEMH at older ages.
Key messages:

- **C&L needs** in aggregate across England and London account for a greater proportion of need than in Tower Hamlets, the proportion in London is almost double that of Tower Hamlets.

- **Moderate Learning Difficulty** accounts for the third largest proportion of need in primary school in Tower Hamlets (10%) and London (2nd highest for England) and secondary school (14%) in Tower Hamlets. **Moderate** and **Specific Learning Disabilities** account for the highest and second highest need in secondary school in England.

- For **Profound and Multiple Learning Disability** Tower Hamlets has a greater proportion of pupils in special schools than does London and England (23%, compared to 7% for London and 9% for England).

- The proportion of pupils with **C&L needs** has fallen over three years in primary and secondary school (down by 2% in primary and 9% in secondary schools) and the number of children with SEN with **C&L needs** has fallen by 200 over this period (with the exception of Severe Learning Difficulty which has risen by 6 pupils).
The local picture: Sensory and physical needs

Key messages:
- Proportions of children with sensory and physical needs in primary and secondary school as reported in statutory returns are similar to London and England but substantially lower for special schools in Tower Hamlets.
- The proportion of children with a hearing impairment in Tower Hamlets is higher than that for London and England in primary and secondary schools.
- The proportion of pupils with sensory and physical needs has remained stable over three years in primary and special schools but has fallen in secondary schools.

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary need S &amp; P in England</th>
<th>Primary need S &amp; P in London</th>
<th>Primary need S &amp; P in Tower Hamlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>1.7%</td>
<td>1.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>2018</td>
<td>0.9%</td>
<td>0.7%</td>
<td>0.7%</td>
</tr>
<tr>
<td>2019</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting the scene</th>
<th>Policy context</th>
<th>What works?</th>
<th>Local picture</th>
<th>Local actions</th>
<th>Impact on indicators</th>
<th>Public perspective</th>
<th>Knowledge gaps</th>
<th>Priorities</th>
<th>Key contacts &amp; Appendices</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary need S &amp; P in England</th>
<th>Primary need S &amp; P in London</th>
<th>Primary need S &amp; P in Tower Hamlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>5%</td>
<td>6%</td>
<td>.3%</td>
</tr>
<tr>
<td>2018</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>2019</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Number of children known to LBTH Sensory Support Service: Data as of July 2019

<table>
<thead>
<tr>
<th>Setting</th>
<th>Hearing Impairment</th>
<th>Visual Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1.7%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Active</td>
<td>1.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Pre-school</td>
<td>2.3%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Primary</td>
<td>2.1%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Secondary</td>
<td>3.2%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Special</td>
<td>1.1%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Special school</td>
<td>1.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Post 16</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Specialist school for SI</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting</th>
<th>Physical Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2.8%</td>
</tr>
<tr>
<td>London</td>
<td>2.3%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>2.1%</td>
</tr>
</tbody>
</table>
The SEND system for Tower Hamlets has been modelled using data from 2013 – 2018 allowing estimates of future need to be produced

**Key messages:**
- Modelling suggests that the SEND population will continue to expand but with a less steep rate of increase
- Due to underlying patterns of population trend change, different age groups will have different rates of increase
- Demand upon the range of education settings is likely to increase
- Those pupils with needs linked to ASD are likely to form the largest subgroup of the SEND population from 2020

*Analysis provided by Mastodon C (Bennet F, 2019b)*
The local picture: Wider health and housing factors for children with SEN

- The Whole Systems Data Project is a LBTH project aimed at processing health, social care and local authority data to better understand the health and service needs of residents and the social and environmental factors that affect those needs.
- A total 38,348 records in analysis, 13% identified as having SEN support, 4% identified as having a Statement/EHCP.
- 12% of children with a Statement/EHCP and 5% with SEN support were known to Children’s Social Care (compared to 2% of those with no identified SEN need) which is statistically significantly more than we would expect.
- The findings of the analysis are set out in the table to the right.

<table>
<thead>
<tr>
<th>SEN Support</th>
<th>0 to 4 years</th>
<th>5 to 11 years</th>
<th>12 to 18 years</th>
<th>18+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEN Support</td>
<td>3%</td>
<td>57%</td>
<td>40%</td>
<td>1%</td>
</tr>
<tr>
<td>Statement or EHCP</td>
<td>2%</td>
<td>52%</td>
<td>44%</td>
<td>3%</td>
</tr>
</tbody>
</table>

When adjusted for age, gender, ethnicity and deprivation and compared to children with no identified SEN needs:

<table>
<thead>
<tr>
<th>Children on SEN support are significantly:</th>
<th>Children with EHCP are significantly:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH</strong></td>
<td><strong>HEALTH SERVICE USE</strong></td>
</tr>
<tr>
<td>More likely to have asthma, epilepsy or diabetes</td>
<td>More likely to have epilepsy or diabetes (a stronger association than for SEN support)</td>
</tr>
<tr>
<td>More likely to have one long term medical condition</td>
<td>More likely to have poor mental health</td>
</tr>
<tr>
<td>More likely to live in a smoking household</td>
<td>More likely to have two long term conditions (very strong association)</td>
</tr>
<tr>
<td>More likely to be obese or live in a household where someone is obese</td>
<td>More likely to be obese or live in a household where someone is obese</td>
</tr>
<tr>
<td>More likely to have full MMR immunisation</td>
<td>More likely to have full MMR immunisation</td>
</tr>
</tbody>
</table>

**HEALTH SERVICE USE**

- More likely to have had a higher number of A&E attendances in 2017/18
- More likely to have had 1-2 unnecessary A&E attendances or to be a new frequent attender (i.e. recently attended more than 3 times a month)
- Less likely to have a higher number of total GP appointments

**HOUSING**

- More likely to be on free school meals and be in social housing, and significantly less likely to be in private housing (stronger association for children with EHCP)
- More likely to live in a household with complaints related to the external environment (such as noise, antisocial behaviour, fly tipping etc.) or within 200 meters of a gambling or a fast food outlet
- Less likely to live in a household with poor conditions (such as no heated rooms, lowest energy rating, overcrowded etc.) or within 200 meters of a gambling or a fast food outlet
The local picture: LSOA of residence of children with EHCP (derived from WSD project)
The local picture: LSOA of residence of children with SEN support (derived from WSD project)
### The local picture: Resource allocation (APOLLO 1/2)

<table>
<thead>
<tr>
<th>Segment names (shading represents indication of relative service resource intensity)</th>
<th>Medical: Defined by disease or condition, and further defined by acute/chronic nature of that disease/condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total children with SEN identified = 1,711 (2.4% of total children)</td>
<td>Clinically healthy child</td>
</tr>
<tr>
<td><strong>Activities &amp; participation:</strong> Defined by level of ability to:</td>
<td>Standard support needed</td>
</tr>
<tr>
<td>- Move around</td>
<td></td>
</tr>
<tr>
<td>- Understand</td>
<td></td>
</tr>
<tr>
<td>- Self-care</td>
<td></td>
</tr>
<tr>
<td>- Participate</td>
<td></td>
</tr>
<tr>
<td><strong>Environment:</strong> Defined by the support/barriers created by:</td>
<td>Needs targeted support</td>
</tr>
<tr>
<td>- Family relationships</td>
<td>SEN - 360</td>
</tr>
<tr>
<td>- Access to services or equipment</td>
<td>Needs intensive support</td>
</tr>
<tr>
<td>- Attitude</td>
<td>SEN - 360</td>
</tr>
</tbody>
</table>

- Tower Hamlets CCG (*NHS Tower Hamlets CCG (2017)*) ‘Apollo’ segmentation framework analysis tool – prototype built in 2016/17 utilising General Practice, Hospital (acute), NHS specialist commissioning, NHS Community services, SEN and children’s social care data from 2015/16
- Each segment represents a level of medical (‘M’) or social or environmental (‘S’) need, graded from 0 (no additional needs), with higher numbers indicating higher levels of need for support or intervention
- The shading illustrates the relative total level of resource need from statutory services for children and young people that fall into each segment, (darker colour = greater levels of resource need)
- Number of appointments per child increases with increasing complexity of both medical and social segments, so that CYP in the most complex segments (M4S1 and M4S2) have most primary care appointments and A&E utilisation per child
- Numbers of in-patient and out-patient episodes per child increase with complexity of condition and situation. The largest total volume of hospital-based activity is for segment M2S0 (CYP with a single long term condition)
- Some gaps - individual costings data for community and mental health services limited the extent to which the prototype could derive meaningful information on total spend per person per segment.
## The local picture: Resource allocation (APOLLO 2/2)

<table>
<thead>
<tr>
<th>Segment description</th>
<th>Attendance/cost per child</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Healthy’ child, no acute or chronic medical problems</td>
<td>M0 S1</td>
</tr>
<tr>
<td>Child/family requires targeted / occasional help to participate and be fully active, and/or some barriers to engagement with peers, community or usual services. <strong>Example: Child in need</strong></td>
<td>Children with SEN - 360</td>
</tr>
<tr>
<td>Medical diagnosis of short duration condition (6 - 8 weeks) with expectation of return to original state of health and wellbeing afterwards. Targeted/occasional help required to participate and be fully active, and/or some barriers to engagement with peers, community or usual services. <strong>Example: Non-English speaking family, requiring interpreter</strong></td>
<td>M1 S1</td>
</tr>
<tr>
<td>Diagnosed long term condition affecting a single body system. Targeted/occasional help required to participate and be fully active, and/or some barriers to engagement with peers, community or usual services. <strong>Example: ADHD and young carer</strong></td>
<td>M2 S1</td>
</tr>
<tr>
<td>Diagnosed long term condition affecting a single body system. Intensive/permanent help required to participate and be fully active, and/or significant barriers to engagement with peers, community or usual services. <strong>Example: Personality disorder</strong></td>
<td>M2 S2</td>
</tr>
<tr>
<td>Medical diagnosis of short duration condition (6 - 8 weeks) but with potential longer term sequelae and/or requiring significant medical specialist support. Targeted/occasional help required to participate and be fully active, and/or some barriers to engagement with peers, community or usual services. <strong>Example: Traumatic spinal injury, lives in apartment block</strong></td>
<td>M3 S1</td>
</tr>
<tr>
<td>Medical diagnosis of short duration condition (6 - 8 weeks) but with potential longer term sequelae and/or requiring significant medical specialist support. Intensive/permanent help required to participate and be fully active, and/or significant barriers to engagement with peers, community or usual services. <strong>Example: Neurodisability, with mostly family-provided support</strong></td>
<td>M3 S2</td>
</tr>
<tr>
<td>Child with medical diagnosis of a condition with long term impact and/or requiring significant healthcare specialist support. Targeted/occasional help required to participate and be fully active, and/or some barriers to engagement with peers, community or usual services. <strong>Example: Neurodisability, with mostly family-provided support</strong></td>
<td>M4 S1</td>
</tr>
<tr>
<td>Child with medical diagnosis of condition with long term impact and/or requiring significant healthcare specialist support. Intensive/permanent help required to participate and be fully active, and/or have significant barriers to engagement with peers, community or usual services. <strong>Example: Severe neuro-disability requiring home care, Palliative care</strong></td>
<td>M4 S2</td>
</tr>
</tbody>
</table>
The local picture

SEND early years/school age system map

**Key**:
- Health
- Local Authority
- Referrals and/or notifications
- New birth notification
- Universal provision
- Referrals/processes under review

**Antenatal screening**
- Newborn screening

**LBTH Integrated Early Years Service**
- EYFS 2 years
- EYFS 4/5 years

**Health Visiting Service/Family Nurse Partnership**
- New birth visit
- 6-8 week review
- 3-4 month review
- 12 month review
- 2/2.5 year review

**General Practice**
- Referrals from acute Trust perinatally
- Referrals from external health providers - ‘tertiary centres’ GOSH and Guys & St Thomas’ NHS Trust

**NHS SPoA Triage + MDT triage**
- Specialist Childrens’ Services: Paediatricians, therapies, Childrens’ Community Nursing, continence service, asthma nurse
- CAMHS

**LBTH Early Help Hub**
- SEND team
- Support for learning service
- Educational Psychology

**Childrens’ Social Care**
- Statutory school age – 4/5 years

**School Health and Wellbeing Service**
- School Health and Wellbeing Service

**Key facts**
- Setting the scene
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Local actions: what is being done to address the issue

Tower Hamlets SEND Improvement Journey provides a historical narrative of key developments from 2016 to 2018:

External review, internal audits by Council/CCG and feedback by the DfE through the Local Area’s SEND Adviser identified immediate priorities:

i. Lack of progress (and capacity) to implement 2014 reforms
ii. No clear plan to manage conversions from Statements and LDPs (post-16) to EHCPs
iii. Local Offer was not compliant (difficult to access and navigate)
iv. No planned direction underpinned by an SEND Joint Strategic Needs Assessment, strategy or joint commissioning framework
v. No clear governance in place or clarity on data sharing and joint working arrangements across the SEND system
vi. A lack of effective pupil place planning, with capacity rapidly reaching a critical point
vii. Parental concern over the range of provision, particularly at post-16
viii. No action had been taken to convert co-production training into processes
ix. Low parental awareness of personal budgets.

Subsequent progress has been made around these priority areas:

**Identifying children**

1. Five year Tower Hamlets SEND Strategy was launched in 2018 providing a road map for improving services for children and young people with SEND over the next five years
2. The use of the High Needs Funding Block was reviewed in 2018 and a number of operational action plans put in place
3. A restructure of the Early Years’ Service was undertaken in 2017 leading to the development of the Integrated Early Years’ Service
4. Increased capacity and expertise built into LBTH SEND team and new head of SEND and Educational Psychology posts established
5. Additional staff training, new oversight of EHCP assessments and SEND panel operational improvements were introduced.
Local actions: what is being done to address the issue

Meeting needs

1. Evidenced base planning for SEND provision and school sufficiency was a key issue particularly for special schools concerned with autism and PMLD, external research and modelling of SEND numbers led to senior support and capital for interim new site and expansion plan for Phoenix from 2018 and for Beatrice Tate from 2019
2. Creation of a new 14-25 SEN Manager post enabled development of a more cohesive high quality post-16 offer for young people with EHCPs entering adult life
3. Strategic approach to commissioning was initiated, a new Joint Commissioning Forum (director level) was established, providing the mechanism for considering joint commissioning priorities and detailed proposals in relation to SEND. A joint (CCG and local authority) director for integrated commissioning and joint head of children’s integrated commissioning have been appointed
4. CCG SEND oversight is through Designated Medical Officer role, this has been strengthened with Deputy DMO post (Consultant Psychiatrist in East London Foundation NHS Trust) from 2018
5. ‘Born Well Growing Well’ (a children’s integrated care partnership) established (building on Tower Hamlets Vanguard programme), providing a strategic delivery and improvement mechanism for the SEND programme (one of the partnership’s commissioning priorities)
6. Key transitions (from nursery into school, from primary to secondary school, post-16 transitions and preparation for adult life and the transition to adult services) have been through restructuring (Integrated Early Years Service), improvements to annual review processes and SEND team capacity building

Improving outcomes

1. Statistical and individual case management data systems have been strengthened to facilitate better tracking of individual’s system journeys and to ensure senior leadership has necessary oversight
2. Joint CCG and LBTH work to strengthen decision making pathways, governance structures and infrastructure development was in the final stages at this point.
3. An external SEND review was carried out in October 2018, which highlighted areas of strength and areas for further development
Local actions: what is being done to address the issue

The Tower Hamlets Self-Evaluation Framework for SEND provides self-evaluation of the success of the ongoing improvement journey from 2019 and identifies areas for further development.

Next steps

1. LBTH has commissioned a number of external reviews in order to support the further strengthening of the SEN system:
   i. SEND in Tower Hamlets – projecting future SEND need in order to ensure school sufficiency and support special school pupil place planning
   ii. SEMH Schooling Review (2019) – reviews education provision for children with/at risk of needing EHC plans and makes recommendations to improve outcomes (educational) and cost effectiveness of provision
2. Work on aligning LBTH childrens social care data with education data sets
3. Multi-agency task and finish therapies group is working to develop the borough’s approach to improving speech and language therapies offer across early years, school and home settings consistently, and supporting the best use of available resources. Current waiting times of up to 18 weeks for assessment. Jointly commissioned Speech and Language Therapy, Occupational Therapy, Physiotherapy services and Child and Adolescent Mental Health Services will be operational from April 2020
4. An ASD group is focussing on streamlining the clinical pathways to reduce waiting times
5. Timeliness of EHCPs continues to improve and work to support timely responses to annual review documentation and on using outcomes information to track progress of CYP with EHC Plans is underway as is a review of the processes for children transferring from pre-school settings to school settings and those transitioning from primary school to secondary school
6. SEND commissioning route map is in development, proposals to enable full integration, including streamlined planning and decision-making arrangements and pooled budgets as part of the commissioning of services.
7. A proposal for a system-wide review of support for autism and neurodiversity is being scoped
8. Supported development of an independent parent and carer forum is being facilitated by Contact (external VCS organisation)
9. Work ongoing to increase personal budgets and direct payments including through a joint health and social care pilot for integrated personal budgets for children with SEND who have an EHCP
Impact on indicators: evidence we are making a difference

Cross cutting

- The number of children growing up in poverty in Tower Hamlets has fallen to 30% (from 63% 10 years ago) but levels of poverty remain higher (30% of under 16’s in low income families in 2016) than in London (19%) and England (17%)

Preconception and pregnancy

- **Premature birth** – Rates of premature birth (<37 weeks) are similar in Tower Hamlets (76/1000) to London and significantly lower than England (80.6/1000). Data on extreme prematurity is not routinely available. Similar rates of multiple births for Tower Hamlets (15/1000 live births) as London and England; differential risk of prematurity by ethnicity - highest for Black Caribbean women (10%) and lowest for White British (7%). Tower Hamlets has the highest percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups in England at 72%  
  - Low birth weight (<2,500gms) of term babies in Tower Hamlets is highest in London at 4% (179 births in 2017) higher than England at 3%. Very low birth weight (<1,500gms) in 2016 was similar to London and England at 1% (59 births). Local data is available for a number of the 14 risk factors accounting for 60% of LBW births:  
    - **Active smoking** is significantly lower in Tower Hamlets at 4% or 161 births SATOD; environmental tobacco smoke exposure is unknown but there are significantly higher rates of smoking in adults in Tower Hamlets at 20% (42% for adults in routine/manual occupations) than London and England at 14%  
    - **Substance misuse** (drug and alcohol) - out of 264 females starting treatment in 2017/18, 3% of women (8) starting treatment were pregnant at the point of assessment. The number of pregnant drug and alcohol users is considered to be higher than those in treatment. Tower Hamlets Local Authority commissions a Substance Misuse Midwife Service to work with complex substance users who are pregnant. In 2017/18, the service worked with 39 women. No comparative data for London or England is available  
    - Levels of some **sexually transmitted infections** are significantly higher in Tower Hamlets than London  
    - Levels of **intimate partner violence** in Tower Hamlets are amongst the highest in London – with 12/1000 population domestic abuse offences over last 12 months  
  - **Lower levels of coverage of some antenatal and postnatal screening tests** in Tower Hamlets than London/England e.g. foetal anomaly scan and timeliness of antenatal sickle cell and thalassaemia screening, coverage of newborn blood spot screening and lower test quality and lower coverage of newborn component of Newborn and infant physical examination (NIPE)  
  - Increased **genetic risk** to children born within consanguineous unions - recording of consanguinity across services remains inconsistent and impact on population health in Tower Hamlets remains unclear. Approaches should be informed by 'empowering informed reproductive decision making'
Impact on indicators: evidence we are making a difference

**Early years - prior to statutory school age**
- Higher coverage of 4 of the 5 mandated universal Healthy Child Programme (Conception – 5) reviews than England and London in 2017/18, new birth visit (97.9%), 6-8 week check (92.1%), 12 month review (79%) and 2-2.5 year review (78.6%). In Tower Hamlets 85% of eligible infants receive additional review at 3-4 months to allow for assessment and early intervention for any maternal mental health or infant/primary care giver dyad attachment/attunement concerns.
- Childhood population vaccination coverage is falling year on year in Tower Hamlets (as it is across London and England). Coverage of MMR for 2 doses at 5 years old are higher in Tower Hamlets at 82% in 2017/18 than London (78%) but well below levels required to confer population protection.
- **School Readiness** as measured by the percentage of children achieving a good level of development at the end of reception has increased by 25% over 5 years (from 46% in 2012/13 to 70% in 2017/18) and the gap between Tower Hamlets and London (74%) and England (72%) is narrowing.

**Statutory school age**
- Education outcomes for children in Tower Hamlets are better than those for England as a whole, across the lifecourse from 4-5 years old as measured by the Early Years Foundation Stage Profile through to Key Stage 2 and Key Stage 3;
- At the end of key stage 4 in 2018 all pupils with SEND made better average progress across the subjects they studied than similar pupils nationally;
- A 6% drop in percentage of children in receipt of SEN support between Year 6 and 7 (i.e. between primary and secondary school) and subsequent rise back to primary school level suggests transition between primary and secondary school could be strengthened;
- The percentage of EHC plans issued within 20 weeks increased from 21% to 40% from 2017 – 2018 (with the number of new plans issued rising from 248 to 315 over that period); although London and England figures are higher (58% and 60% respectively) regional and national trend is downwards;
- Poor school attendance for pupils with SEND in 2017/18 was below that seen for similar pupils nationally and has fallen over the last five years. Overall attendance for pupils with SEND have remained consistently lower than for similar pupils nationally over the same time period;
- Fixed term exclusion for pupils who have SEND are low. It was less than half that seen for similar pupils nationally in 2017 (16% of pupils with statement/EHCP and 15% for pupils with SEN support for England). The level of permanent exclusion was very low in 2017 (nationally .2% of pupils with statement/EHCP and .3% for pupils with SEN support).

Other evidence of impact to explore could include outcomes for School leavers, Children Looked After, Entering further education, Entering employment and Housing.
Public perspective

Tower Hamlets’ partners have in place a number of ways to support information sharing and participation in decision making:

• **Parents Advice Centre (PAC)**, which is also the Local Area Special Educational Needs and Disabilities Information, Advice and Support Service (SENDIASS) has extensive reach and positive relationships with parents and carers, actively promoting engagement and participation opportunities

• **SEND Ambassadors** - parents or carers of children with SEND. Role includes information sharing, supporting participation of other parents and carers and consultation on changes

• **Tower Hamlets SEND independent parents forum** - provides parents with opportunity to talk to other parents

• **Our Time Youth Forum** - supports a proactive group of young people. A member of this forum now attends the SEND Improvement Group

• **SEND Engagement Workshops (2019)** – 11 themed consultations on: 1) what an EHCP should achieve; 2) Money with each EHCP; 3) Updating SEND services and reducing duplication; 4) Help needed to becoming an independent adult

Parents and carers wanted more involvement in groups and decision making bodies, wanted more information on the funding associated with EHCPs and personal budgets in Tower Hamlets, wanted clearer EHCPs, with health and social care input as well as education and more effective annual reviews and clear concise overview of SEND processes in Tower Hamlets

• More generally there are consistent concerns expressed by parents and carers of children with SEND around
  - Progression pathways, particularly around mental health/CAMHS – both from the perspective of how transition is managed and of what the content of the adult offer is compared to childrens offer
  - Time taken for ASD diagnosis
  - Low rates of diagnosis of ADHD – difference in perceptions amongst Tower Hamlets communities

• Multiple active service user groups exist (e.g. Deaf Childrens’ Society, ASD groups, Downs Syndrome group and settings based groups). Ensuring collective representation and harnessing these groups’ insights for their strategic value is the challenge for statutory bodies

• There has been some expressed demand from parents and carers for a more holistic approach to support, where parents and services/professionals work in partnership to build competence and confidence for independence
Knowledge gaps: what more do we need to know?

1. A greater understanding of emerging needs and future trends in SEN presentation; this will be supported by:
   - Analysis of ‘primary need’ of children with EHC plans in the school population
   - An analysis of the resident population (as opposed to existing analyses of the school population), also including an analysis of ‘primary need’
   - Analysis of health data – specifically Specialist Childrens Services data (OT, physio, SLT) and CAMHS data
   - Development of a SEND analysis strategy utilising all of the available data sources

2. Use data gathered through Healthy Child Programme (universal contacts) and Early Years Outcomes Framework (at 2 years) to generate and test a model to help support predictions of future need

3. There may be variation in how ‘primary’ and ‘secondary’ needs are assigned as such; analysis using combined primary and secondary categories may provide greater understanding of local experience of needs

4. More work is needed to understand why more children are identified with ASD as their primary need in Tower Hamlets. There may be a number of possibilities – good diagnostic services, misdiagnosis (the presenting issues of ASD, attachment disorder and Foetal Alcohol Syndrome Disorder are very similar, particularly in early childhood), the ‘pull factor’ of good local provision or ‘real’ greater local need.

5. More work is needed to understand the high levels of Speech, Language and Communication Need in Tower Hamlets.

6. An analysis of vulnerable groups using social care and YOT data for children with SEND needs which is important for greater understanding of the needs of vulnerable groups:
   - Number of Looked After Children with EHCP’s or/and identified SEND needs
   - Unaccompanied Asylum Seeking Children with EHCP/SEND needs
   - YOT SU’s with EHCP/SEND need

5. There is no consensus on what explains the steeper increase in numbers of pupils with statements/EHC plan since about 2012/13 or why the percentage of pupils with SEN statement/EHC plan is twice as high as that for England and London whereas the number of pupils with SEN support is approximately the same.

6. There is the need for greater understanding of the effectiveness of early identification of needs and subsequent outcomes for children across frontline services

7. Further work is needed to identify meaningful outcomes with the metrics by which to measure them.
Priorities: what are the priorities for improvement?

**Prevention priorities**
1. Improve pregnancy outcomes for women. Across a number of indicators pregnancy outcomes are significantly worse than for London. There is an increased risk of SEN need associated with many of these factors and these factors are amenable to influence.
2. Improve the health of women and their partners before and during pregnancy. Improving pre-conceptual health of women (and there is increasing evidence of impact of paternal health) will support improved pregnancy outcomes and infant health.

**Service priorities**
3. Review developmental assessments carried out by universal services in order to better understand impact and outcomes.
4. Develop shared outcomes for ‘early years sector’ language support and conduct analysis of impact on improving speech and language outcomes for children and reducing pressure on SaLT services. Significant development of language support offer has taken place across early years and a language pathway is under development.
5. Adopt national SLCN assessment tool and model SLCN pathway as they are developed.
6. Support universal services to begin to build longitudinal data view to support future need projections and planning.

**Commissioner priorities**
7. Further development of health data systems – to allow greater granularity of analysis by diagnosis and greater understanding of need (and increasing need) underpinning the four broad areas of SEND.
8. Ensure consistent and costed training and skills sharing programmes by local service providers (e.g. SaLTs) for frontline staff are in place/commissioned. The value of work done to up-skill and support front line workforce has been acknowledged although there may be gaps across some areas of need and a review of training needs could usefully be undertaken.

**System priorities**
9. Complete SEND mapping and pathways.
10. Strengthen understanding of movement of children through SEND identification system map (slide 29).
Key contacts and stakeholder involvement

- This publication was produced by Simon Twite, LBTH Public Health Programme Lead, Maternity & Early Years and approved by Tower Hamlets SEND Improvement Group in September 2019
- This publication was signed off by Dr Katie Cole in September 2019
- Any queries regarding this publication should be sent to simon.twite@towerhamlets.gov.uk
- Stakeholders who contributed to this publication include:
  1. Tower Hamlets SEND Progress Group 30/04/2019
  2. Tower Hamlets SEND Improvement Group 17/07/2019
  3. Tower Hamlets Together ‘Born Well, Growing Well’ Partnership Board (e-consultation) 23/07/2019
  4. LBTH Children’s Services DLT 09/09/2019
  5. Tower Hamlets Together ‘Born Well, Growing Well’ Partnership Board 17/09/2019
  6. SEND Improvement Group 19/09/2019

About the JSNA process
The Joint Strategic Needs Assessment (JSNA) is a process through which the council’s social care services (Education, Social Care and Wellbeing) work together with public health and NHS services to assess the needs of the Tower Hamlets population and determine priorities for commissioning services.

As described in the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies 2012, the Health and Wellbeing Board brings together key NHS, public health and social care leaders in Tower Hamlets to work in partnership to establish a shared local view on the needs of the local community and support joint commissioning of NHS, social care and public health services.

The Health and Wellbeing Board develops joint health and wellbeing strategies based on the assessment of needs outlined in the Joint Strategic Needs Assessment. This joint approach to needs assessment will continue to enable an increasingly integrated approach to health and social care commissioning and provision, with many benefits to service users, patients and carers, not least a more seamless experience of health and social care services.

Understanding residents’ needs is crucial to reducing health inequalities and improving health and wellbeing for the population of Tower Hamlets. The JSNA highlights some key strategic priorities for improving health, preventing illness and reducing health inequalities.

Tower Hamlets JSNA documents can be accessed from: https://www.towerhamlets.gov.uk/lgnl/health__social_care/joint_strategic_needs_assessme/joint_strategic_needs_assessme.aspx
References

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• Bennet F, 2019b. Tower Hamlets SEND modelling – Baseline 2019 projection results Version 1.0 (internal LBTH document)
• NHS Tower Hamlets CCG (2017). Apollo project: segmentation analysis of population of children and young people in Tower Hamlets, Insight report (internal TH CCG document)