Joint Strategic Needs Assessment for Tameside & Glossop

May 2020

Special Educational Needs and Disability

0 to 25 years

Produced by policy, performance and intelligence

Contents page

Acknowledgements

This JSNA would not have been possible without the provision of data, information and support from across the Tameside and Glossop health, education and care system. So thank you to all those who have provided data, intelligence and support to make this needs assessment possible.

National and Local Policy Context:

This area is fundamentally driven by the following policies and guidance.

National

- The Special Educational Needs and Disability Regulations 2014
- The Special Educational Needs (Personal Budgets) Regulations 2014
- The Special Educational Needs and Disability (Detained Persons) Regulations 2015
- The Children and Families Act 2014 (Transitional and Saving Provisions)(No 2) Order 2014
- The Care Act 2014
- Special educational needs and disability code of practice: 0 to 25 years statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities

Local

- Our People Our Place Our Plan – Corporate Plan for Tameside & Glossop

There are duties on local authorities and NHS bodies to act under the statutory guidance produced by the Government to accompany each of the above policies.

Introduction and Background

Joint Strategic Needs Assessment

The purpose of this Joint Strategic Needs Assessment (JSNA) is to assess the current and future health and social care needs of children and young people with a special educational need including a learning difficulty and/or disability (SEND). This SEND JSNA will focus on the 0-25 years population

The purpose of a JSNA is to identify ways to improve the health and wellbeing of the local population and reduce inequalities for all ages. This JSNA has collected data and information from a range of sources including national and local datasets.

Source: DfE, Special educational needs and disability code of practice: 0 to 25 years, January 2015

Its aim is to gain a better understanding of the current and future health and care needs of the SEND population to inform and guide the planning and commissioning of health, well-being and care services within Tameside & Glossop. This JSNA should inform any future strategies, action plans and outcomes frameworks that instigate system change and improvements in the outcomes of our 0-25 years SEND population.

The 2014 Children and Families Act extended the SEN system age range to 0 to 25 years – this is why this age range will be the focus of this JSNA.

The information and data in this JSNA will include Tameside council data for children and young people who live and are educated in and out of Tameside. Education data for Glossop will be included separately where available. Health data for the 0-25 population will be for residents and patients within the Tameside & Glossop boundaries.

What are Special Educational Needs and Disabilities (SEND)

SEND is a term which encompasses children and young people with Special Educational Needs (SEN) and / or a Disability.

SEN: The 2015 SEND Code of Practice states that children and young people have Special Educational Needs if they: "have a learning difficulty or disability which calls for special educational provision to be made for him or her"

Disability: The 2010 Equality Act defines someone with a disability as having: '…a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'. 'Long-term' is defined as 'a year or more' and 'substantial' as being 'more than minor or trivial'. As such, this definition is relatively broad and encompasses a range of conditions including sensory impairments and long-term health conditions such as asthma or epilepsy.

SEN and disability are concepts which overlap in many, but not all, children and young people.

The 2015 SEND Code of Practice identifies four broad areas of need and support, however, many children and young people will have needs in more than one area, and the type and degree of need can fluctuate over time.

1. Communication and interaction
2. Cognition and learning
3. Social, emotional and mental health 4. Sensory and/or physical needs

What types of support are available to the SEND population?

There are two types of support available to children and young people with SEND who are considered to have additional needs.

SEN support: Where a young person is identified as having special educational needs, school should take action to remove barriers to learning and put effective special educational provision in place. This SEN support should take the form of a four-part cycle through which earlier decisions and actions are revisited, refined and revised with a growing understanding of the young person's needs and of what supports the young person in making good progress and securing good outcomes. This is known as the graduated approach. It draws on more detailed approaches, more frequent review and more specialist expertise in successive cycles in order to match interventions to the SEN of children and young people.

Where a child or young person continues to make less than expected progress, despite evidence based support and interventions that are

matched to the child or young person's area of need, the school should consider involving specialists, including those secured by the school itself or from outside agencies. Schools may involve specialists at any point to advise them on early identification of SEN and effective support and interventions. A school should always involve a specialist where a child or young person continues to make little or no progress or where they continue to work at levels substantially below those expected of children and young people of a similar age despite evidence-based SEN support.

The SENCO and class teacher, together with the specialists, and involving the child or young person's parents/carers, should consider a range of evidence-based and effective teaching approaches, appropriate equipment, strategies and interventions in order to support the child's progress. They should agree the outcomes to be achieved through the support, including a date by which progress will be reviewed.

All mainstream schools, including local academies, are provided with resources to support those with additional needs, including young people with SEN and disabilities. Schools have an amount identified within their overall budget, called the notional SEN budget. This is not a ring-fenced amount, and it is for the school to provide high quality appropriate support from the whole of its budget. This will enable schools to provide a clear description of the types of special educational provision they normally provide and will help parents and others to understand what they can normally expect the school to provide for children and young people with SEN.

EHC plan: An educational, health and care (EHC) plan is created following a formal assessment for children and young people who require specialist provision to be made in accordance with an EHC Plan. This is a legal document which specifies outcomes sought for the child or young person in line with them outlining the specialist provision which is required. EHC plans replaced 'Statements of SEN' in 2014 and most children have now been transferred over to EHC plans. (All young people in Tameside have transferred)

Tameside and Glossop provide a number of services to support children and young people with SEND. These services are commissioned and delivered by a large number of organisations. The Tameside Local Offer website provides an overview of available information, services and support for those aged 0 to 25 years, including in relation to:

- Information and support for families
- Children's Health service for young people aged 0-25 with
- Leisure activities
- School local offer
- Learning and employment
- Transition
- Professionals
- Social Care

Implications for the population's health and well-being

Issues relating to the SEND population are wide ranging and relate to the educational, health and care needs of the child or young person. Children and young people with SEND have worse educational outcomes and more complex health needs than their peers with no SEND

Children and young people with Special Educational Needs (SEN) may have learning difficulties or disabilities that make it harder for them to learn than most children and young people of the same age.

These children and young people may need extra or different help to others.

This could include

- **Communicating and interacting** - children and young people have speech, language and communications difficulties which make it difficult for them to make sense of language or to understand how to communicate effectively and appropriately with others.
- **Cognition and learning** – children and young people learn at a slower pace than others their age, have difficulty in understanding parts of the curriculum, have difficulties with organisation and memory skills, or have a specific difficulty affecting one particular part of their learning performance such as in literacy or numeracy.
- **Social, emotional and mental health difficulties** – children and young people have difficulty in managing their relationships with other people, are withdrawn, or they behave in ways that may hinder their and other children's learning or have an impact on their health and wellbeing.
- **Sensory and/or physical needs** – children and young people with visual and/or hearing impairments, or a physical need that means they must have additional ongoing support and equipment.
- Some children and young people may have SEN that covers more than one of these areas. The code of practice sets out a more individualised response to support children with special educational needs and disabilities

However not all children and young people with SEN have a learning disability. In 2018, 28% of children in England with a statement of SEN or an Education, Health and Care (EHC) plan had a primary SEN associated with learning disability. However, at the broader level of SEN support (previously School Action and School Action Plus), 87% of children had a primary SEN associated with learning disability?[1]

Many children and young people who have SEN may also have a disability. A disability is described in law (The Equality Act 2010) as 'a physical or mental impairment which has a long-term (a year or more) and substantial adverse effect on their ability to carry out normal day-to-day activities.' This includes, for example, sensory impairments such as those that affect sight and hearing, and long-term health conditions such as asthma, diabetes or epilepsy.[2]

Inequalities

Children and young people with a disability are more likely to live in poverty than those without a disability[3] and those with SEN are more likely to be eligible for free school meals than children and young people without SEN.[2]

Children with disabilities face a range of inequalities, including accessing services, health outcomes, and educational attainment.

Children with special educational needs and disabilities are a diverse group, who may require extra help or support across health, social services and education for highly complex needs, while others require much less support.

[1] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/children-research-and-statistics

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417435/Special_educational_needs_and_disabilites_guide_for_parents_and_carers.pdf

[3] Emerson, 2012; PHE 2015

Raising a child with a disability involves extra costs, with 33% of families facing extra costs of over £300 per month for their disabled child or £64,800 from birth to 18 years. Over half (56%) of families say that these extra costs are only partly covered by their disability benefits.[4]

Risk and Vulnerability

Risk factors are those that increase the chances of a child or young person experiencing poor outcomes. These can occur in various areas. They can be related to the child's own characteristics, such as their experience of a disability, or to the child's family, such as parents' occupational position, or parenting behaviours. A child's school experience can present risks for their educational or wellbeing outcomes, for example through their peer groups, the quality of their education or through their experience of bullying; and similarly, disadvantaged neighbourhoods or those without good access to community assets can result in poorer outcomes.

Children with special educational needs require greater support to reach their potential than children without SEND, not only because of the disabilities they have, but also because they are more likely to have other risk factors that are associated with poorer education outcomes – such as living in deprived circumstances.

Children with special educational needs and disabilities are at higher risk of harm than most children. Disabled children are at significantly greater risk of physical, sexual and emotional abuse and neglect than non-disabled children.[5]

Disabled children at greatest risk of abuse are those with behaviour/conduct disorders. Other high-risk groups include children with learning difficulties/disabilities, children with speech and language difficulties, children with health-related conditions and deaf children.[6]

Bullying is a feature in the lives of many disabled children.[7] Research indicates that disabled children are more likely to experience the negative aspects of social networking sites than non-disabled children. Disabled children (and severely disabled children even more so) may disclose less frequently and delay disclosure more often compared to typically developing children.[8]

Adverse childhood experiences (ACEs) which include neglect, bullying, abuse and other stressful or traumatic experiences can have a huge impact on children and young people throughout their lives.

Childhood adversity can create harmful levels of stress which impact healthy brain development.[9] This can result in long-term effects on learning, behaviour and health. Children and young people with SEND are at increased risk of experiencing ACEs compared to their non-SEND peers.

[4] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/children-research-and-statistics
[5] https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-report.pdf
[6] (Utting 1997; Sullivan and Knutson 2000; Kvam 2004; Spencer et al. 2005; Briggs 2006; Hershkowitz et al. 2007; Fisher et al. 2008
[7] (Marchant et al. 2007; Reid and Batten 2006; Mencap 2007
[8] https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-report.pdf
[9] https://www.gov.scot/publications/adverse-childhood-experiences/

Latest Local Data and Intelligence

How large is the SEND population in Tameside & Glossop

In 2019 there were 6,045 children and young people aged 0 to 25 years with SEND in Tameside. Of this number, 78% (4,701) are in receipt of SEN support and 22% (1344) have an EHC plan. (Table 1)

68% of the total SEND population is male. The majority of those with EHC plans are also male (74%); the highest proportion of those receiving SEN support are also male.

Table 1: Total size of SEND population (0 to 25 years) in Tameside according to SEND code and gender, *2019 (Tameside Council, school census and SEN2 data)*

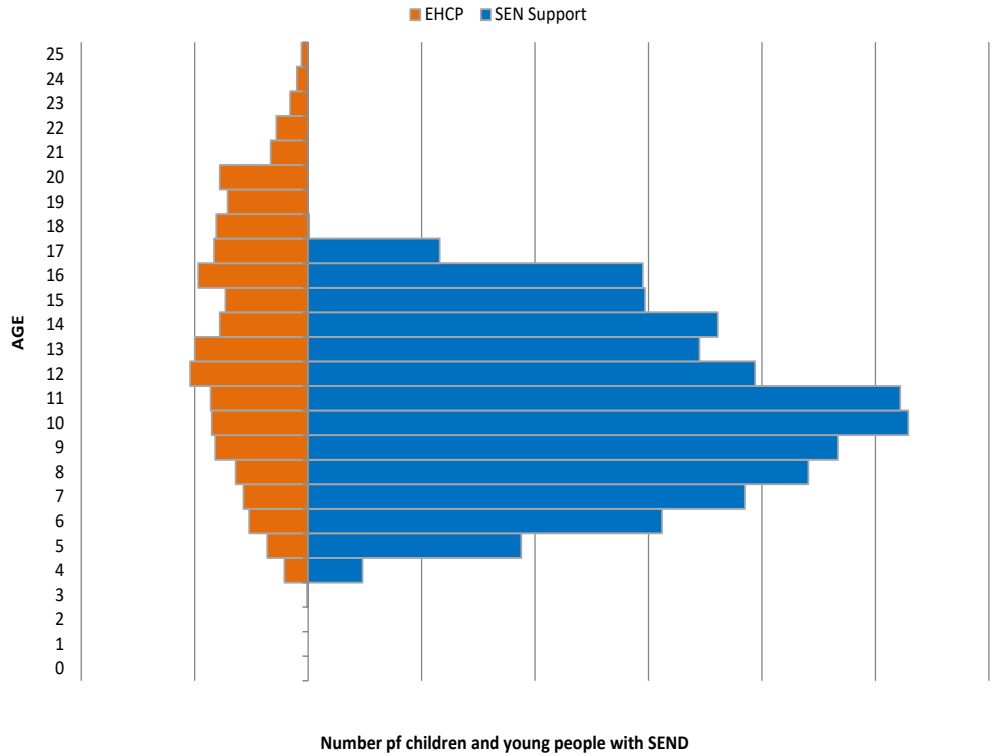
2019	males	Females	Total
ECH Plan	995 (74%)	349 (26%)	1344
SEN Support	3120 (66%)	1581 (34%)	4701
Total	4115	1930	6045

Across Glossop 635 children are SEND, 19% of the SEND population have an EHC plan and 81% have SEN support.

Table 2: Total SEND population (0-25 years) in Glossop 2019 (Derbyshire County Council school census data)

ECH plan	SEN Support
120 (19%)	515 (81%)

Chart 1: Age profile of SEND population in Tameside, 2019

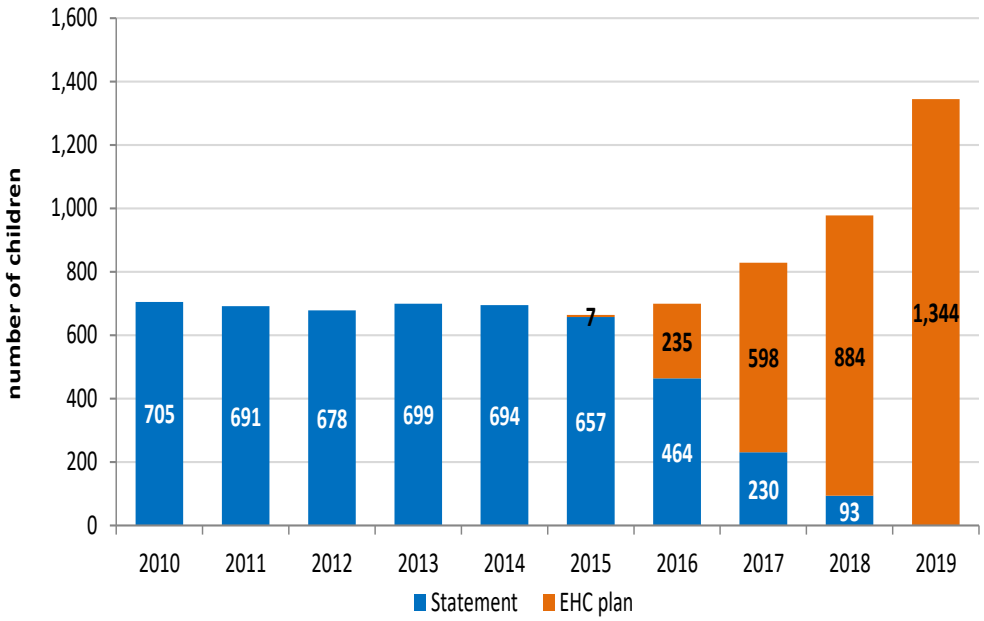


Source: Tameside council SEN2 data

Trends in the SEND population 0 to 25 years

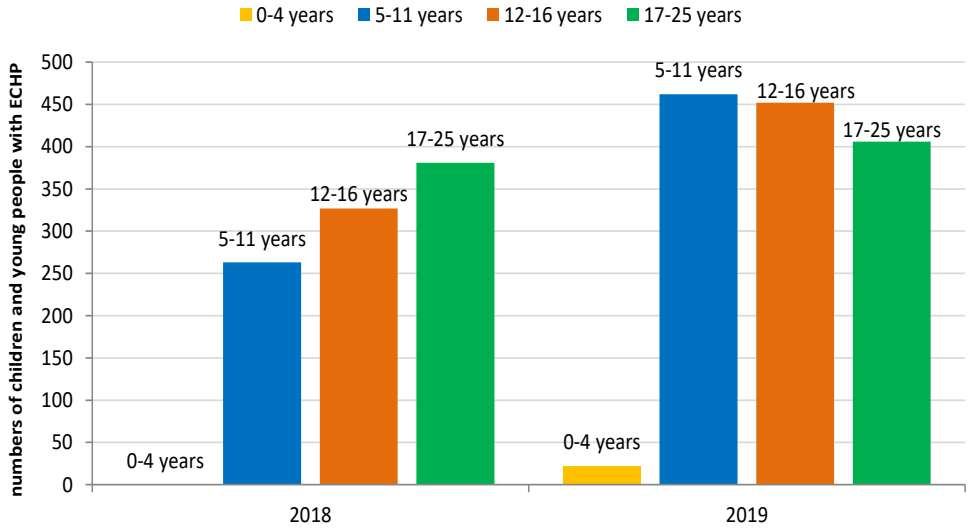
The numbers of school aged children and young people with either a Statement or the new EHC plan has fluctuated over the last ten years, but the numbers have increased year on year since 2016. Since 2010 to 2019 there has been a 57% increase in the number of children with a statement or EHC plan.

Chart 2: Children and young people with an EHC Plan or Statement in Tameside



Source: Department of Education and Tameside council school census data

Chart 3: Numbers of children and young people aged 0-25 with an EHC plan in Tameside by age band, 2018-2019 (Tameside Council, SEN2 data)



The chart above illustrates the breakdown of EHC plans by age bands across 2018 and 2019. It shows that numbers across all four age bands have increased between 2018 and 2019. The lowest EHC plans can be seen in the 0-4 year's age group.

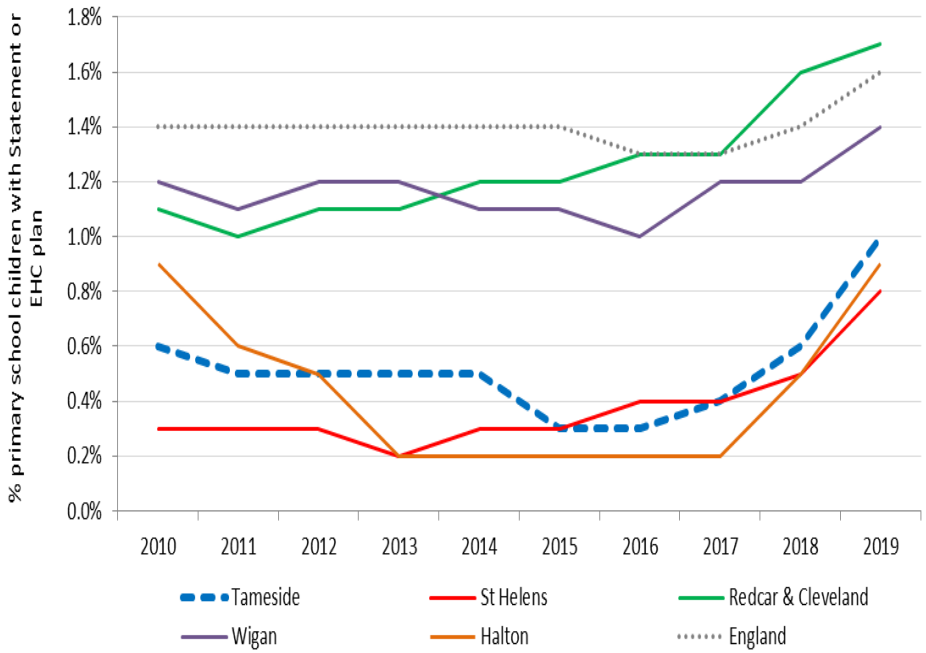
All early years and childcare providers have a responsibility to identify children with special educational needs (SEN) and make sure they put in place support as early as possible to help them learn and progress.

The Early Years Foundation Stage (EYFS) is the national framework for learning, development and care for children from birth to the end of Reception year. All registered early years and childcare providers (nurseries, pre-schools, and child minders) must follow this framework. The identification of SEN is built into the overall approach to monitoring the progress and development of all children.

Change in SEND Population Compared to Closest Statistical Neighbours

When we compare the proportion of school aged children with a statement or Educational Health Care Plan (EHCP) over a 10 year time frame, Tameside has significantly lower proportions than the England averages for both primary school and secondary school aged children and young people.

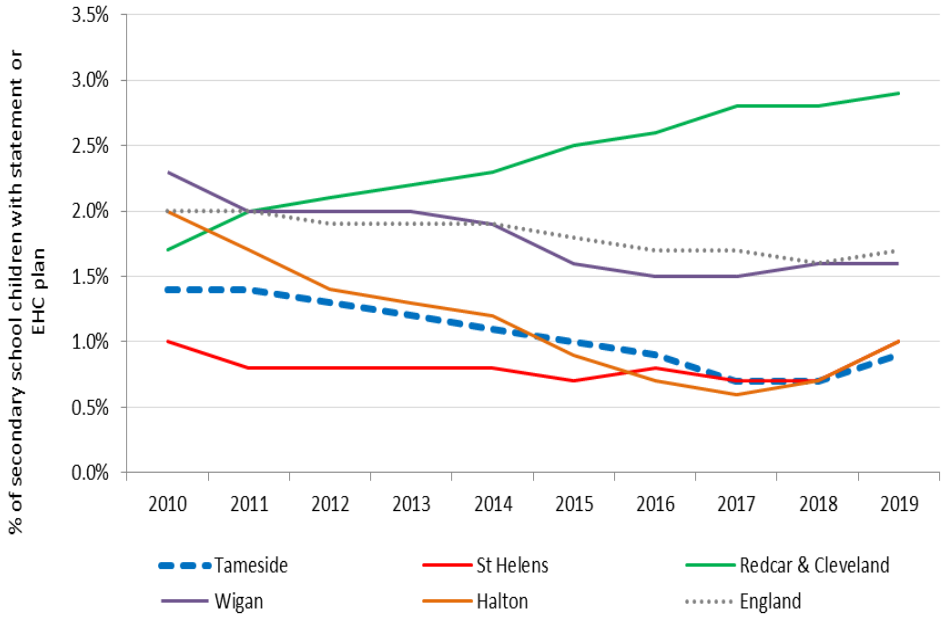
Chart 4: Trends in the proportion of Primary school children with a Statement or EHC plan for Tameside compared to closest statistical neighbours



Source: LAIT

The charts (chart 4 & 5) also illustrate that there are more children and young people with a statement or EHC plan in secondary school than in primary school. It is also worth noting that since 2016 Tameside and its closest statistical neighbours have seen an increase in the proportion of primary school children with an EHC plan.

Chart 5: Trends in the proportion of Secondary school children with a Statement or EHC plan for Tameside compared to closest statistical neighbours



The Primary Needs of Children and Young People with SEND in Tameside

Table 3: Primary Needs of the SEND population with an EHC plan across Tameside in 2018 and 2019

Primary Need	2018		2019	
	number	%	number	%
ASD= Autistic Spectrum Disorder	207	21.3%	259	19.3%
HI = Hearing Impairment	20	2.1%	20	1.5%
MLD = Moderate learning difficulties	314	32.3%	401	29.8%
MSI = Multi-Sensory Impairment	<5	<1%	<5	<1%
OTH = other	<5	<1%	7	0.5%
PD = Physical Disability	25	2.6%	34	2.5%
PMLD = Profound and Multiple Learning Difficulties	46	4.7%	52	3.9%
SEMH = Social, Emotional Mental Health need	122	12.6%	138	10.3%
SLCN = Speech, Language & Communication Needs	153	15.8%	275	20.5%
SLD = severe learning difficulties	21	2.2%	31	2.3%
SPLD = Specific Learning Difficulties	53	5.5%	117	8.7%
VI = visual impairment	<5	<5%	7	0.5%
Total with EHC plan	971		1344	

Source: Tameside council SEN2 data

Table 3 lists the SEND codes which are used as part of the SEND assessment process to classify the different needs relevant to this population. It lists the numbers and proportions of children with EHC plans in Tameside in 2018 and 2019 according to their primary type of need. This is based on data for the whole population (aged 0 to 25 years).

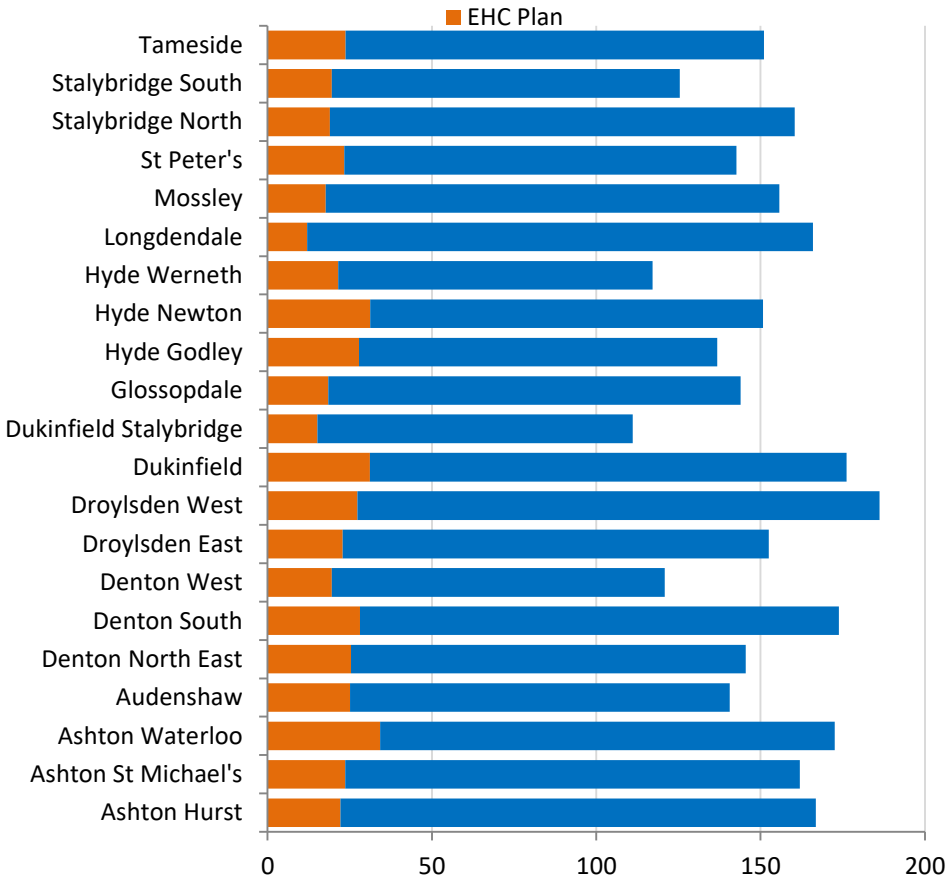
In 2019, the most common types of need were Moderate Learning Disability (MLD), which accounted for 30% of all EHC plan primary needs, followed by Speech Language and Communication needs (21%) third highest was Autistic Spectrum Disorder (ASD) (19%) and forth was Social, Emotional and Mental Health need (10%). These four primary needs account for 80% of all primary needs in children and young people with an EHC plan.

The least common primary needs were Multi Sensory impairment (0.2%), visual impairment (0.5%) and other (0.5%).

Sociodemographic profile of Children and young people with SEND

Tameside is made up of 19 wards and 158 LSOAs. The chart below illustrates the rate per 1000 school aged children who have A EHC plan or SEN support by ward.

Chart 6: Rate per 1000 school aged children with SEND by ward 2019



Source: Tameside Council census data

The chart illustrates that the wards of Droylsden West and Dukinfield have the highest rate of children and young people with SEND. (186.2 and 176.2 respectively) The lowest rate can be found in the ward of Dukinfield/Stalybridge (111.1). The wards with the highest rate of children and young people with SEN support in place in 2019 was Droylsden West, followed by Longdendale. The wards with the lowest rate of SEND support plans were Hyde Werneth and Dukinfield/Stalybridge.

The wards with the highest rate of EHC plans were Ashton Waterloo and Hyde Newton, the lowest rate was found in the ward of Longdendale.

Map 1 illustrates the distribution of all 0 to 25 years old children and young people with SEND in 2019.

The darker the area the higher the population of SEND (146.5 to 197.2 per 1,000 0-25 population)

The map is also split into four neighbourhoods North, South, East and West. The following key identifies the geographic wards each neighbourhood represents,

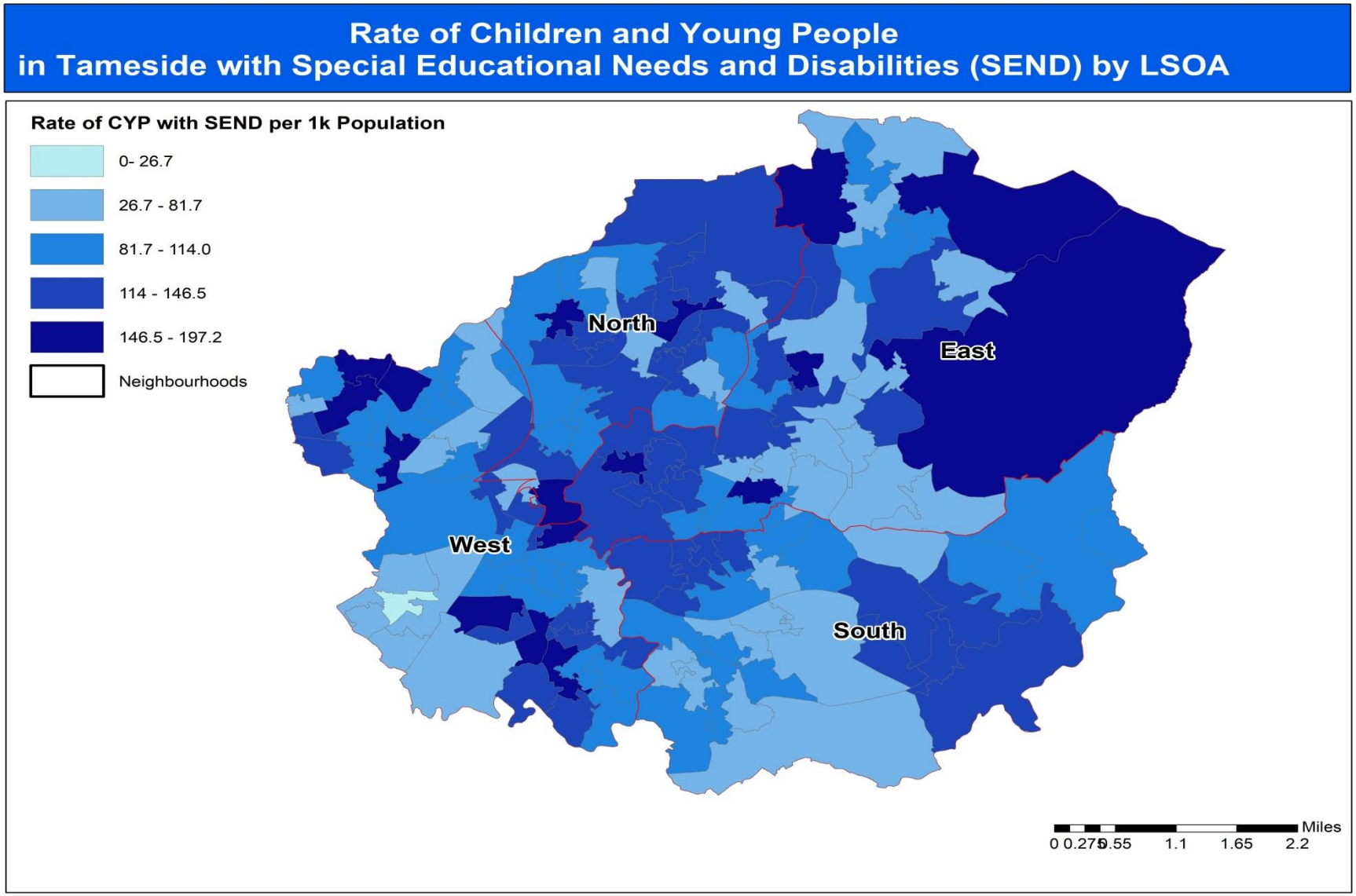
North: Ashton St. Peters, Ashton St. Michaels, Ashton Hurst and Ashton Waterloo

South: Hyde Newton, Hyde Godley, Hyde Werneth and Longdendale

East: Mossley, Dukinfield, Dukinfield/Stalybridge, Stalybridge North, Stalybridge South

West: Audenshaw, Denton North East, Denton West, Denton South, Droylsden East and Droylsden West

Map 1: Where our children and young people with SEND live

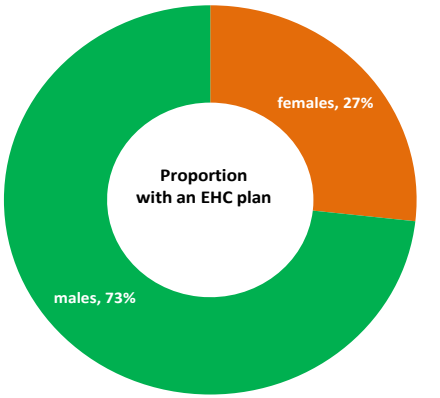


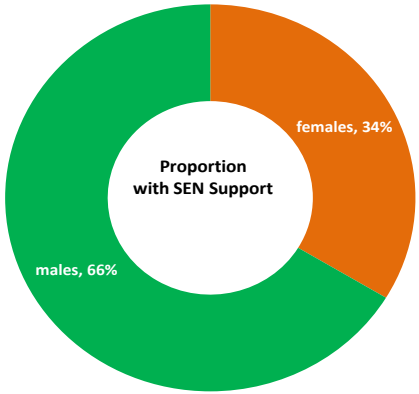
In 2019 there were 226 children and young people who live in Tameside but were educated outside of Tameside and 62 children who live outside of Tameside educated in Tameside with an EHC plan in place

Gender

The proportion of children and young people with an EHC plan and SEN support is higher in males than females, with males making up 68% of all SEND in Tameside Schools

Chart 7: Proportion of EHC plan and SEN Support by Gender



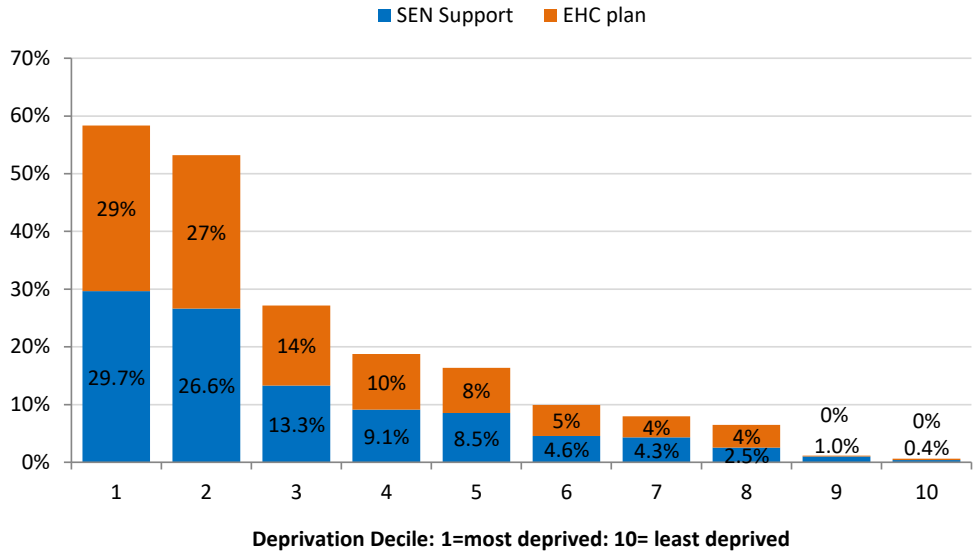


Source: Tameside council school census and SEN2 data

Deprivation

The chart below illustrates the proportion of SEN Support and EHC plans by deprivation decile.

Chart 8: SEND by Deprivation Decile 2019



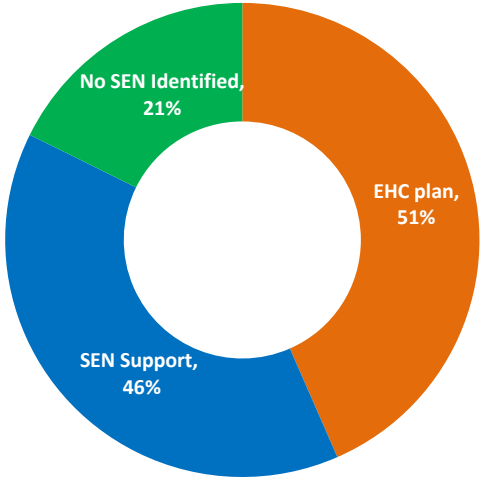
Source: Tameside council census data and Ministry of Housing, Communities & Local Government

The chart clearly illustrates that children and young people with SEND are highest in deprivation deciles 1 and 2 (most deprived) and the lowest proportions are in the least deprived communities.

Free School Meals

The chart below illustrates the proportion of school aged children who took up free school meals in 2019.

Chart 9: Free School meal take up by SEND provision



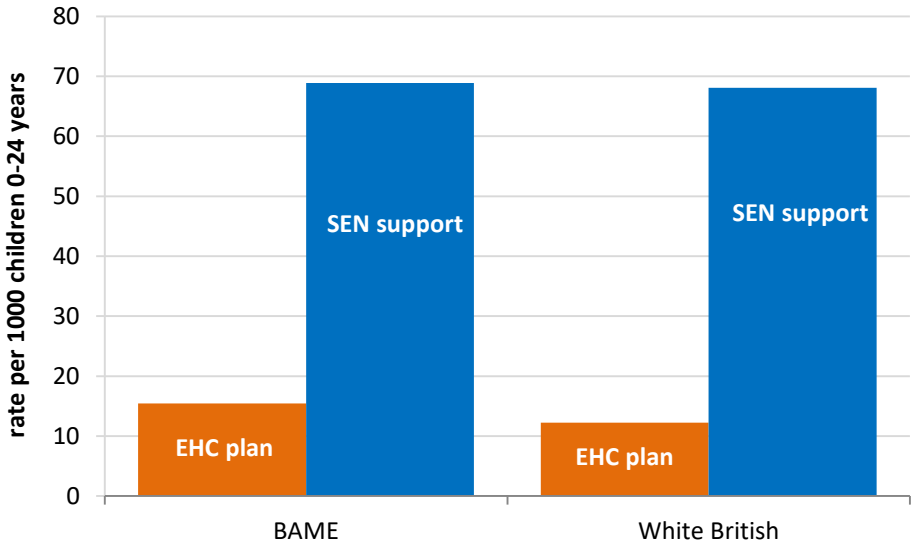
The chart clearly shows that children with SEND have higher proportions of children and young people on free school meals when compared to children with no SEN identified. The proportion of children on free school meals was highest in those with an EHC plan.

Ethnicity

When looking at the SEND population by ethnicity, the numbers show that 4542 children and young people with SEND come from a British white background with 977 being from a British Asian and Minority Ethnic background (BAME) (82% v18% respectively)

However when you compare the actual numbers to the resident population of Tameside the results for SEND change.

Chart 10: Rate of SEND per 1000 population by ethnicity



Source: Tameside council school census data and ONS population estimates

The chart above clearly illustrates that the rates of SEN support in BAME children and young people are slightly higher than in the British white population and 21% higher for EHC plans.

The primary needs of Children by ethnicity show that primary needs vary across ethnicity and gender. White British boys have the highest level of primary need for specific learning difficulty and severe learning disability. Boys from BAME groups have the highest proportion of primary need for visual impairment.

Table 4: Primary need by gender and ethnicity for children and young people with an EHC plan in place in 2019

Primary Need	BAME		White British	
	Girls	Boys	Girls	Boys
ASD= Autistic Spectrum Disorder	3%	29%	9%	60%
HI = Hearing Impairment	14%	14%	21%	50%
MLD = Moderate learning difficulties	4%	8%	33%	55%
MSI = Multi-Sensory Impairment	29%	29%	0%	43%
OTH = other	0%	20%	30%	50%
PD = Physical Disability	7%	14%	33%	47%
PMLD = Profound and Multiple Learning Difficulties	4%	16%	38%	42%
SEMH = Social, Emotional Mental Health need	4%	11%	12%	73%
SLCN = Speech, Language & Communication Needs	12%	18%	23%	47%
SLD = severe learning difficulties	0%	5%	34%	61%
SPLD = Specific Learning Difficulties	3%	3%	16%	78%
VI = visual impairment	22%	75%	1%	2%

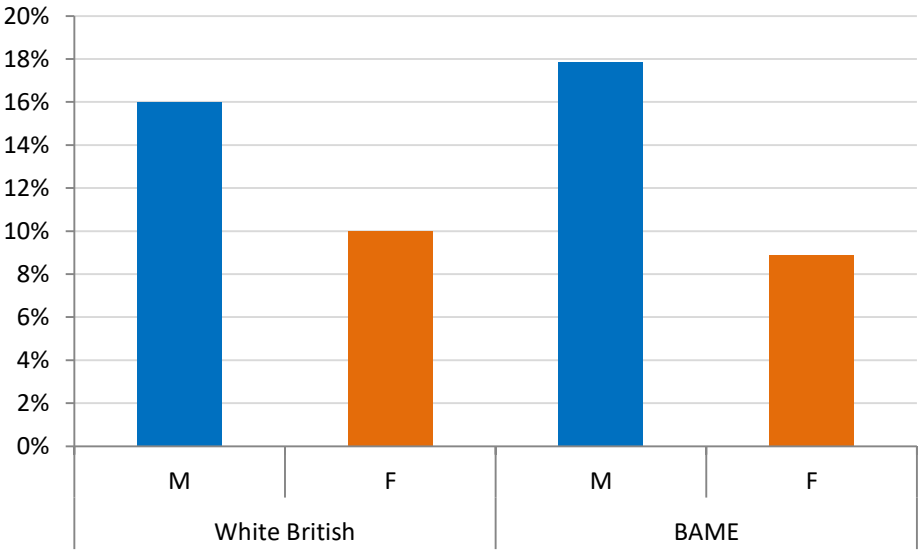
Source: Tameside council census data 2019

The table above (table 4) illustrates the proportion of primary need by ethnicity. For example of the 259 children and young people with a primary need of Autism Spectrum Disorder (ASD), 60% of this group are white British boys.

White British girls have higher levels of profound and severe learning disabilities. Girls from BAME groups have higher levels multi-sensory impairment and visual impairment.

For Children and Young people with SEN support, the largest need in both the white British and BAME populations is Moderate Learning disability. Moderate Learning Disabilities account for 26% of overall need of the SEN support population.

Chart 11: Proportion of children and young people with Moderate Learning Disability with SEN Support 2019



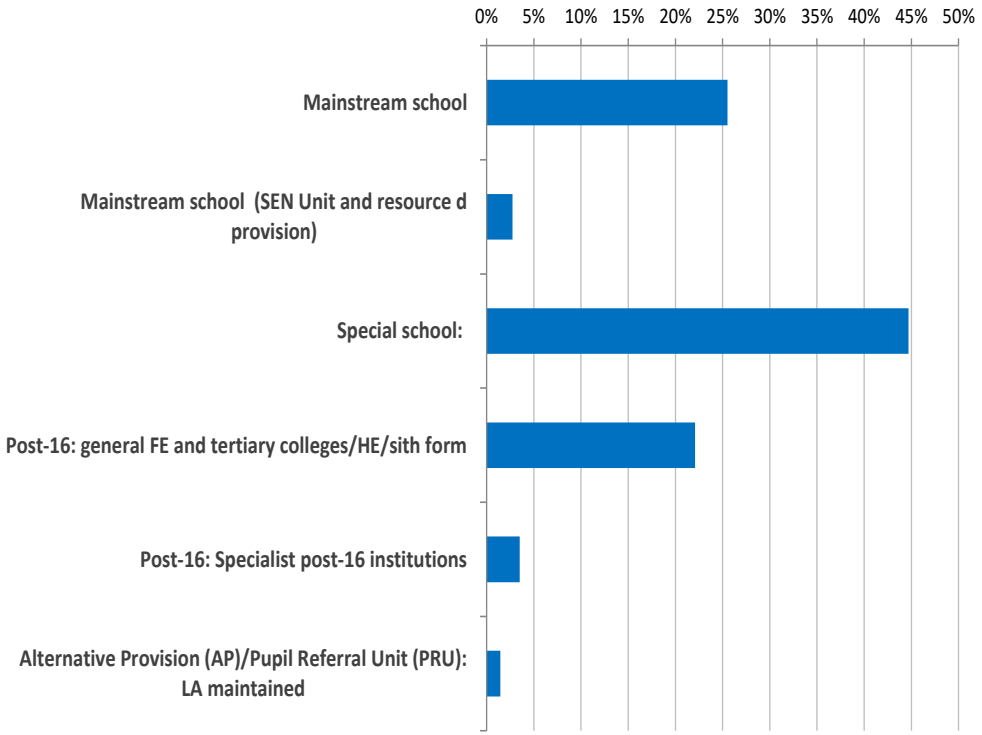
Source: Tameside council census data 2019

The second highest need for children and young people from a BAME background is speech and language (17.3% (M) and 8.7% (F)). For white British children and young people the second highest need is Social, Emotional and Mental health (15.4% (M) and 5.7%) (F)).

Education provision and outcomes for the SEND population

Children and young people with SEND are educated in a variety of settings. The chart below illustrates this and shows that the highest proportion of children and young people were educated in LA maintained special schools.

Chart 12: Where SEND children and young people were educated 2019 (EHCP)

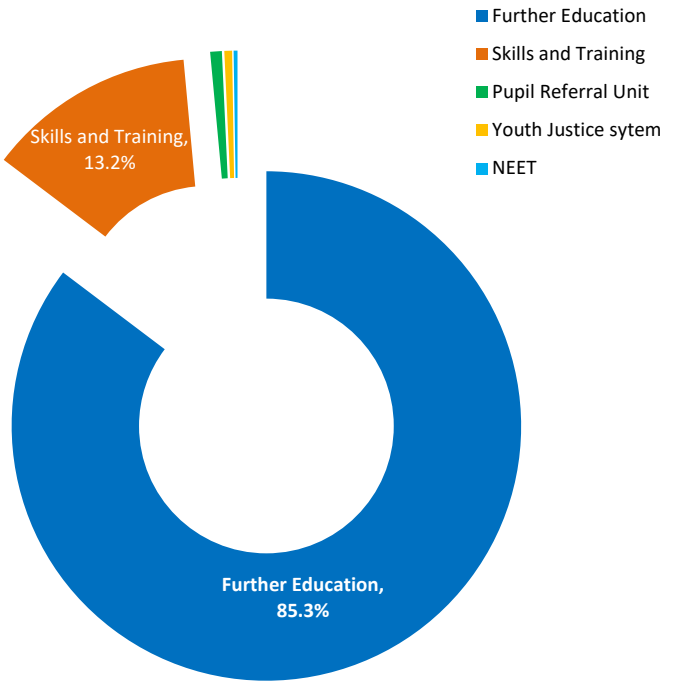


Source: SEN2 2019 Department of Education

There were a small number of children with a EHC plan educated in early year's settings who were under 5 years (1.6%). 0.5% of school aged children were educated at home.

For young people aged 17 to 25 years with an EHC plan, 85% stayed in further education, 13% were in training, 1% were in Pupil Referral Units, 0.5% were within the youth justice system and 0.3% were NEET (Not in Education or Training).

Chart 13: Post 16 provision for young people with EHC plans 2019



SEND provision compared to our Nearest Statistical neighbours and England

Table 5 compares the proportion of the SEND school-age cohort being educated in different educational settings in Tameside with other areas.

Table 5: Proportion of Children with EHC plans receiving SEND provision

Proportion of children and young people with EHC plans receiving provision 2019 in:	England	Tameside	St Helens	Redcar & Cleveland	Halton	Wigan
Mainstream school	36%	26%	26%	37%	22%	41%
Mainstream school (SEN Unit and resource d provision)	5%	3%	4%	5%	5%	1%
Special school:	41%	45%	51%	40%	57%	43%
Post-16: general FE and tertiary colleges/HE/sith form	16%	22%	14%	18%	15%	11%
Post-16: Specialist post-16 institutions	1%	4%	2%	0%	0%	3%
Alternative Provision (AP)/Pupil Referral Unit (PRU): LA	1%	1%	3%	0%	0%	0%

Source: Department for Education

26% of children and young people with SEND in Tameside are educated in mainstream schools. This is lower than the England average and the second lowest when compared to our nearest statistical neighbours. The highest proportion of children and young people with EHC plans are educated in special schools in Tameside (45%), this is higher than the England average but lower than some of our nearest statistical neighbours. Tameside has the highest proportion of post 16 young people with EHC plans in general further education provision, such as sixth forms and colleges.

School Absence and Exclusions[10]

Every school has a behaviour policy, which lists the rules of conduct for children and young people before and after school as well as during the school day.

Only the head teacher[11] of a school can exclude a child or young person and this must be on disciplinary grounds. A child or young person may be excluded for one or more fixed periods (up to a maximum of 45 school days in a single academic year), or permanently. A fixed-period exclusion does not have to be for a continuous period.

In 2019 a total of 1,329 school aged children were excluded from school on a fixed term an increase on 2018 by approximately 1%.

Table 5 illustrates the proportion of fixed and permanent exclusions. It shows that for 2019 34% of all children and young people who were given fixed term exclusion were SEND and of the permanent exclusions 30% were SEND.

[10] 2018/19 exclusions data is provisional and subject to change

[11] (Pupil Exclusions and Reviews) (England) Regulations 2012.

Table 6: Fixed and permanent exclusions for 2018 and 2019 in Tameside[12]

Exclusion Type	Total number of children and young people excluded		Proportion that were SEND		Proportion of SEND that had SEN Support		Proportion of SEND that had an EHC plan	
year	2018	2019	2018	2019	2018	2019	2018	2019
Fixed	1319	1329	35%	34%	89%	83%	11%	17%
Permanent	97	64	39%	30%	100%	95%	0%	<10%

When investigating average number of exclusions each child or young person received in year and the number of sessions distributed each time. Table 7 shows that school aged children and young people with an EHC plan had on average three exclusion periods in the year with non-SEND children and young people having the lowest average number of exclusions. Those with EHC plans also had the highest average sessions they were excluded for, 11.8 sessions compared to 7.1 sessions in non-SEND children and young people

Table 7: Number of and length of fixed term exclusions 2019

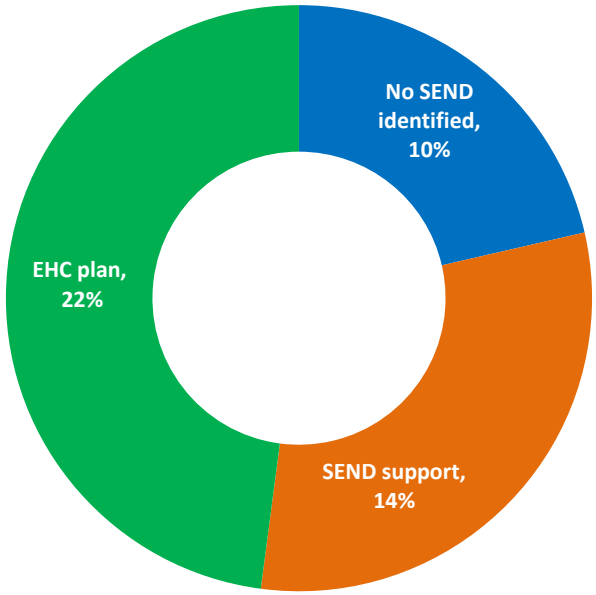
Fixed term exclusions	No SEND identified	SEND support	EHC plan
Average number of times given a fixed term exclusion	2	2.6	3
Maximum number of fixed term exclusions	20	16	12
Sum of average sessions excluded	7.1	10.6	11.8
Sum of maximum sessions excluded	78	80	80

2 sessions = 1 day

Source: Tameside council education data 2019

Children and young people with SEND are more likely to be excluded more times and for longer than those with no SEND. The proportion of children and young people excluded for five times or more in year was more than twice as high for children with an EHC plan than those with no identified SEND.

Chart 14: Proportion of children and young people exclude five or more time in year (2019)



Source: Tameside council education data 2019

Exclusion Reasons

There are many reasons why children and young people with or without SEND get excluded from school. Chart 14 illustrates this. For children with SEND support the highest proportion of fixed term exclusions was for persistent disruptive behaviour (29%), for those with an EHC plan the highest proportion of fixed term exclusions was for physical assault against an adult (36%).

For those children and young people permanently excluded the main reason for those with SEND support was persistent disruptive behaviour (47%)

Chart 15: Reason for Exclusions 2019 in Tameside

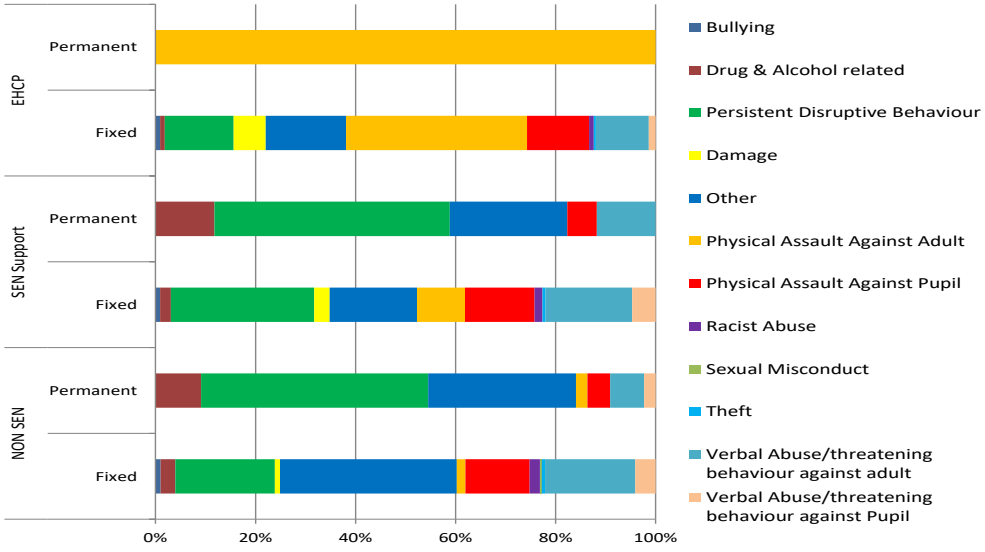
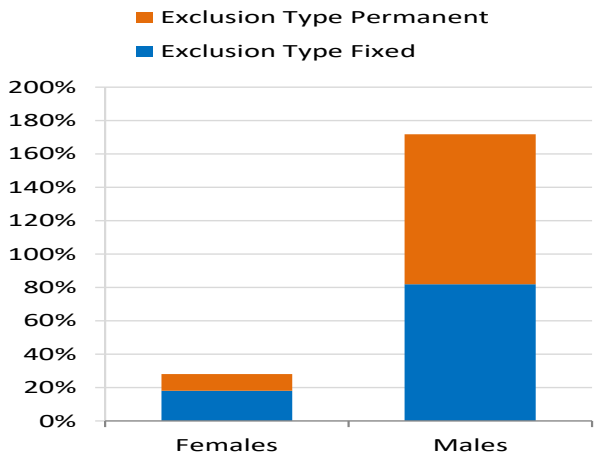


Chart 16 illustrates exclusions by gender; it shows that boys are more like to be excluded than girls. Boys with special educational needs are five time more likely to be fixed term excluded than girls and nine times more likely to be permanently excluded.

Chart 16: Exclusions by gender



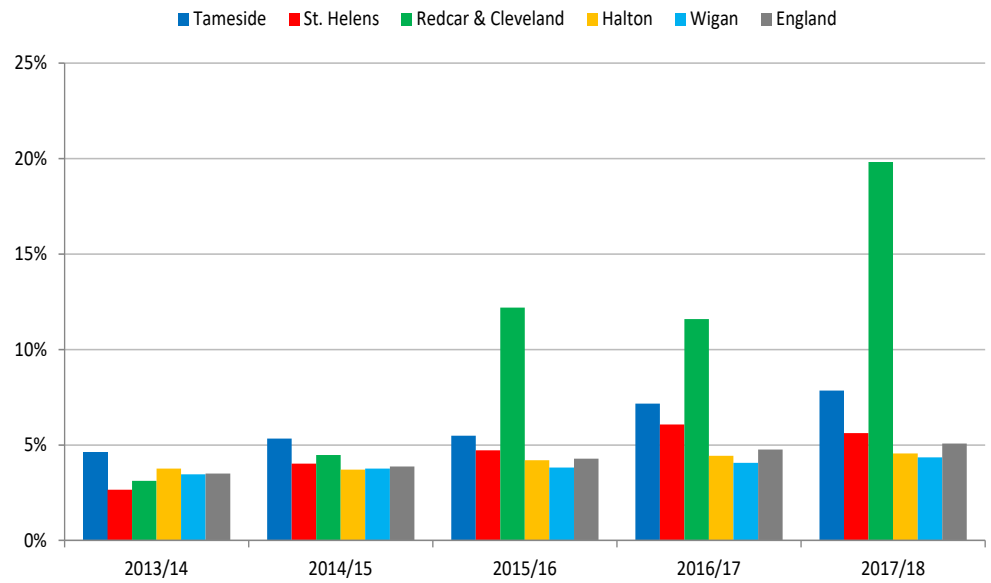
Source: Tameside council education data

SEND fixed term exclusions compared to England and nearest statistical neighbours

There is no available data on local authority exclusions for children and young people with special educational needs, so the comparison of fixed term exclusions is for all children with and without SEND. When comparing Tameside to England and our closest statistical neighbours, a clear rise in the number of fixed term exclusions being issued can be seen since 2013/14. Local data also supports this rise among children and young people with SEND.

Across our statistical neighbours and compared to England, Tameside had the second highest level of fixed term exclusions for all children and young people across all years since 2013/14. Permanent exclusions follow a similar pattern with Tameside having higher levels of permanent exclusions when compared to England and our closest statistical neighbours.

Chart 17: Fixed term exclusions over time



Source: Department for Education

School Absence

Looking at overall school absence, 2017/18 data shows that the proportion of sessions missed across the school term is higher in children with SEND.

Table 8, shows that children and young people with an EHC plan have an overall absence rate that is nearly twice as high as children and young people with no SEND

Table 8: Levels of absence 2017/18

2017/18	
% overall absence for SEN support pupils	**6.5**
% overall absence for Non- SEN support pupils	**4.8**
% overall absence for SEN pupils with an EHCP	**8.0**
Number of Children who are persistent absentees (below 90% attendance) - SEN Support	**16**
Number of Children who are persistent absentees (below 90% attendance) - EHCP	**21**

Source: Department for Education

Wider evidence suggests that exclusions and absence levels for children and young people with special educational needs and disability are disproportionately higher than their peers.

It is the most vulnerable children who are likely to be excluded. 1 in 2 has a recognised mental health need. They are four times more likely to be from the poorest families, three times more likely to be interacting with social services and ten times more likely to have a mental health problem.[13]

[13] https://www.ippr.org/news-and-media/press-releases/new-programme-to-reduce-exclusions-in-england-and-make-the-difference-for-vulnerable-students

Educational Outcomes for Children and Young People with SEND

The impact of SEND on academic attainment is closely related to the EEF's[14] focus on economic disadvantage: 27% of children and young people with special educational needs are eligible for free school meals compared to 12% of children and young people without special educational needs. Children and young people who are both eligible for FSM and identified as having SEND have much lower average attainment than other groups of students.[15]

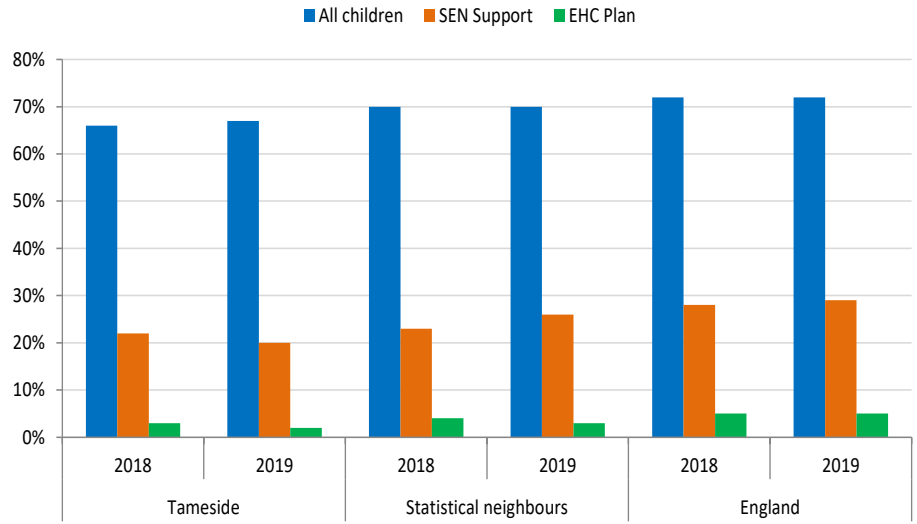
Early Years Foundation Stage and Key Stage 2 outcomes for children with SEND needs

The national curriculum is organised into blocks of years called 'key stages' (KS). At the end of each key stage, children and young people will formally be assessed.

The first key assessment stage is the 'Early Years Foundation Stage' or school readiness. School readiness for children across Tameside as of 2019 was 67%, this is a slight increase from 2018 but still lower than the England and statistical neighbour averages.

For children with SEN support 20% of children were ready for school and for children with an EHCP 2% were ready for school in 2019. This is again lower than our statistical neighbours and England.

Chart 18: Early Years Foundation Stage 'School Readiness' 2018 and 2019



Source: LAIT

Key stage 2 is an assessment stage completed at ages 7 to 11 years. It includes assessment around English reading, English grammar, punctuation and spelling and maths.

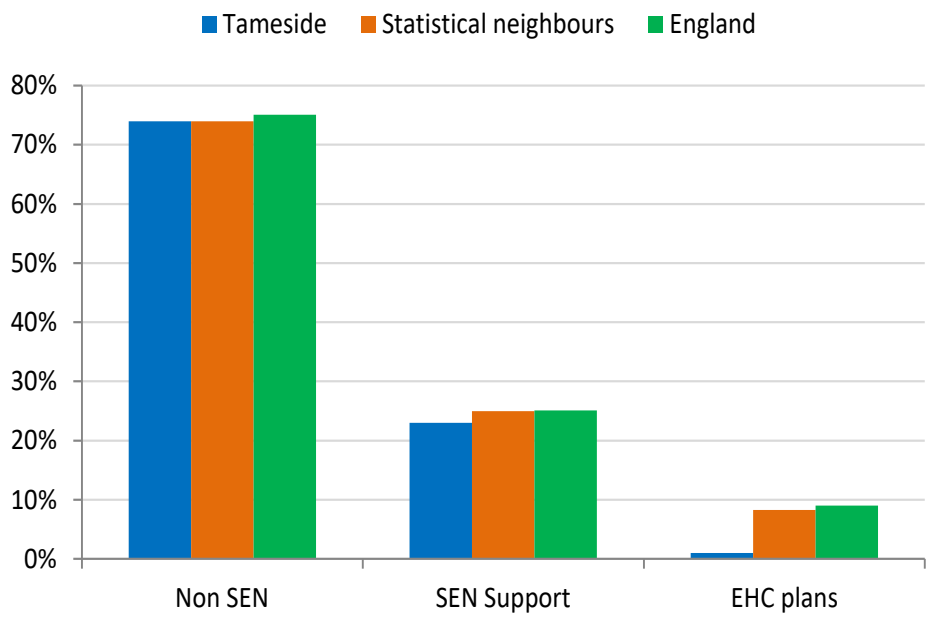
Comparing outcomes at key stage 2 for children with SEND, chart 18 clearly illustrates the disparity in outcomes between children with SEND and children with no identified SEN need.

In Tameside only 1% of children at key stage two with an EHC plan achieved the expected standards in reading, writing and maths. This is significantly lower than our statistical neighbours and England. For Children with SEN support 23% achieved the expected standard, similar to both our statistical neighbours and England averages.

[14] Education Endowment Foundation

[15] https://educationendowmentfoundation.org.uk/projects-and-evaluation/how-to-apply/themed-rounds/improving-outcomes-for-pupils-with-send/

Chart 19: Children and young people achieving the expected standards in reading, writing and maths 2019

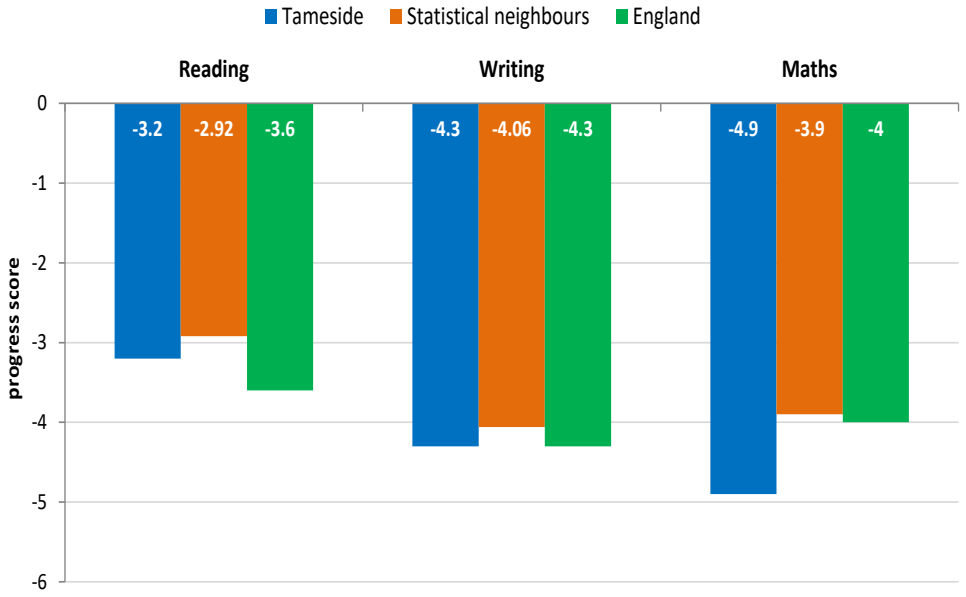


Source: LAIT

KS2 Progress scores compare Childrens' KS2 results to those of other children nationally with similar prior attainment. Positive scores indicate performance is above-average; negative scores indicate below average performance.

Chart 20 compares KS2 Progress scores for SEN children in Tameside with those in other areas. These show that, although all progress scores are negative, performance in Tameside is worse than our statistical neighbours for reading and maths, but similar to for writing.

Chart 20: Progress scores for Key Stage 2 children and young people with SEN 2019



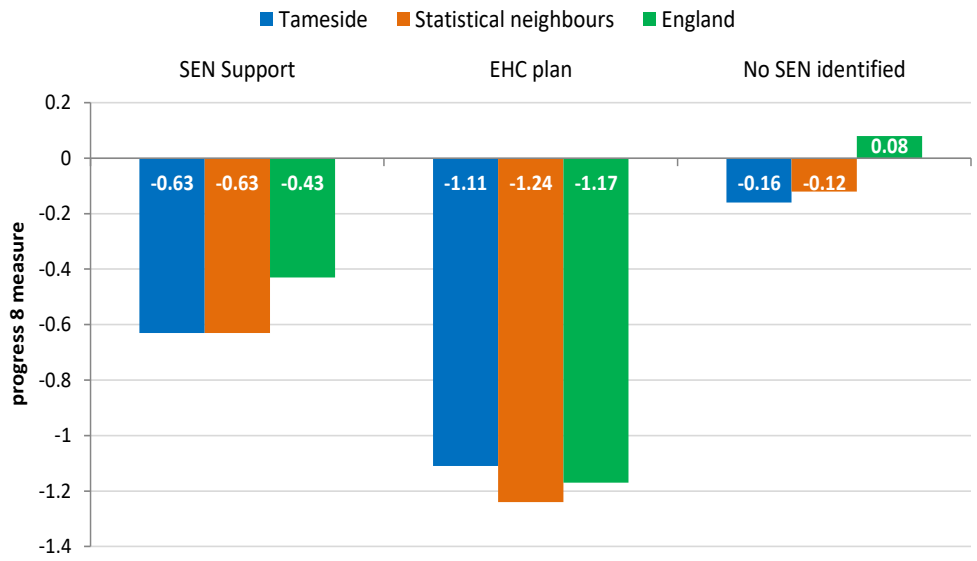
Source LAIT

Progress 8 outcomes for young people with SEND needs

Progress 8 is a measure of the progress which children make between the end of primary and the end of secondary school, based on performance in 8 qualifications. A score of 0 indicates that, at the end of secondary school, students are performing in line with those who reached a similar level of attainment at the end of primary school.

Chart 21 shows that, in Tameside, negative scores are seen for both the group with EHC plans (-1.11) and those receiving SEN support (-0.63). This compares to an average score of -0.16 for those with no identified SEND. However for young people with EHC plans, Tameside performs better than both or statistical neighbours and England.

Chart 21: Progress 8 scores for young people 2019



Source: LAIT

For children and young people with SEN support, Tameside performs similar to our statistical neighbours but is worse than the England average. For children and young people with no SEND identified, Tameside performs worse than both our statistical neighbours and the England averages.

Trends over time show that since 2016 average Progress 8 scores for key stage four young people with SEN support and ECH plans has decreased year on year, with 2019 achievement being the lowest over the four years.[16]

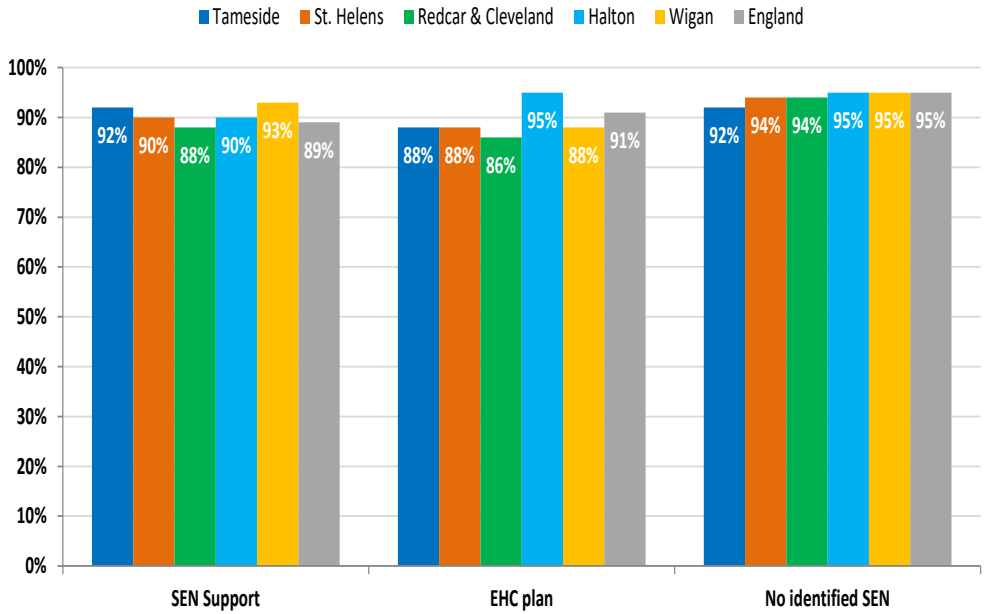
This is a worrying trend has it also indicates an increasing gap between children with a SEND need and those without.

Further education and employment outcomes for young people with SEND

The law requires all young people in England to continue in education or training until at least their 18th birthday and Local authorities have broad duties to encourage, enable and assist young people to participate in education or training.

Improving education attainment and raising employment rates among disadvantaged groups are key targets for the current government.[17]

Chart 22: Proportion of young people going to or remaining in education, training or employment (2018)



Source: LAIT

[16] https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

[17] https://www.jrf.org.uk/report/education-and-employment-disabled-young-people

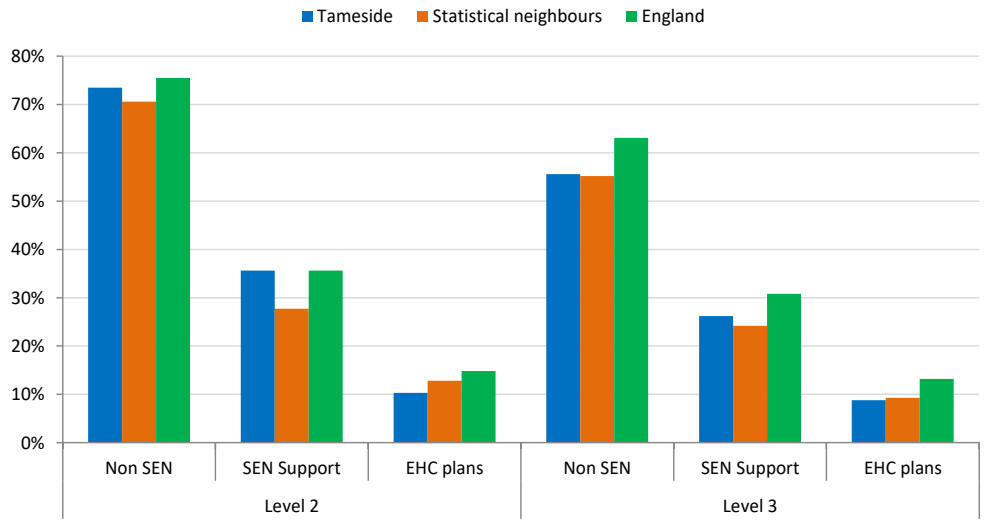
Chart 22 illustrates that in 2018, 92% of young people with SEN support and 88% of young people with EHC plans were in education, training or employment after leaving school in year 11.

Compared to our nearest statistical neighbours and England. Tameside has the second highest level for young people with SEN support remaining in education, training or employment and similar outcomes to our statistical neighbours for young people with an EHCP. Although EHC plan outcomes are lower than the England average.

Overall 12% of young people with an EHC plan and 8% with SEN support were not in education, employment of training (NEET).

The transition from secondary school to further education or employment can be challenging for many young people with SEND and their parents/carers. The recent move towards having a standard 0 to 25 year offer is intended to help address some of these challenges allowing young people to transition more smoothly with support for longer.

Chart 23: Proportion of 19 Year Olds Qualified to Level 2 and 3 (2018)



Good qualifications and skills will increase earnings and directly links higher qualification/skill levels to higher productivity and hence a greater probability of employment and higher earnings and income, and a lower risk of poverty.[18]

Children and young people from a disadvantaged background are less likely to get good GCSEs and go on to higher education. The effects of this slow start can last a lifetime, widening social inequality. Children and young people with SEND might face significantly greater challenges in learning than the majority of their peers, or have a disability which hinders their access to the teaching and facilities typically found in mainstream educational settings

Chart 23 illustrates the disparity between young people with SEND and their peers when it comes to qualification attainment at age 19 years. Young people receiving SEN support are 50% less likely to gain level 2 qualifications and young people with an EHC plan 90% less likely to gain level 2 qualifications. For level 3 qualifications the gap is similar.

Many young people with SEND come from disadvantaged backgrounds; with the addition of low attainment levels this puts these young people in particular at further risk to poor future prospects. There is a very large attainment gap between young people with SEND and their peers that needs to be addressed.

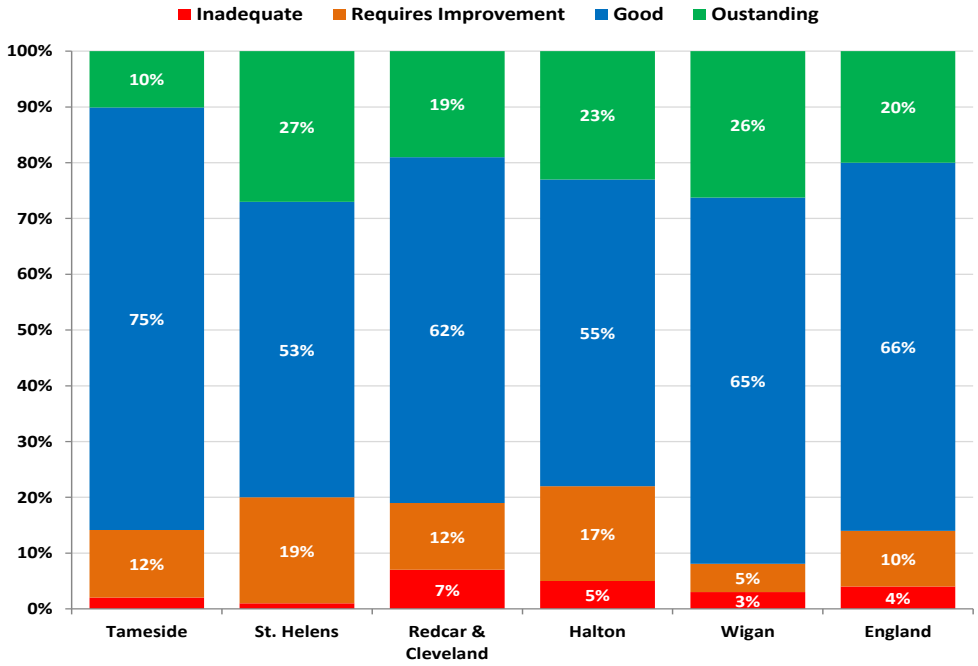
Quality of Education

The **OfSTED** framework 2019 is interested in the rounded quality of education. This would enable schools to capture the whole range of their provision. The education inspection framework sets out the principles that apply to inspection, and the main judgements that inspectors make when carrying out inspections of maintained schools, academies, non-association

[18] https://www.jrf.org.uk/report/skills-employment-income-inequality-and-poverty

independent schools, further education and skills providers and registered early years settings in England.[19]

Chart 24: Proportions of All Schools Rated Inadequate to Outstanding by Ofsted (31st August 2019)



Source: OfSTED 2019

Chart 24 illustrates the inspection results across all schools in Tameside. It shows that 75% of schools are rated 'GOOD', this is higher than all our statistical neighbours and England.

Tameside has the least proportion of schools that are outstanding than the England average and has the lowest proportion compared to our statistical neighbours.

The schools that were rated inadequate or needs improvement at their last inspection had similar outcomes for their students, for example

- Progress of children and young people was below expectations, in particular for disadvantaged children and children with SEND
- Weak leadership
- Poor attendance rates
- Poor preparation of students attainment progress
- Children and young people not engaged in their learning
- Curriculum not meeting the needs of students
- Inconsistencies in teaching quality

The schools that were rated outstanding at their last inspection had common themes across their reports, for example

- Strong leadership
- Students well supported
- Attainment and progress in key subject areas is high
- Very effective teaching
- Detailed policies for example, behaviour policies
- Very safe place for students and staff
- Achievement of student outstanding
- School provides very well for those with additional needs
- Low exclusions and absence
- School has a positive atmosphere

[19] https://www.gov.uk/government/publications/education-inspection-framework

Health and Wellbeing of Children and Young people aged 0-25 years

Health and wellbeing outcomes for children and young people in Tameside and Glossop are generally worse than the England average. This section of the JSNA will explore this in more detail and will look at the main health and wellbeing outcomes for our children and young people.

It is currently not possible to link educational and health records of SEND children and young people and so the health data presented here is for the entire 0 to 25 population in Tameside & Glossop.

There were 67,635 children and young people aged 0-25 years registered with a GP in Tameside & Glossop in January 2020. 88% were registered with a Tameside GP and 12% registered with a Glossop GP.

Table 9: 0-25 years registered population by neighbourhood

Health Neighbourhoods		Total population	Male	Females
East neighbourhood	Stalybridge, Dukinfield & Mossley	10,890	5,602	5,288
Glossop neighbourhood	Glossop	8,192	4,144	4,048
North neighbourhood	Ashton	16,475	8,455	8,020
South neighbourhood	Hyde & Longdendale	18,377	9,215	9,162
West neighbourhood	Audenshaw, Denton & Droylsden	13,701	6,865	6,836
Tameside & Glossop		67,635	34,281	33,354

Source: GP lists, NHS Digital

The 0-25 year's age group make up around 30% of the total registered population. They account for approximately

- 32% of all A&E attendances
- 19% of all urgent care admissions
- 6% of planned care admissions

Children and young people growing up in Tameside & Glossop today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

However there is still room for improvement as children and young people in Tameside & Glossop have some of the worst health outcomes compared to other areas and England.

For example:

- Under 18 conception rates are significantly higher than the England average
- More babies here have a low birth weight than the England average
- Very low levels of breast feeding compared to England
- Only 44% of children and young people are physically active
- Nearly a quarter or reception aged children and more than a third of year 6 children are overweight or obese

Chart 25: Extract of Child Health profile 2019 (PHE fingertips)

* a note is attached to the value, hover over to see more details

Compared with benchmark: Better | Similar | Worse | Not compared

Recent trends: Could not be calculated | Increasing / Getting worse | Increasing / Getting better | Decreasing / Getting worse | Decreasing / Getting better | No significant change | Increasing | Decreasing

Indicator	Period	England	CA-Greater Manchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Hospital admissions for asthma (under 19 years) (Persons, 0-18 yrs) New data	2018/19	178.4	311.9	232.0	320.4	485.9	432.6	344.0	227.6	256.2	351.4	195.6	145.9
Admissions for epilepsy for children and young people aged under 19 years (Persons, 0-18 yrs)	2016/17	72.1	74.2*	85.3	57.7	75.7	97.0	77.5	52.1	82.3	98.2	41.5	68.5
Admissions for diabetes for children and young people aged under 19 years (Persons, 0-18 yrs)	2016/17	55.1	59.0*	71.1	62.1	55.2	63.0	55.3	43.4	62.5	90.5	29.4	61.5
Percentage with a long-term illness, disability or medical condition diagnosed by a doctor at age 15 (Persons, 15 yrs)	2014/15	14.1	-	15.2	13.9	16.5	13.7	13.5	14.4	12.6	11.8	14.2	15.0
Year 6: Prevalence of overweight (including obesity) (Persons, 10-yrs)	2018/19	34.3	36.5	35.1	34.4	41.0	37.4	38.1	37.6	31.4	35.8	31.6	37.2

Primary Care

The concept of disability is less clearly defined than that of SEN. Some forms of physical impairment are short-lived, while the functional impact of a given diagnosis is highly variable.

Chart 26 shows the age distribution of the 12 most common conditions or disability, taken from GP data. This shows that the three most commonly coded conditions in general practice are Enuresis/incontinence, asthma and depression. For each condition there is a different age distribution which has implications for service provision. For example, the prevalence of asthma is reasonably stable across the age groups 5 to 25 years, while the rates of depression increase with age. However, not all of these conditions will meet the definition of disability for SEND purposes or for social care provision.

Chart 26: Distribution of conditions by category and age band

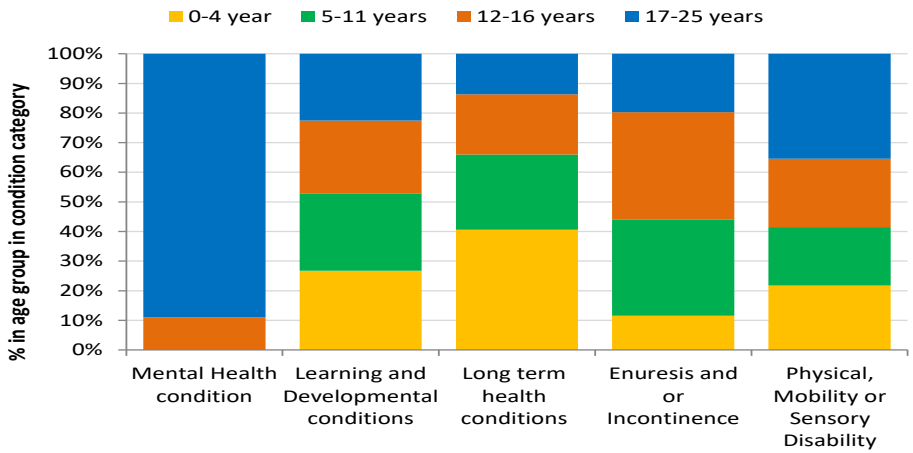
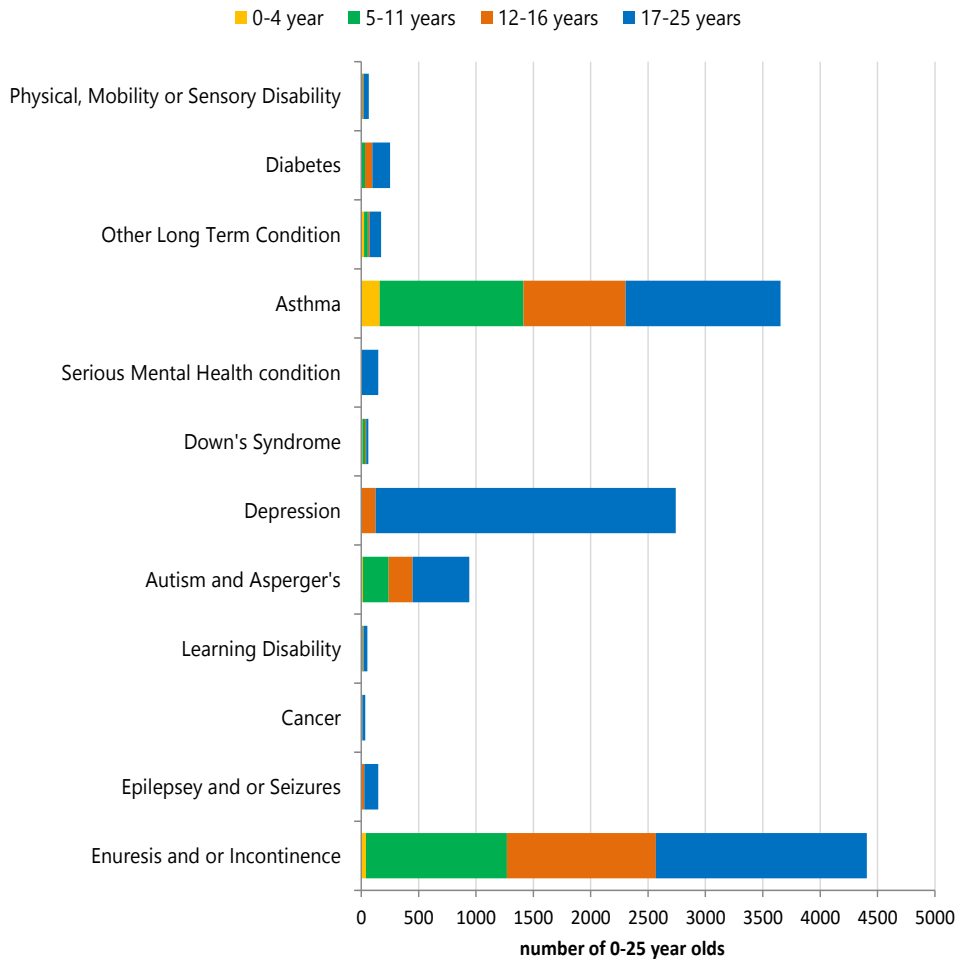


Chart 27 shows the distribution of conditions within defined categories and illustrates the difference by age bands. It shows that there are higher proportions of long term health conditions in the 0-4 years age group and mental health conditions are more prevalent in the 17-25 age groups.

Please note that the primary care data referred to in the primary care section is for 36 practices only. There are 37 practices across Tameside & Glossop

Chart 27: Prevalence of common childhood conditions across GP practices in Tameside & Glossop by age band

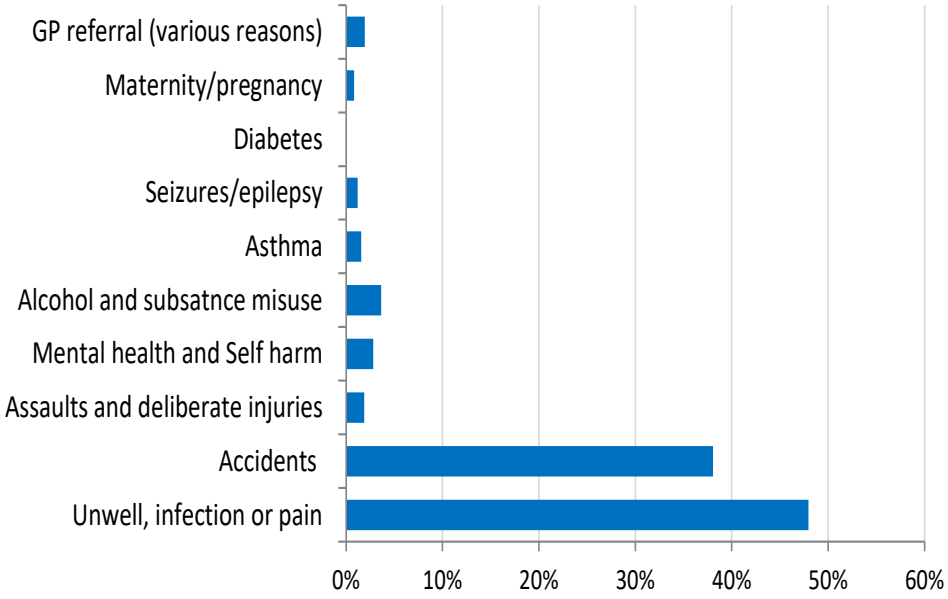


Source: Tameside & Glossop primary care data (GP practice data from 36 practices)

A&E attendances and Urgent Care admissions

In 2019 there were 20,543 A&E attendances for children and young people aged 0-25 years. The main reasons for attendance are illustrated in chart 26. It can be seen that the highest proportion of attendances were for general illness and accidents. There were however attendances for mental health and self-harm (3%), alcohol and drug misuse (4%) and conditions relating to long term conditions such as Asthma, epilepsy and diabetes (3%).

Chart 28: A&E attendances by reason for attendance for children and young people aged 0-25 years in 2019

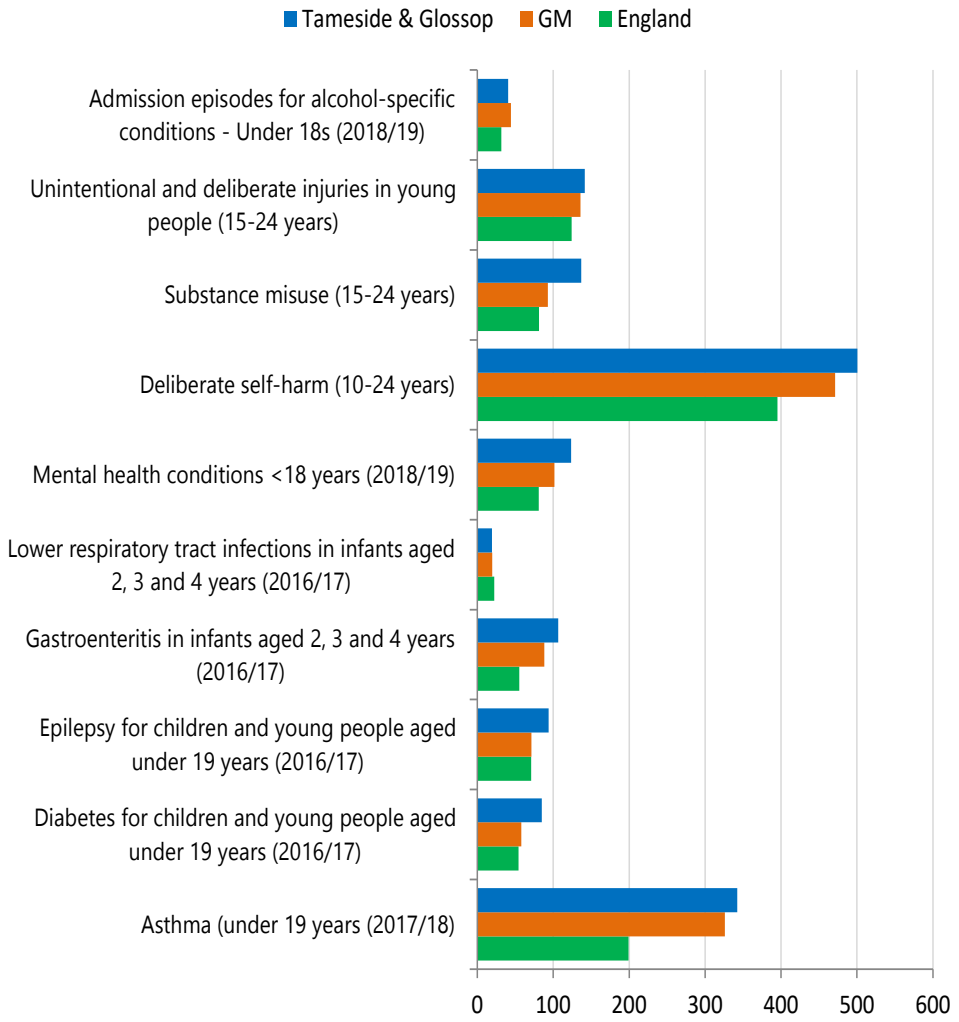


Source TIIG, LJMU

In 2019 there were 8,715 urgent care admissions for children and young people age 0-25 years from Tameside and Glossop. This is an increase on 2018 where there were 7,250 urgent care admissions.

The chart below (chart 29) highlights some of the main reasons why our children and young people are admitted to hospital as an emergency.

Chart 29: Rates per 100,000, Emergency hospital admissions by diagnosis



Source: PHE Fingertips

Chart 29 shows that Tameside and Glossop have high levels of emergency hospital admissions across all diagnosed conditions compared to Greater Manchester and England averages. Tameside and Glossop have higher average urgent care admission for eight out of the ten conditions illustrated in chart 27 and have significantly higher levels of admissions for childhood asthma and deliberate self-harm.

Looking at trends over time for some of the conditions illustrated in chart 29, it is a mixed picture with rates for substance misuse, mental health conditions and accidents and injuries reducing; with increases in rates of self-harm, gastrointestinal and respiratory infections.[20]

Health Visiting Service

Health Visiting is a universal service and therefore has an important role in the early identification of children who have, or may have special educational needs or disability. This is provided through the processes of routine developmental surveillance as part of the national Healthy Child Programme, outcomes-focussed interventions, and the building of supportive relationships with parents. The Ages and Stages Questionnaire (ASQ-3) is used to support the health and development reviews all children are offered at 6-8 weeks, 9-12 months and 2-2 ½ years, so that each child's developmental progress is objectively tracked. . Health Visitors have also participated in piloting a 48 month development follow-up of children who were born pre-term and are therefore more likely to experience developmental problems (NICE Guidance 72)

All families receive a new birth visit, and parents are also offered an antenatal contact in the third trimester of pregnancy, as well as additional support and child development assessments according to level of need. Health Visitors are responsible for ensuring that all children have received the new born blood spot screening programme, which identifies a number

[20] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133230/pat/46/par/E39000037/ati/165/are/E38000182

of serious diseases within the first weeks of life. Health Visitors also have a strong focus on parent-infant mental health, which is an important foundation of healthy child development.

Early identification of potential difficulties is crucial, so that tailored support can be provided as early as possible. Children access this support through early intervention pathways, focussing on developmental areas such as communication or motor development; these typically involve attending groups in children's centres, and some may progress to accessing therapy. Community Nursery Nurses from the Health Visiting Service co-facilitate these groups in their localities.

Health Visitors inform the Inclusion Team in the local authority if their assessment at any point in early life suggests that a child has, or may have special educational need – under Section 23 of the Children and Families Act (2014). The total number of 'Section 23' notifications to the Inclusion Team has increased between 2018-19 and 2019-20, from 39 to 49. Importantly, notifications are being made earlier in life, suggesting that children's needs are being identified for multi-agency support much earlier. 18 notifications were made between the ages of 0-2 years in 2019-20, compared with just one at 2 years, and none earlier than that, the year before. In 2018-19, the most common age of notification was 3-5 years, but in 2019-20, it was 3 years, with few at 4 years and none at 5 years. Where possible or actual special educational need is identified, they work closely with parents and early years education providers on a 'person-centred plan' (PCP) and this may eventually lead to assessment for an Education, Health and Care Plan. These children are discussed at the multi-agency SEND Early Years Panel, and a Health Visitor sits on this Panel. When a child reaches school age, their care is handed over to the School Nursing Service.

School Nursing Service

School Nursing is a commissioned universal public health service for children and young people of school age, 0-19. The service is delivered by a team led by Specialist Public health Community Practitioners who are qualified Nurses with additional training in Public Health. The aim of the service is to ensure that children, young people and their families have access to a core programme of preventative health care and additional care based on need where required.

The universal Healthy Child Programme includes targeted immunisations and screening reviews. The service is available to both those accessing formal education and being educated at home. Parents of Reception and Year 6 children are sent a health questionnaire, inviting them to identify any issues or concerns they may have about their child's health and development. The children's vision, hearing, height and weight are reviewed. If any concerns are identified, the School Nurse engages with parents, Paediatricians, School, Social Care and any other identified agency to formulate a plan to support the children, young people and their families.

School Nurses will support with,

- writing of individual Educational Health and Care plans (EHCP) for children with additional needs,
- providing or facilitating specific training for staff to support children and young people in school
- Ensuring that referrals' to appropriate services are undertaken and care for family is coordinated.

All children with an EHCP in Tameside will have a named School Nurse who will be a point of contact in coordinating the child's care. In addition to this, our teams operate in the four neighbourhoods with every school having an identified team that supports it. It is important to note that support

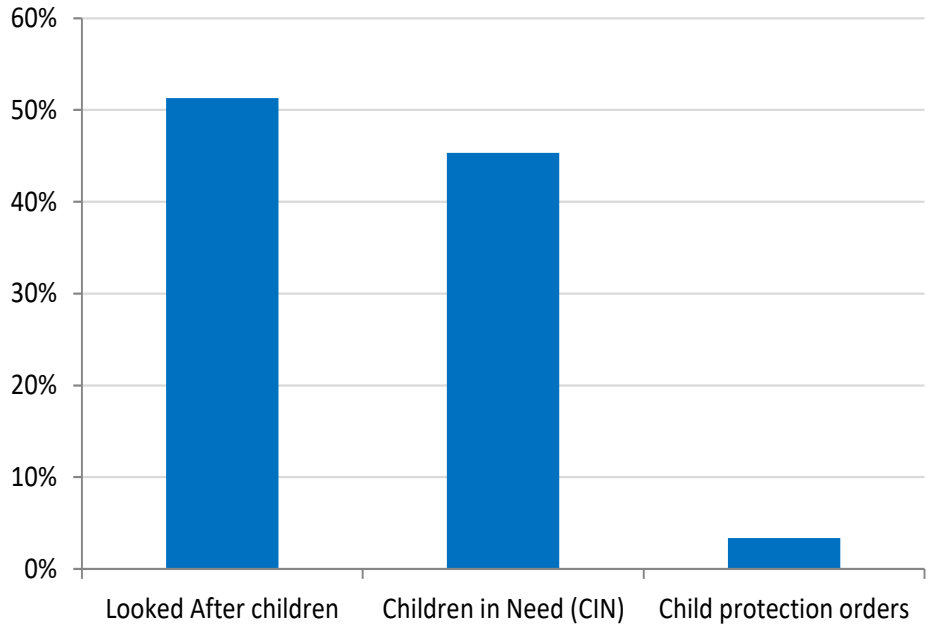
needs can be identified at any point and these can be in the form of referrals from a young person, parents, school or any other partners. Help is offered to children, young people and their families as soon as a need is identified. Early identification is therefore key to ensuring that care is delivered in a timely way at the right time buy the right person.

Social Care

This section of the JSNA looks at social care provision for children with SEND, in particular those with an EHC plan.

There was in (February 2020) **318** (36%) children and young people with a current EHC plan in place involved with children's social care or early help assessment.

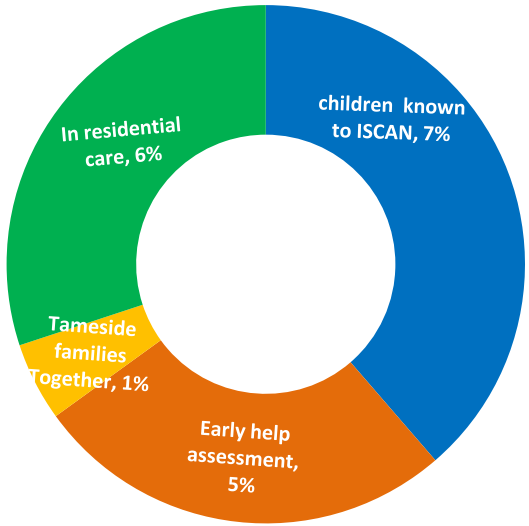
Chart 30: Children and young people with EHCP known to children services by type of service



Source: Tameside council children's services

There were also a number of children with EHC plans known to other services across health and social care. These include integrated services for children with additional needs, Tameside families' together and residential care

Chart 31: Children and young people known to health and social care services with EHCP



Source: Tameside council children's services

49% of all children and young people with an EHC plan in place are known to one or more health and social care providers. 16% of children and young people with an EHC plan are looked after children.

The highest proportions of Children in Need (CIN) were children and young people with a learning disability, Autism or Asperger's and behavioural problems. 79% of CIN had a primary need relating to abuse or neglect. For

children and young people with a child protection plan in place in 2019, a high proportion of plans were related to emotional abuse and or neglect.

Across children's social care in general (April 2020), there are currently 2,252 children and young people known to services. 703 looked after children, 1,183 children in need (CIN) and 366 child protection orders in place. 2019 annual statistics shows that Tameside had significantly higher rates of children and young people known to social care services compared to both England and Statistical neighbours.

Referrals to children's social care are increasing in line with population increases. The increase demand across children services has significant financial impacts for the council. A recent survey by the Local Government association (LGA) showed that the high level of children in care and child protection plans was related to an increase in 'family conflict' for instance, domestic abuse, substance misuse and offending.[21] There was also strong evidence to suggest that 'an increase in family hardship' such as poverty, poor housing and debt had played a part.

An 'increase in family hardship' – including poverty, poor housing and debt – had contributed most heavily to the increase in the number or complexity of children and young people receiving child protection or looked after children services, according to 31 per cent of survey respondents.

'Increased complexity of need' was ranked as the highest issue facing children's social care budget in 2019/20, according to the lead members for children's services, followed by 'increased demand for child protection services'. This increase in demand at the complexity level will have wider impacts on other services such as 'Early Help' and 'Troubled Families' programme

These pressures could have a major impact on children with SEND due to options for support being reduced. Existing evidence paints a picture of instability for the provision of support to vulnerable children in particular those children with SEND.

There is a strong relationship between deprivation and contact with social services, as well as with the areas of need identified in CIN assessments, including family mental illness – and the Institute for Fiscal Studies (IFS) predicts child poverty is on the rise.[22] Additionally, research shows that the most deprived areas have faced the greatest fall in early intervention funding since 2010/11 and area deprivation is linked to Ofsted effectiveness rating.

Youth Justice Service

Children and young people in the youth justice system are vulnerable by virtue of their age. However a high proportion of children and young people who come to the attention of youth justice services also have complex learning needs, low levels of educational attainment, speech, language and communication needs (SLCN) and more untreated health issues than their peers.[23]

The proportion of children and young people with EHC plans known to the Youth Offending Service (YOS) in Tameside as of 2020 was 14%. This is an increase on precious years

[21] https://local.gov.uk/childrens-social-care-budgets

[22] 2 Institute for Fiscal Studies, 2018, 'Living Standards, Poverty and Inequality in the UK: 2017-18 to 2021-22', https://www.ifs.org.uk/uploads/publications/comms/R136.pdf

[23] Lader, D., Singleton, N. and Meltzer, H. (2000): Psychiatric Morbidity among Young Offenders in England and Wales, London: Office for National Statistics;

Chart 32: Children and young people with and EHC plan known to youth justice service in Tameside

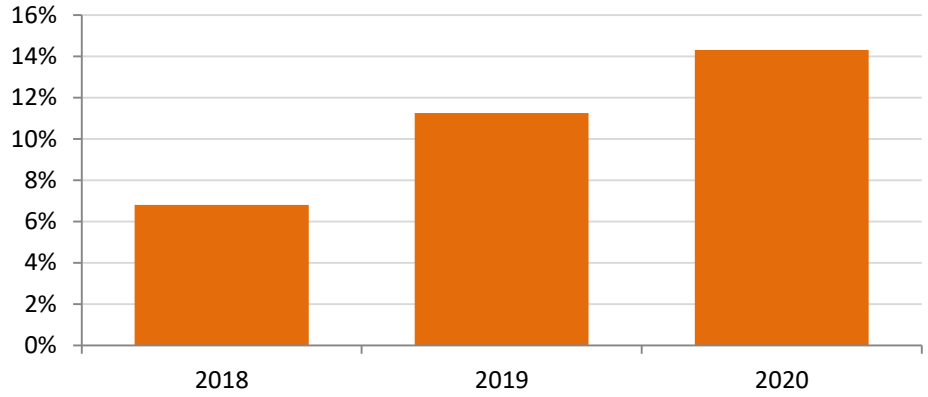


Table 10: Type of housing young people known to adult social care aged 18-24 years in Tameside live in

Accomodation Type	%
Living independently	11%
Supported accommodation	17%
Living with family or friends	39%
Residential care	5%
Shared lives (adult placement scheme)	2%
Unsettled	3%
Unknown	23%

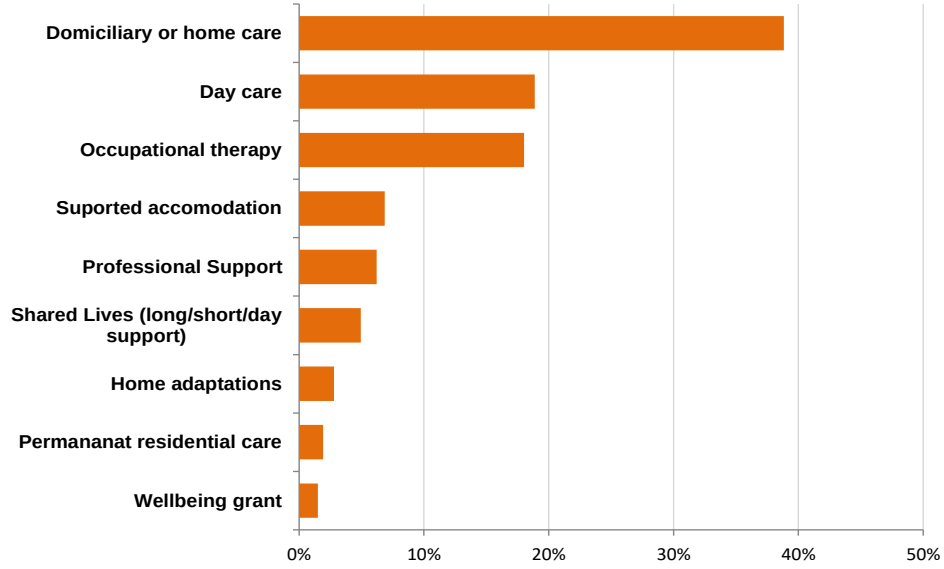
Source: Tameside council adult social care

For young people receiving adult social care services a high proportion of young people are in secure living arrangements with family or friends. 17% are in supported accommodation and 11% living independently.

Chart 33 illustrates the types of support and services young people aged 18 to 14 years currently receive.

The types of services individuals receive vary widely. A high proportion (39%), receive domiciliary care which includes help around the home and/or personal care. 19% use day care services and 18% receive services from occupational health.

Chart 33: Types of Service/support young people are receiving from Adult services



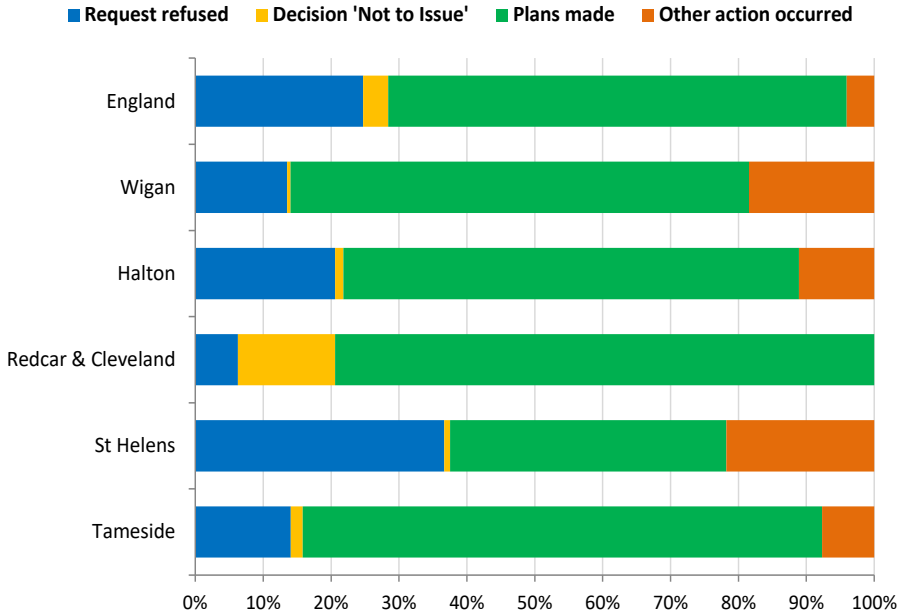
Source: Tameside council adult social care

The SEND Assessment Process

Following a request for an assessment, the local authority must determine whether this is needed. All requests are considered against a set of conditions in line with legislation under the Children and Families Act 2014. A specialist panel, made up of relevant professionals, will help the local authority decide whether an EHC needs assessment is required.

In 2018 there were 455 new requests made for assessment for an EHC plan in Tameside, the outcomes of these requests can be seen in chart 31.

Chart 34: Outcomes of initial requests that were made for assessment for an EHC plan during the 2018



Source: Department of Education

Tameside had high levels of EHC plans made in 2018 compared with statistical neighbours. There were also low levels of refused requests and decisions not to issue.

The EHC assessment process has 5 stages and takes a maximum of 20 weeks.[24]

Stage 1: Is an assessment needed weeks 1 to12

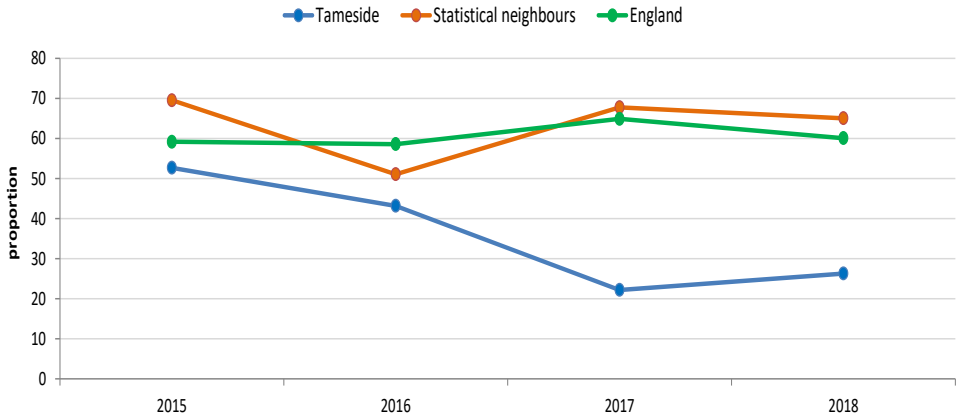
Stage 2: Preparation and information gathering weeks 1 to12

Stage 3: Analysing all the information weeks 8 to16

Stage 4: Consultation weeks 16 to 20

Stage 5: Final plan weeks 16 to 20

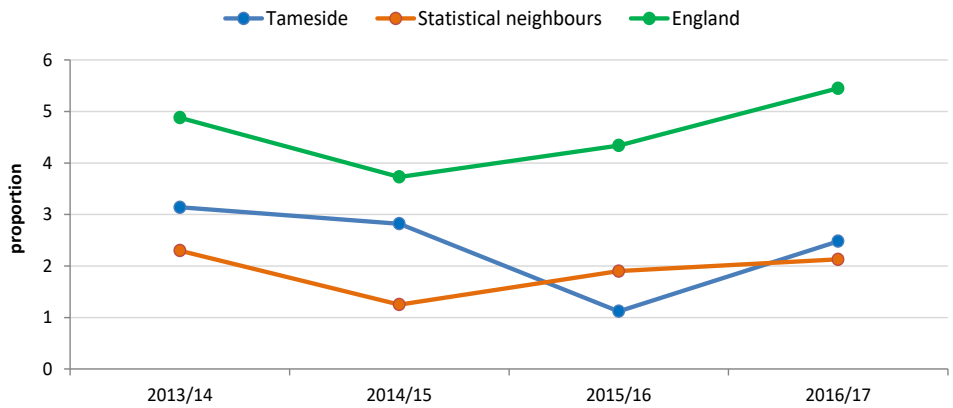
Chart 35: New EHC plans issued in 20 weeks-excluding exceptions 2018



Tameside has lower levels of EHC plans issued within 20 weeks compared to statistical neighbours and England. This means that although high levels of plan are issued they are taking longer to issue than other areas.

[24] https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Chart 36: SEN appeals 2018



SEN appeals, which are appeals related to a decision not to award an EHC plan have been increasing since 2015/16 but are lower than the England average.

Personal Budgets

A personal budget is an amount of money identified by the local authority to deliver all or some of the provision set out in an EHC plan. By having a say in the way this budget is used, a parent or young person can control elements of their support' – *Children and Families Act 2014.*

Personal budgets should be seen as an integral part of the coordinated assessment and EHC planning process. Parents and young people will be able to request a personal budget when the local authority has completed a statutory EHC assessment and confirmed that it will prepare an EHC plan. They may also request a personal budget during a statutory review of an existing EHC plan.

How a young person or family decide they want to use a personal budget and/or direct payment has to be set out in the EHC Plan, this includes payment process.

Table 11 shows that the allocation of personal budgets for children and young people with an EHC plan varies widely across statistical neighbours. Tameside has the lowest number of allocated personal budgets with less than five personal budgets being in place in 2018

Table 11: Number of Personal budgets allocated in 2018

Loca Authority	Number of personal budgets taken up for EHC plans issued or reviewed in 2018	Number of personal budgets taken up for EHC plans issued or reviewed in 2018 with organised arrangements
Tameside	**<5**	**0**
St Helens	**<5**	**0**
Redcar & Cleveland	**63**	**0**
Halton	**150**	**15**
Wigan	**264**	**48**

**please note low numbers of less than 5 have been supressed to <5*

Source: Department of Education

Personal health budgets

The 'right to have' a personal health budget currently applies both to adults and young adults who are eligible for NHS Continuing Healthcare, and children in receipt of continuing care.

There are currently a small number of children and young people who as part of their continuing health care hold personal health budgets (number <10).

Personal health budgets can improve people's quality of life and their experience of care, by helping people to have more choices about how their healthcare needs are met.

Referrals to SEND Services

Table 12: Referrals to SEND health and care services

Referrals to Services	2014/15	2015/16	2016/17	2017/18	2018/19	Trend
Paediatrics	4474	5087	6089	6527	6235	
Paediatric Audiological Medicine	927	1105	1094	1224	1254	
Physiotherapy	1192	1242	1272	1027	917	
Ophthalmology	923	961	1011	916	988	
Neurology	253	258	494	411	361	
Cardiology	325	374	313	257	317	
Pain Management	237	183	201	119	75	
Occupational Therapy	28	67	87	77	86	
Dietetics	54	130	74	93	65	
Diabetic Medicine	55	25	40	46	16	
Rheumatology	130	136	91	122	108	
Clinical Neurophysiology	205	281	217	220	196	
Child and Adolescent Psychiatry/mental health	65	53	35	24	32	
Portage	28	49	36	46	51	
Learning Disability Health Checks (all ages)			262	253	260	
CAMHS			2205	2845	3270	
Speech and Language Therapy (children <18)		929	1068	1398	1454	
Speech and Language Therapy (adults)		1199	1237	1327	1155	
Autism assessment		31	34	53	32	
ADHD assessment		112	122	162	169	

Source: local data

Services involved in supporting children and young people with SEND in Tameside & Glossop report that they are dealing with increasing demands on their services, in excess of any increase in the SEND population itself. This suggests an increase in the complexity of needs within this group

Table 12 shows the number of referrals to a variety of SEND services across both the hospital and community. The table shows that for services such as occupational therapy, portage and Childrens speech and language therapy there has been increases in referrals. Child and Adolescent Mental Health services (CAMHS) have seen an average 17% increase in referrals over the last three years.

Table 13: Referral waiting times services that support the SEND population (2019/2020)

Waiting times for SEND support services	Annual average 2019/20
Average waiting time for Hospital Paediatrics assessment (Weeks)	5
% of Hospital Paediatric referrals seen within 18 weeks	98%
Average waiting time for Community Paediatrics assessment (Weeks)	8
% of Community Paediatric referrals seen within 18 weeks	97%
Average waiting time for MAAT assessment (weeks)	64
% of MAAT referrals commenced within 12 weeks	29%
Average waiting time for ADHD assessment (weeks)	42
% of ADHD referrals seen within 18 weeks of referral to pathway	84%
Average waiting time for SALT assessment (Weeks)	21
% of SALT referrals seen within 18 weeks	52%
Average waiting time for Physio assessment (Weeks)	16
% of Physio referrals seen within 18 weeks	55%
Average waiting time for OT assessment (Weeks)	25
% of Occupational Therapy referrals seen within 18 weeks	29%
Average waiting time for HYM assessment (weeks)	5
% CYP seen within 18 weeks in HYM	91%

Source: Local data

Increased demand leads to increased waiting lists and times to access some services. Waiting times for children's therapy services are monitored against a 12 and 18 week standard. The informtion in table 13 illustrates that although some services are coping with demand and children and young people are seen within standard times. A high proportion of services have considerably longer waiting times.

Children waiting long periods to see specialists services and professionals can have a significant impact on outcomes for children and young people and their family. The lack of early intervention could translate into more complex issues later – that means more of an impact on schools, or added costs in later years due to mental health issues or eductional impacts.

Transition

The transition period (between 14-18 years) represents a time during adolescence and early adulthood when young people have to make choices about their future, from leaving school to finding employment and moving away from home. For all young people, the transition from childhood to adulthood involves consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation.

For young people who are sick or disabled, this transition is made more difficult by concerns about whether, how and where their health and social care needs will be met.

Transition is also an important time for services as they prepare to transfer responsibility of care for young people: Children's Services want to know that the young people in their care have somewhere to transition to; Adults Services need to know the numbers and needs of young people likely to transition so that they can plan adequately for their support.

Local evidence suggests that many young people who come to the attention of adult social care at or post-18 are already known to children's services.

The number of children aged 14 years to 18 years who currently receive services through the Tameside & Glossop Integrated Service for Children with Additional Needs (ISCAN) in 2019 was eighty five. The severity of their disability varies from mild to profound.

In year 2019/20 there were around **1,315**, 14 to 18 year olds with a special education need (SEN) or educational health and care plan (EHCP) in place. 19% (N=245) have an EHCP in place.

Table 14: Primary need for young people 14-18 years with SEND

Primary Needs	%
Autistic Spectrum Condition	19%
Hearing Impairment/multi sensory	2%
Moderate Learning Difficulty	29%
Specific Difficulty/other Disability	3%
Profound & Multiple Learning Disability	3%
Severe Learning Difficulty	5%
Social Emotional & Mental Hlth	33%
Speech,Lang or Comm Diff	3%
Physical Disability/medical need	1%

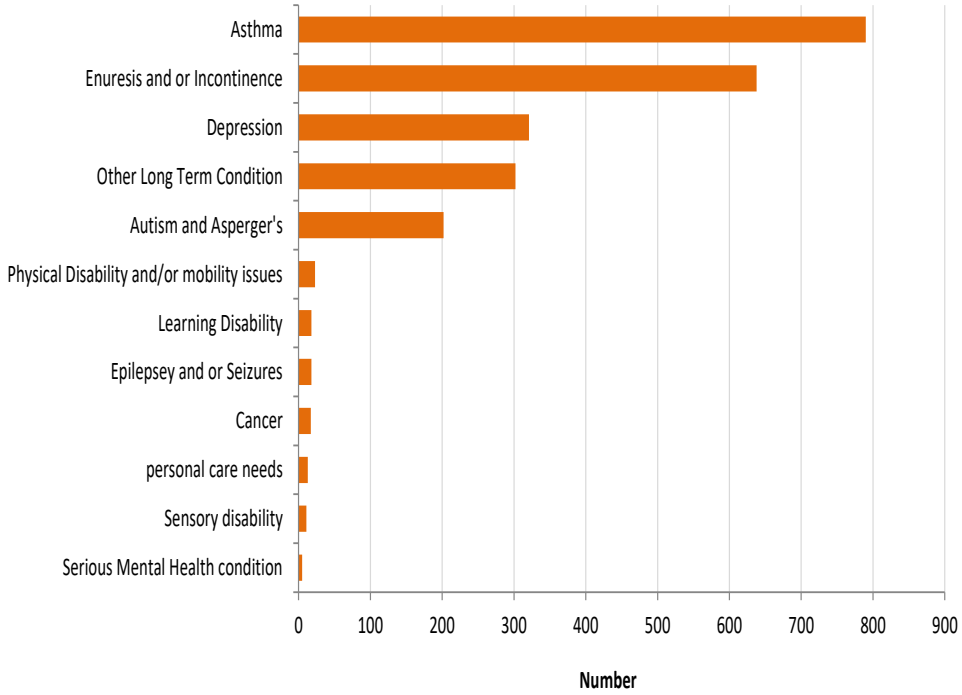
Source: Tameside council SEN2 data

Primary care

GP practice data illustrates that there are 2,358 young people aged 14 to 18 years registered with a long term condition or disability. The data here represents 36 out of 37 practices; data was not made available from one practice.

Chart 34 illustrates the 12 most common conditions this age group are registered with. The learning disability group includes young people with Down's syndrome and the other long term condition group includes health conditions such as heart disease, hypertension, diabetes and rheumatoid arthritis. The highest registered conditions are young people with Asthma (34%), followed closely by young people with enuresis or incontinence issues (27%). Young people with long term depression account for 14% of the total and other long term conditions account for 13% of the total in this age group.

Chart 37: Number of young people aged 14 to 18 years registered with a long term condition or disability 2020



Source: GP Practice data, Tameside & Glossop CCG (36 practices)

Current local information tells us that there are currently (2020) **168**, 18 to 24 year olds receiving services from adult services. In contrast during the period 2017 to 2019 approximately fourteen children aged 14 to 17 years had a record of being transferred into adult services from children's services. This is clearly lower than expected.

From data currently recorded across Children's Services, education and health in Tameside on the transition-age population it is anticipated that a number of young people should make the transition to Adult Services over the next five financial years.

As there are issue with data quality from the various independent local children's systems, it is very difficult to calculate an accurate figure as to what this number looks like. We are however able to show the following.

In 2019 there were 65 young people in year 9 with a EHC plan in place; 29% with Autism, 26% with a moderate learning disability and 26% with a social, emotional, or mental health need, 8% had a severe learning disability and 5% a speech and language need. It is therefore estimated that these **65** young people should be now going through the transition process as per NICE guidance.[25]

In 2019 there were 82 young people in year 8 with an EHC plan in place; 30% with Autism, 21% with a social, emotional or mental health need, 20% with a moderate learning disability, 12% with a profound or severe learning disability and 6% with a speech and language need. It is therefore estimated that in 2020, **82** young people will be eligible to start the transition process as per NICE guidance.[6]

From GP registers there are there are 857 young people aged 14 to 15 years with a long term registered condition or disability. 32% related to enuresis and or incontinence issues, 8% related to a learning disability, 8% for Autism, 8% related to a long term health condition, physical or sensory disability and 5% for depression.

For a high proportion of these young people there will be continued health care provision for the management of long term health issues. However around **205** young people in this age group have potential social care needs relating to personal care, incontinence services and independent living. Not all these young people will have an EHC plan but may have SEN support so it is important that these young people are picked up during the transition process.

[25] https://www.nice.org.uk/guidance/ng43/chapter/Recommendations#overarching-principles

Predicted future trends

What can we predict about the size and needs of the SEND population in the future?

Understanding future trends in the size and characteristics of the SEND population in Tameside is essential in order to commission and design effective and appropriate services to this population. To project future trends for the SEND population in Tameside we need to consider:

1. The overall change in population (0 to 25 years) expected

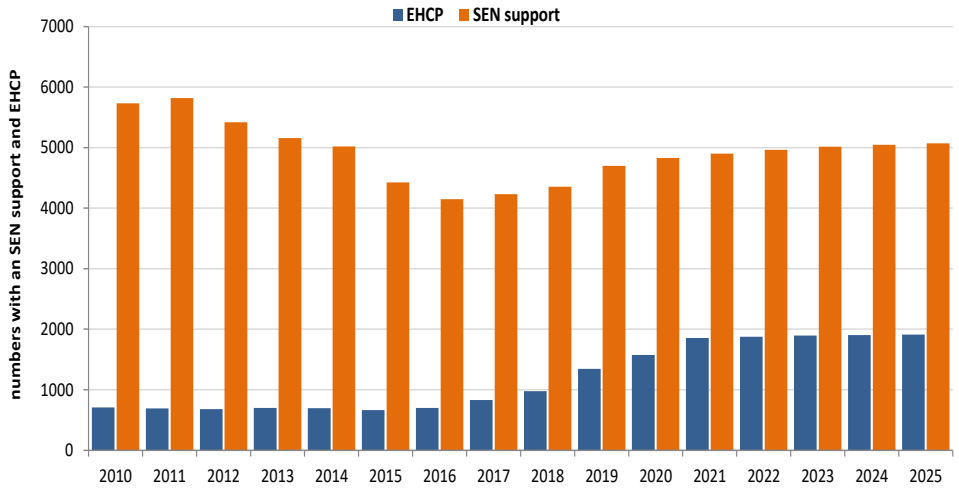
2. Recent trends in the prevalence of SEND locally

Chart 35 applies the expected population growth and the average overall trend in SEN support and EHC plans since 2014, assuming future trends will follow a similar pattern. This gives an overall 17.6% rise in the EHC plan and a 4.8% rise in the SEN support population over the next 5 years, with 336 more with an EHC Plan and 243 additional receiving SEN support.

Table 15 illustrates the projected overall increase in the 0 to 25 years Tameside population (both SEND and non-SEND), based on ONS population projections. There are currently 67,870 children and young people aged 0-25 living in Tameside, and over the next 5 years this population is expected to increase slightly. By 2025 the population will be 1.2% higher, at 68,657. The increase will be greatest in the 10-14 age groups, which will rise by 19% in this period.

It is likely that the prevalence of SEND in Tameside will increase over time bringing Tameside in line with its statistical neighbours and England. A rise in the number of young people aged 16 to 25 will also have an impact on the rise driven by an increased rate of diagnosis among those aged 16 to 25 following the recent change in SEND definition.

Chart 38: Recent trends and predicted future trends in SEN Support and EHC plans



Source: Department of Education SEN2

Table 15: Population change for 0-25 year olds in Tameside

Age Band	2015	2020	2025	change	% change
0-4 years	14,825	14,128	13,635	-1,190	-9%
5-9 years	14,104	15,148	14,395	291	2%
10-14 years	12,332	14,171	15,268	2,936	19%
15-19 years	12,762	11,969	13,725	963	7%
20-24 years	12,995	12,448	11,634	-1,361	-12%
0-25 years	67,018	67,864	68,657	1,639	2%

Source: ONS

‘Voice’ of the SEND child or young person, their parents or carers

All children have a right to have a voice in matters that concern them. Listening to ‘the voice of the child’ when thinking about special educational needs enables us to help children more effectively. Thinking about the ways in which children respond to what is offered helps us to recognise things that may need to be changed.

There is no evidence available of what children and young people themselves think of their experience of the assessment process, SEND services and their educational and non-educational support locally.

However we do have evidence of what parents and carers think of the SEND process and wider support. In 2019 a survey was conducted to gather the views of families’ with experience of the SEND process.

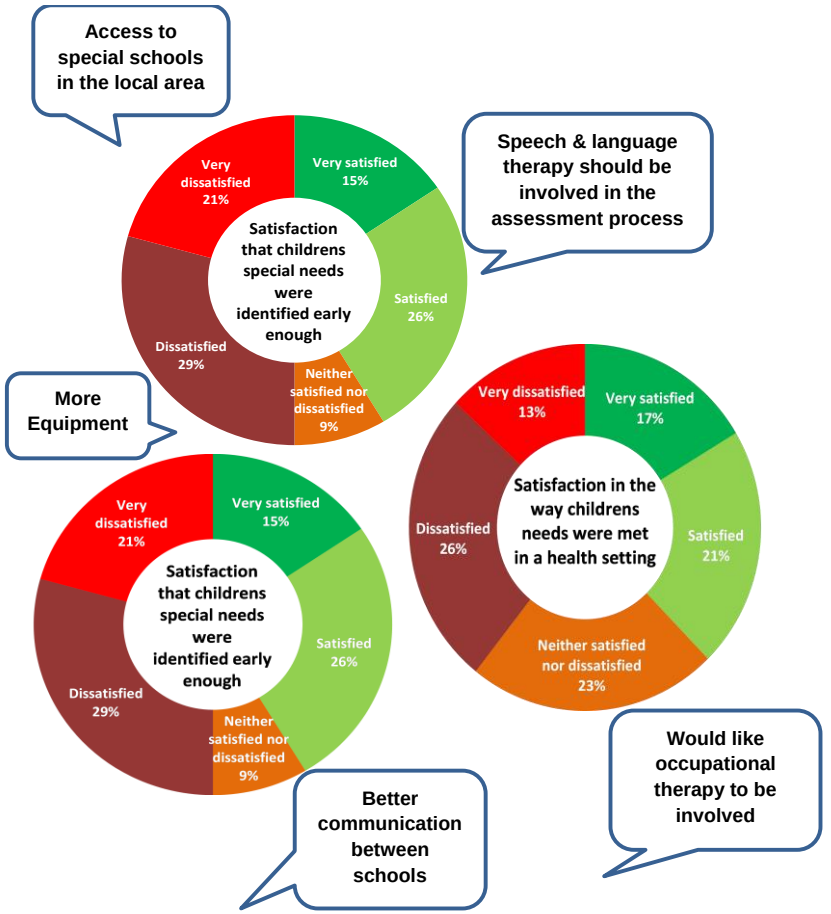
On the whole the responses were fairly positive. More than 50% of parents felt that children’s needs were met within educational settings, this drops to 38% for health care settings.

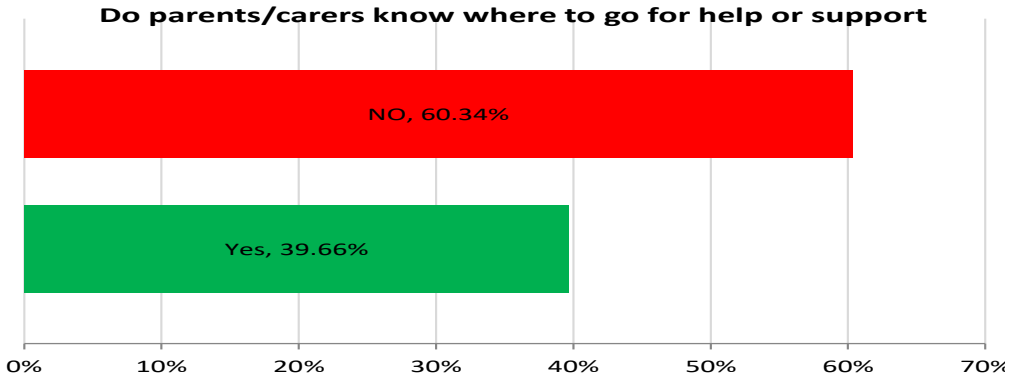
Half of all respondents felt their children’s needs were not picked up early enough compared to 41% who felt the needs of their children were picked up early enough.

58% of parents felt educational support was appropriate and 57% felt the needs of their children were understood.

When it came to knowing where to get help or support just over 60% did not know where to obtain the help and support they needed.

The illustration opposite shows the results of the survey and some of the comments made by parents or carers





Current and short to medium term priorities

What we are doing now

- **Increasing confidence** of parents and carers in services and systems across all of the partners in Tameside.

- **Involving children & young people** who have SEND, in decisions about their future and in the future shaping and delivery of services. (2) (Incorporating - Ensuring services are held accountable for the quality of the services they deliver to children and young people and their families.(12))

- **Improving accuracy & timeliness** with which we identify children and young people's needs (3) (Incorporating Improving the timeliness of Education, Health and Care (EHC) Needs Assessments & Improving the auditing of EHC Plans and their quality.(10 & 11))

- **Increasing inclusion** of children and young people in mainstream settings. (8) (Incorporating - Clarifying the role our special schools play in supporting strategic developments and sharing good practice across the borough.(9))

What we are doing next

- Developing a monitoring and evaluation framework to ensure we can monitor the outcomes we want to improve.

- Building relationships across partnerships which continues to share market intelligence to further understanding of any potential gaps in provision and clarification of respective roles in responding to need

- Increasing emphasis on our provider's ability to demonstrate productivity, cost effectiveness and value-for-money

- Increasing the development of neighbourhood working by increasing the opportunities for children and young people with special educational needs and/or disability to be educated in, and supported by, their communities.

- Developing more resourced provision in mainstream schools and colleges by examining increased delivery from our special schools via mainstream school based satellite provision to ensure there is sufficient Special School provision.

- Reviewing the funding model for children and young people with special educational needs and/or disability so that those in mainstream schools are not disadvantaged in the support they receive.

- Building a closer working relationship between social care, health and education, including developing an integrated information system that enables affective data sharing.

SUMMARY

In 2019/20 there were 6,045 children and young people with a special educational need or disability (SEND) in Tameside, this rises to 6,680 when you include children and young people from Glossop. Preliminary information for 2020 indicates a further increase in this number.

The number of children with EHC plans locally is lower than a high proportion of our statistical neighbours and low when you consider the level of deprivation across the local area.

The primary needs of children and young people vary. For children with EHC plans in place a third are related to a moderate learning disability, with a fifth related to speech, language and communication. A fifth of children and young people have Autism or Asperger's and around ten percent had an EHC plan relating to social, emotional or mental health issues.

More than half of all children and young people with SEN support and nearly a third with EHC plans live in the two most deprived deciles in Tameside.

A high proportion of SEND children and young people are eligible and take up free school meals.

Exclusion rates for children and young people with SEND are significant. A third of all fixed term exclusions are Children and young people with SEND. Those receiving SEN support are more likely to be excluded than those with an EHC plan

Educational outcomes for our children and young people with SEND are considerably worse than their peers of the same age. Children and young people's attainment levels are significantly lower across all key stages when compared to non-SEND children and young people.

Children and young people with SEND are far more disadvantaged than children and young people with no SEND, because not only do they reside in the more deprived areas of Tameside, and so economically disadvantaged. SEND children and young people are more likely to be excluded from school than their peers, affecting educational progress so educationally disadvantaged. Socio-economic circumstances in childhood which result in low qualifications in adulthood help transmit poverty across generations.

The quality of education across Tameside is good according to Ofsted and Tameside does have more schools and further educational establishments rated as 'Good' compared to the England and our closest statistical neighbours. However we do have lower than average schools and further educational establishments rated as 'Outstanding'. Outstanding schools have less absenteeism, exclusions and higher levels of attainment in key subject areas.

The number of children and young people aged 0-25 years registered with a disability or long term condition with a GP in Tameside and Glossop is 11,527. The three most commonly coded conditions in general practice are Enuresis/incontinence, asthma and depression. This number is far higher than the number of children and young people known to SEND services, education and social care.

Waiting times for referrals to specialist's services for children and young people with SEND are considerably long for some services. On average in 2019/20 children and young people were waiting around 64 weeks for an Autism assessment and 42 weeks for an ADHD assessment. Long waits for assessment and diagnosis can have a profound impact on development and outcomes.

There are low numbers of children and young people with SEND using personal budgets across health, social care and education. Personal budgets can offer more control, flexibility and choice over how care and

support needs are met. This is of particular importance for young people in transition when they need to start thinking about the help and support needs required in adulthood.

There is no information regarding the voice of the child for children and young people with SEND. This is an essential part of the SEND process. Incorporating the voice of the child into the SEND process and service provision enables children and young people to be fully involved in their care and support.

The SEND system across education, health and social care is fragmented with each area more or less working in silo. This means that children and young people with SEND will not be receiving joined up or integrated care and support across the various SEND service areas.

The fragmented SEND support system was observed during the production of this JSNA through the collection and collation of the data and information. Different SEND areas hold their own data and there doesn't seem to be a standard data set or data sharing mechanism across the various SEND services. Consistent intelligence and data sharing across the SEND support system is important in ensuring all SEND children and young people receive the level of help and support relevant to their needs.

For services to meet growing SEND population across Tameside there needs to be more collaboration between, health, social care, education and the voluntary sector. In addition, a better balance of provision at a:

- universal level (services provided to all children, young people and their families),
- targeted level (services for children who are at risk of, or already experiencing difficulties) and at a,
- specialist level (children with complex needs requiring an individual approach)

Outcomes across education, health, social care and society for children and young people with SEND needs to improve if we want to reduce inequalities and enable SEND children and young people to live fulfilling lives. Children and young people with SEND should have access to the same opportunities and experiences as their peers as embedded in the Children and Families Act 2014.

It is clear from the section 'What we are doing now' and 'What we are doing next' that improvements across the system are being achieved and that the improvements to the SEND system that supports children and young people across education, health and care is moving in a positive direction.

Recommendations

Continue to improve the identification of children and young people with SEND across the system

Although improvements have been made, identification of children and young people with SEND across the system needs to improve further.

Commissioners should ensure that systems used by services across the health, social care and the education system enable the identification of those with SEND at the earliest opportunity to enable the monitoring of support and outcomes for this population group. This includes reducing the length of time children and young people wait for assessment and diagnosis of conditions.

Continue to improve the monitoring of outcomes for those with SEND

Although much improved continue the development of a holistic set of outcome measures for those with SEND at an individual and population level, covering health and social outcomes in addition to educational outcomes would improve understanding of the needs of this population group. These should be developed collaboratively with partners and

Continue to improve the monitoring of children and young people during transition to adulthood

While information exists on educational outcomes, further work is required to strengthen information collected on young people with SEND after they leave the school system, limiting the ability to measure success in preparing those with SEND for adulthood.

Ensure commissioning plans reflect the needs of the local population

Ensure that the information in this needs assessment - including the increasing number of children with the most complex needs, the demographics and the most common primary needs - underpins commissioning of services, such as educational psychology services

Continue improving educational Outcomes for SEND children and Young people

Continue to review Fixed Term Exclusion policies and practice to ensure schools are supported to gain EHCPs for behaviour (SEMH) where this would best support the child or young person.

Continue to review SEND support at key transition points in educational phases – reception intake, KS1 to KS2, secondary transfer, Post 16, and transition to adulthood to ensure needs or continually met.

Improving Integration and data sharing

Continue to improve integration of pathways, processes and governance between education, health and social care. Align caseloads between education health and social care to minimise data inaccuracies between systems and work toward a single child record for SEND children and young people.

Incorporate the 'Voice of the Child' across the whole SEND system

Continue to embed a meaningful approach to co-produce the SEND process, support and services with children and young people with SEND and their families across health, education and social care