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Sunderland**

Martin-Denham, Sarah, Donaghue, Jacob and Benstead, Helen (2017) The prevalence of Special Educational Needs and Disabilities (SEND) identified in young people, aged 3-16, across the City of Sunderland: University of Sunderland, School of Education. Project Report. University of Sunderland/Sunderland City Council.

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The prevalence of Special Educational Needs and Disabilities (SEND)  
identified in young people, aged 3-16, across the City of Sunderland:  
University of Sunderland, School of Education

**May 2017**



## 1 Abstract

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This paper presents the findings of a mixed methods investigation into the prevalence of Special Educational Needs and/or Disabilities (SEND), identified in children and young people aged 3-16 years, across the City of Sunderland. This study was commissioned by Sunderland City Council, with the aim of informing their 5-year strategy for SEND provision. In providing a backdrop for this investigation, three inter-connected literature bases are explored; firstly, the demographics of the City of Sunderland and the current legislation surrounding SEND; secondly, the literature surrounding the specific primary need of Autism is analysed; and thirdly, literature highlighting alternative forms of education is presented and discussed. Analysis of data gathered through both qualitative and quantitative research methods has highlighted a range of foci for the Council, in formulating their 5-year SEND strategy. The data has indicated that there is a particularly high prevalence of children identified with Social, Emotional and Mental Health difficulties, as well as Autism and Moderate Learning Difficulties in Sunderland compared to national averages. Conversely, there is a lower than expected prevalence of children identified with Specific Learning Difficulties. The recommendations from this study focus on providing quality Continued Professional Development (CPD) opportunities in relation to meeting the varying needs of the SEND population, particularly for Special Educational Needs Co-ordinators (SENCOs); clarifying the role of the Designated Medical Officer (DMO); exploring opportunities for data sharing and ensuring that developing opportunities for effective multi-agency working are a priority for the Council.

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Map 6: Geographical representation of children with a diagnosis of ASD aged 14-16 years based on home postcode in Sunderland.

### 3 Executive summary

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The University of Sunderland, School of Education were commissioned by Sunderland City Council to undertake this piece of research. The aims of the research were as follows:

- To carry out analysis of existing data sets from the Council to gain insight into extent and nature of special educational needs and disability requirements for 3-16 year olds in Sunderland.
- To carry out qualitative research with key stakeholders from the National Health Service (NHS) and Clinical Commissioning Group (CCG).
- To produce a report with supporting evidence on findings to inform Sunderland City Councils 5-year strategy.

The research methods employed in this study included the examination of Pupil Level Annual School Census (PLASC), Early Years Foundation Stage (EYFS) and Department for Education (DfE) data to examine the prevalence of SEND in Sunderland, with comparison to national statistics. Qualitative, semi-structured interviews were undertaken with two Stakeholders from the CCG and the NHS in Sunderland. We also carried out geographical mapping of children and young people with a diagnosis of Autism Spectrum Disorders (ASD) in Sunderland to inform the five year plan for provision. In addition there was analysis of High Needs Funding, Children missing from education and the primary need of children and young people in Pupil Referral Units (PRU).

To enable effective data analysis ten themes were agreed:

- Theme 1:** Analysis of the prevalence trends based on identified primary need: children and young people 5-16 years in Sunderland (2013-2017).
- Theme 2:** Analysis of the prevalence of identified primary need: children and young people 5-16 years based on school year and key stage in Sunderland (2017).
- Theme 3:** Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support in Sunderland (2017).
- Theme 4:** Analysis of national data compared to Sunderland City Council data based on primary type of need identified in children and young people 5-16 years (2016).
- Theme 5:** Analysis of Early Years data (reception year) by primary type of need and Good Level of Development in Sunderland (2014 – 2017).
- Theme 6:** Analysis of interviews with the NHS and CCG.
- Theme 7:** Analysis of the prevalence of Autism Spectrum Disorder in the City of Sunderland (3-16 years) (2017).
- Theme 8:** Analysis of high needs funding.
- Theme 9:** Analysis of the primary need of children missing from education in Sunderland.
- Theme 10:** Analysis of the primary need of children and young people in Pupil Referral Units (PRU).

### **3.1 Main findings: Primary need PLASC data**

The most prevalent primary needs in Sunderland are:

- **Moderate Learning Difficulties (MLD)**, though the data shows that the number of children and young people identified with MLD have fallen since 2013.
- **Social, Emotional and Mental Health (SEMH)**
- **Speech, Language and Communication Needs (SLCN)**
- **Autism Spectrum Disorders (ASD)**, this has seen an increase year on year since 2013



**Recommendation:** For the Council to examine with SENCOs their knowledge and understanding of Moderate Learning Difficulties and to use this information to plan CPD to support educational contexts in accurate identification to meet the needs of children and young people with MLD.

**Recommendation:** Due to increase in prevalence of SEMH between 2016 and 2017, it is recommended that the Council support a focus on early identification of SEMH and ensure that all educational settings in Sunderland are equipped to support children and young people with this primary need.

When considering year group and key stage, the PLASC data identified:

- There is a notable rise in children identified with SEMH from Year 5 to Year 6, in Year 9 and in Year 11.
- In the primary age phase, there is a notable increase in MLD identification from 2.68% of all children in Year 1 to 5.55% in Year 6. The number of young people with MLD peaks between the Key Stage Two and Key Stage Three transition point.
- The number of children identified with SLCN in Sunderland peaks in year 1 at 6.14%. Then there is a dramatic reduction in rate of identification between Year 1 and Year 6. This indicates that the early years and early primary age phases are effectively supporting children in developing age-appropriate speech, language and communication skills.
- The numbers of children identified with ASD as a primary need in Sunderland remains relatively constant across year groups. However, there are notable peaks in prevalence following Key Stage transition points.
- The numbers of children identified with Specific Learning Difficulties (SpLD) in Sunderland are exceptionally low, as a proportion of all children identified with SEND.

**Recommendation:** For the Council to review existing models for effective multi-agency working and explore means by which greater collaboration between clinical teams, educational psychologists, SENCos and CAMHS can work together to support early intervention in educational contexts, by identifying geographical and age related hotspots for SEMH difficulties (DfE, 2015a; Eames and Shippen, 2017).

### **3.2 Main findings: Primary Need by classification (SEN Support, Statement of SEN and Education Health and Care plan)**

- 322 children and young people in Sunderland currently have a Statement of SEN, with 481 children currently in receipt of an EHC plan. This equates to 40% of children who need to be transferred from a Statement of SEN to an EHC plan by April 2018.
- The most prevalent primary needs for those identified as **SEN Support** in Sunderland are:
  - **MLD** (30.56%)
  - **SEMH** (22.94%)
  - **SLCN** (19.60%)
- The most prevalent primary needs for those who have a **Statement of SEN** in Sunderland are:
  - **ASD** (30.12%)
  - **SEMH** (18.32%)
  - **SLCN** (16.77%)
- The most prevalent primary needs for those who have an **EHC plan** in Sunderland are:
  - **ASD** (34.30%)
  - **SEMH** (24.53%)
  - **SLCN** (17.67%)

**Recommendation:** For the Council ensure the timely transfer of all 322 children currently in receipt of a Statement of SEN to an ECH plan, prior to April 2018.

### 3.3 Main findings: National and Sunderland City Council PLASC data

There is higher prevalence of children on Statements/EHC plan, compared to national data, with the following primary needs:

- **Social Emotional Mental Health:** National prevalence = 12.3%; Sunderland = 26.3%. This represents an increase in prevalence of **+14.03%** in Sunderland.
- **Autism Spectrum Disorders:** National prevalence = 25.9%; Sunderland = 31.03%. This represents an increase in prevalence of **+5.13%** in Sunderland.
- **Physical Disability:** National prevalence = 5.8%; Sunderland = 10.14%. This represents an increase in prevalence of **+4.34%** in Sunderland.

With regard to SEN Support, compared to national data, Sunderland has a higher prevalence of children with **Moderate Learning Difficulties**, at **32.72%**. This is **5.92%** higher than the national average.

**Recommendation:** For the Council to use the National Data to monitor the prevalence rates of SEMH in Sunderland to inform future service planning and CPD needs of educational contexts. There needs to be further analysis carried out as to why SEMH is 14.03% above the national average.

There is lower prevalence of children on Statements/EHC, compared to national data, with the following primary needs:

- **Moderate Learning Difficulty:** National prevalence = 13.4%; Sunderland = 5.93%. This represents a decrease in prevalence of **-7.47%** in Sunderland.
- **Severe Learning Difficulty:** National prevalence = 13.1%; Sunderland = 7.29%. This represents a decrease in prevalence of **-5.81%** in Sunderland.
- **Specific Learning Difficulty:** National prevalence = 4%; Sunderland = 0.37%. This represents a decrease in prevalence of **-3.63%** in Sunderland.

**Recommendation:** For the Council to respond to the under identification of SpLD by evaluating the effectiveness or impact of arrangements for identifying and assessing the needs of specific groups of children and young people with SpLD across provision in the City. This will require the Council to provide school based training on neurodiversity.

### 3.4 Main findings: Early Years

- The main primary need is SLCN within Early Years in the current academic year with 55.61% of all children with identified need.
- The second highest primary need is SEMH is 11.48% of the SEND population.
- ASD is the third most prevalent primary need of 10.97% of the SEND population.

**Recommendation:** To explore providing an accredited SLCN programme for early years practitioners, either level 2 (GCSE) level 3 (A level equivalent) or Undergraduate credits (Level 4, 5, 6) or MA credits (level 7).

### 3.5 Main Findings: Interviews

- **Multi-agency working**

- Collaboration between Education and Health was deemed to be effective. This was cited as being due to open and honest communication between stakeholders.
- The participant from the NHS considered working closely with Social Care to be more challenging due to higher thresholds for working with families in light of demands on the service provision and staff changes in Child and Adolescent Mental Health Services (CAMHS).

**Recommendation:** For the Council, in collaboration with stakeholders to examine ways of consistently engaging social care to promote effective multi agency working across the stakeholders.

- **Increase in prevalence of specific needs**

- It was suggested by interviewed participants that there has been a significant and visible increase in the number of children and young people identified with ASD, Diabetes, Child Obesity and Child Mental Health Difficulties in Sunderland over recent years.

- **Relationships with parents**

- Good practice was identified with regard to the building of effective relationships with parents and carers. Multiple examples of engagement opportunities were highlighted particularly within the NHS
- There was a suggestion that some parents were reluctant to liaise with social care due to possible underlying stigma related to social services.
- Good practice was evident in terms of supporting parents when a child is born prematurely; clear pathways of support exist within the NHS.

- **Supporting SENCos**

- There is currently no standardised exemplar EHC plan used by educational settings which can result in setbacks when there is incomplete or inconsistent evidence at SEN panel meetings. This is resulting in some children and young people encountering delays in acceptance of EHC plans and frustration for those involved in the process.

**Recommendation:** For the Council to devise and distribute an exemplar Education, Health and Care Plan and accompanying evidence to support SENCos. This will have the added benefit of improving the efficiency of the SEN panel meetings.

- **Data sharing**

- One respondent identified challenges in meeting the needs of children and young people who have been educated in multiple settings, often due to inadequate data sharing across settings. This was believed to be particularly widespread when children have attended Pupil Referral Units (PRUs) and/or young offender's institutions.
- Both respondents interviewed identified that there are opportunities for improvements in data sharing across the services.

**Recommendation:** To formally assess children and young people in a PRU context on entry, to ensure that their range of needs are identified early and that EHC plan can be either created or updated to reflect their current needs. This assessment must involve multi-agencies, as it is highly likely that the child will require support from CAMHS as well as from the educational setting itself.

**Recommendation:** Review current data sharing policies to enable sharing of data, where appropriate, between CCG, NHS Digital, LA and DMO to inform better identification of needs and local decision-making around SEND.

- **Role of Designated Medical Officer (DMO)**
  - Both respondents interviewed in this study highlighted that the responsibilities associated with the DMO role require clarification as it is currently a shared position.

**Recommendation:** For the Council to devise role descriptions, clearly delegating specific responsibilities to the two parties sharing the DMO role. These should focus on supporting joined up working across Education, Health and Care.

### **3.6 Main findings: Prevalence of Autism Spectrum Disorders (ASD)**

- The Autism Outreach Team (AOT) have reported that there are 6 new diagnoses of ASD per week in Sunderland, which is reflected in the very high prevalence rate of ASD across all Key Stages, when compared to national figures, and particularly in Key Stage 2. This could be due to the broadening of diagnostic criteria in recent years and/or increased awareness of Autism.
- There are areas where prevalence rates are higher, such as Washington North and Shiney Row. However, the reasons for this are unknown and could be due to population rates.

**Recommendation:** For the Council to conduct additional analysis into where there needs to be additional provision particularly in terms of nursery and school placements and where the children and young people reside, this should inform capacity building within the Autism Outreach Team. The local offer needs to be reviewed to ensure it effectively signposts families to support and services.

### 3.7 Main findings: High needs funding

It is evident from discussions with the stakeholders that Sunderland City Council has a robust banding system in place that is transparent and related to costed provision planning.

Following discussions with stakeholders it is clear the Council operate a robust, costed four point banding system for allocation of funding on a per pupil basis. This has been in place and will remain in position during the academic year 2017-2018. A second phase of consultation by the DfE (2016a) on the new National Funding Formula (including a consultation on funding for High Needs which ran concurrently) closed on 22<sup>nd</sup> March 2017. Due to the date of the closure and the time of submitting the completed research to Sunderland City Council it was not feasible to future forecast beyond the current financial year.

Until the government release their findings from this consultation and legislate for the new funding formula, it is not appropriate to make predictions although there is a guarantee that in 2018-2019 no school will receive more than 1.5% reduction per-pupil funding and a 3% overall cut for this financial year. It would be wise to assume that this would be based on pupil data from 2017-2018, as has happened historically, although this is not specifically highlighted. Further to this per-pupil gains in funding are capped at 3% for 2018-2019 and 2.5% in 2019-2020.

Using these discussions and the limited amount of information available, Sunderland City Council should consider the following recommendations:

**Recommendation:** For the Council to develop a strategic SEND Provision map for the next five years in line with guidance (DfE, 2016a). This map will support optimal allocation of funding, resources and provision for SEND across Sunderland. The data contained in this report will support this process.



### **3.8 Main finding: Children missing from education**

- Unfortunately current data was not available. The following recommendation is therefore made:

**Recommendation:** For the City Council to appoint a senior officer responsible for obtaining and collating data on children missing from education to ensure they are meeting their statutory obligations.

### **3.9 Main finding: Primary needs of children and young people in a Pupil Referral Unit (PRU)**

- 86% of children and young people are identified as SEMH as their primary need with 101 children on SEN Support and 1 with an EHC Plan (also for SEMH).

**Recommendation:** For the Council to commission further research into effective alternative provision models that support children and young people in achieving good outcomes in terms of education and to examine good practice approaches in meeting social, emotional and mental health needs.

#### **4 University of Sunderland: Researchers and Authors**

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The planning for this research began in January 2017, following full ethical approval from the University of Sunderland Ethics Committee, with data collection beginning in February 2017. This research was conducted in accordance with University of Sunderland ethical protocols and the BERA (2011) Guidelines for Educational Research.

##### **Project Director, Lead Researcher and Author: Sarah Martin-Denham**

Sarah is a Senior Lecturer at the University of Sunderland and the Lead for Special Educational Needs and Disability in the School of Education. She has extensive knowledge of teaching in the North East of England in a variety of settings from Early Years to Post 16, where she has developed a particular interest and expertise in meeting the needs of children and young people with Special Educational Needs and Disabilities. Sarah is the Programme Leader for the Post Graduate Certificate National Award for Special Educational Needs Co-ordination, and she leads and teaches on the MA Special Educational Needs, Disability and Inclusion. In addition, Sarah teaches on the Initial Teacher Education programmes to extend trainees knowledge and understanding of meeting the needs of children with diverse learning and care needs. Sarah's research interests include how we can better meet the needs of excluded children and young people through effective professional learning and collaboration with families. She is also interested in how the Special Educational Needs Co-ordinator (SENCo) can be enabled to effectively lead improvements in provision and practice for children and young people in partnership with parents and carers. Her recent publications include Martin-Denham, S. (Eds.) (2015) *Teaching Children with Special Educational Needs and Disabilities 0-25 years*. London: Sage and a collaboration with Stewart, C. (2017) SENCO magazine: 'Ports in a Storm'. Teach Primary.

**Head of the School of Education: Dr Lynne McKenna**

Lynne is Head of the School of Education and Head of Research in the Faculty of Education and Society at the University of Sunderland. Prior to this, Lynne was Director of Initial Teacher Education in the Faculty of Health and Life Sciences at Northumbria University. Lynne has a wealth of experience as a practitioner, a senior education manager and a researcher in teacher education, family learning and parental engagement. Prior to joining the University, Lynne designed and delivered one of the fourteen national pilot Family Numeracy Programmes. She was involved in the evaluation of the pilot project and contributed to the Basic Skills Agency/NFER (1999) final report Family Numeracy Adds Up. As Family Numeracy co-ordinator for South Tyneside Local Authority, Lynne was responsible for the roll out of this programme. She has conducted a number of evaluations of Sure Start programmes. More recently Lynne led a social impact research which examined the impact of the Foundation of Light's Wider Family Learning programmes (2012). Lynne was a member of the research reference group for the National Inquiry into Family Learning which published its final report in October 2013. Lynne is also an invited member of the Early Intervention Foundation Evidence Panel.

**Professor of Vocational Education: Professor Maggie Gregson**

Maggie is Professor of Vocational Education, Director of the University of Sunderland's Centre for Excellence in Teacher Training (SUNCETT) and Research Lead for the School of Education. From 2003- 2005 she was a Principal Investigator, in an Evaluation of a Thinking Skills in Schools in Northumberland Project and Lead Author in the final report Raising Achievement and Aspirations in Northumberland. Maggie was invited to present advisory evidence to the National Commission for Adult and Vocational Teaching and Learning (CAVTL) in 2013. She is a member of the National Expert Panel Member the ETF Professional Standards for teachers and the Panel for Higher Level Technical Education. Her research interests include the initial and continuing professional development teachers and the collaborative approaches to educational evaluation and improvement.

Her recent publications include, Gregson, M and Hillier, Y. (eds.) (2015) *Reflective Teaching in Further, Adult and Vocational Education*. London: Bloomsbury Press and Gregson, M. , Nixon, L. Spedding, P., (eds.) (2015) *Readings for Reflective Teaching in Further, Adult and Vocational Education*. London: Bloomsbury Press. She is currently Principal Investigator for the ETF National Research Development Fellowship and Exploratory Research Programmes which support practitioner-researchers in the Further Adult and Vocational Education in the improvement of their practice.

**Researcher and Author: Dr Helen Saddler**

Helen undertook a BA (Hons) Primary QTS at the University of Sunderland between 2007 and 2011 and won the Langham award for outstanding academic contribution with her thesis. She completed an MPhil with Distinction from the University of Cambridge in 2012 and went on to receive full ESRC funding for her PhD in Education, completed through the University of York in 2015. Helen has worked in central and local government, as a Youth Policy Advisor at the Cabinet Office, and for the Mayor of London's Education and Youth Team at Greater London Authority. Helen is the Founder and Director of Inclusive Classrooms, a social enterprise organisation providing training and professional development opportunities for Teaching Assistants in mainstream primary schools. Helen has published a range of papers on her research into the role of TAs, has been the sole author of the Mayor of London's London Curriculum programme for primary schools since 2015 and has authored a range of professional development materials for Teaching Assistants through her work with Inclusive Classrooms. Helen's research interests include the process of social inclusion for children identified with Special Educational Needs and the influence of Teaching Assistants on academic and social outcomes of children identified with Special Educational Needs.

**Researcher and Author: Simon Ripley**

Simon has 15 years of classroom and leadership experience. Early in his career he began developing his skills and those of others in relation to the education of children and young people with Special Educational Needs and/or Disabilities including the support for those now termed 'disadvantaged' and in receipt of pupil premium. Simon was an Assistant Head Teacher and then Head Teacher of an all-age Specialist School for pupils with complex needs. During this time he represented pupils with additional needs on several regional and national forums and working groups including the strategic development of multi-disciplinary provisions. He currently works as an Associate Tutor for the School of Education at the Sunderland University. He is an Academic Tutor on the NASENCo qualification, the MA in Special Educational Needs, Disability and Inclusion, Initial Teacher Education Mentor and is also a mentor for a large cohort of trainees studying for the International PGCE qualification. Simon's research interests include improvement of the outcomes for children and young people with Special Educational Needs and/or Disabilities, contextual factors that influence and inform provision planning, Leadership, pedagogy and how technology can support and improve learning.

**Research Analyst: Jacob Donaghue**

Jacob graduated in 2015 with a Distinction in MSc Psychological Research Methods and in 2014, with BSc in Psychology. Jacob has worked on projects for the Schools of Psychology and Social Science. Recent projects include The Wolf and the Lion: Conceptualising Dyslexia and Social Class and the Athena Swan Award for the Faculty of Education and Society. Jacob's current research interests include how Assistive Technologies and Inclusive User Experience benefit individuals with specific learning difficulties - namely Dyslexia.

The research team would like to thank Jacqui Cassidy, Senior Lecturer at the University of Sunderland, for her contribution to the project.

## 5 Glossary of acronyms

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ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorders
BERA	British Educational Research Association
CAMHS	Child and Adolescent Mental Health Services
CAVTL	Commission for Adult and Vocational Teaching and Learning
CCG	Clinical Commissioning Groups
CMOOE	Children Missing Out of Education
CoS	City of Sunderland
CPD	Continuing Professional Development
CSF	Cerebrospinal Fluid
CYPS	Children and Young People Services
DfE	Department for Education
DMO	Designated Medical Officer
DO	Designated Officer
DoH	Department of Health
EFA	Education Funding Agency
EHC plan	Education, Health and Care plan
EYFS	Early Years Foundation Stage
EYFSP	Early Years Foundation Stage Profile
FE	Further Education
FSM	Free School Meals
GLD	Good Level of Development
GP	General Practitioner
HI	Hearing Impairment
IMD	Index of Multiple Deprivation

ITE	Initial Teacher Education
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LSOA	Lower Layer Super Output Layer
MLD	Moderate Learning Difficulty
MSI	Multi-Sensory Impairment
NCTL	National College for Teaching and Leadership
NHS	National Health Service
NSA	No Specialist Assessment
Ofsted	Office for Standards in Education
OH	Occupational Health
ONS	Office for National Statistics
PCHI	Permanent Childhood Hearing Impairment
PD	Physical Difficulty
PLASC	Pupil Level Annual School Census
PMLD	Profound and Multiple Learning Difficulties
PRU	Pupil Referral Unit
SEMH	Social, Emotional and Mental Health
SEN	Special Educational Needs
SENCo	Special Educational Needs Co-ordinator
SEND	Special Educational Needs and/or Disability
SIO	School Improvement Officers
SLCN	Speech, Language and Communication Needs
SLD	Severe Learning Difficulty
SOC	Standard Occupational Classification
SPARK	Simons Foundation Autism Research Initiative
SpLD	Specific Learning Difficulty
SPSS	Statistical Package for the Social Sciences
TA	Teaching Assistant
TaMHS	Targeted Mental Health in Schools
VI	Visual Impairment
YOT	Youth Offending Team

## 6 Glossary of terms

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(Definitions taken from DfE, 2014a; DfE 2015a; NICE, 2017).

**Alternative Provision (AP):** These are education settings for children unable to attend a mainstream school. Local Authority maintained establishments providing alternative provision are often referred to as pupil referral units. There are also an increasing number of alternative provision academies and free schools.

**Annual review:** The review of an EHC plan which the Local Authority must make as a minimum every 12 months.

**Care pathway:** The route a person takes through healthcare services. For example, a care pathway might show the order in which various tests are done to diagnose an illness, which treatments should be tried, and when care moves from primary to secondary care, or from hospital back into community care.

**Child and Adolescent Mental Health Services (CAMHS):** These services assess and treat children and young people with emotional, behavioural or mental health difficulties. They range from basic pastoral care, such as identifying mental health problems, to specialist 'Tier 4' CAMHS, which provide in-patient care for those who are severely mentally ill.

**Classification of Primary Need:** When children and young people are entered onto the Special Educational Needs register they are entered for their primary need (these classifications can be found on p.43-44).



**Clinical Commissioning Group Outcomes Indicator Set:** Support to enable Clinical Commissioning Groups (CCGs) and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs.

**Clinical Commissioning Groups (CCGs):** Groups that co-operate with the Local Authority in jointly commissioning services, ensuring there is sufficient capacity contracted to deliver necessary services, drawing the attention of the LA to groups and individual children and young people with SEND, supporting diagnosis and assessment, delivering interventions and reviewing support regularly.

**Commissioning:** The process used by health services and local authorities to: identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated.

**Compulsory school age:** A child is of compulsory school age from the beginning of the term following their 5th birthday until the last Friday of June in the year in which they become 16, provided that their 16th birthday falls before the start of the next school year.

**Data set:** A collection of data, usually presented in a table. Each column represents a particular variable. For example, the dataset from a survey of school children could be organised so that the data could easily be compared by the age and gender of respondents. The tables might then be summarised so that you could compare behaviour or illnesses experienced by these characteristics.

**Deprived areas:** Geographic regions or areas that have significantly higher levels of unemployment and lower rates of income per head than the national average.

**Designated Medical Officer (DMO):** The DMO supports the CCG in meeting statutory responsibilities for children and young people with SEND, primarily as a point of contact for local partners, when notifying parents and LAs about children and young people they believe may have SEN or a disability, and when seeking advice on SEND.

**Diagnosis:** The process of identifying a disease or condition by carrying out tests or by studying the symptoms.

**Early Years Foundation Stage (EYFS):** The EYFS sets standards for the learning, development and care of children from birth to five years.

**Early Years Provider:** A provider of early education places for children under five years of age. This can include state-funded and private nurseries as well as child minders.

**Education Funding Agency (EFA):** A Government agency who manage £54 billion of funding a year to support all state-provided education for 8 million children age 3-16 years, and 1.6 million young people aged 16-19 years.

**Education Health and Care Plan (EHC plan):** An EHC plan details the education, health and social care support that is to be provided to a child or young person who has SEN or a Disability. It is drawn up by the Local Authority after an EHC needs assessment of the child or young person has determined that an EHC plan is necessary, and after consultation with relevant partner agencies.

**Effect Size:** The observed association between interventions and outcomes, or a statistic to summarise the strength of the observed association.

**Extent Rank:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 30% in the country.

**Good Level of Development (GLA):** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.

**Graduated Approach:** A model of action and intervention in early education settings, schools and colleges to help children and young people who have special educational needs. The approach recognises that there is a continuum of special educational needs and that, where necessary, increasing specialist expertise should be brought to bear on the difficulties that a child or young person may be experiencing.

**Health and Wellbeing Board:** A Health and Wellbeing Boards acts as a forum where local commissioners across the NHS, social care and public health care work together to improve the health and wellbeing of their local population and reduce health inequalities. The boards are intended to increase democratic input into strategic decisions about health and wellbeing services, strengthen working relationships between health and social care and encourage integrated commissioning of health and social care services.

**Healthy Child Programme:** The Healthy Child Programme covers pregnancy and the first five years of a child's life, focussing on universal preventative service that provides families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

**Index of Multiple Deprivation (IMD):** The official measure of relative deprivation for small areas or neighbourhoods in England.

**Joint Strategic Needs Assessment:** Information, Advice and Support Services provide advice and information to children with SEN or disabilities, their parents, and young people with SEN or disabilities. They provide neutral and factual support on the special educational needs system to help the children, their parents and young people to play an active and informed role in their education and care. Although funded by local authorities, Information, Advice and Support Services are run either at arm's length from the Local

Authority or by a voluntary organization to ensure children, their parents and young people have confidence in them.

**Listwise Deletion:** This is a method of handling missing data where a record is removed from the analysis if a single value is not present.

**Local Authority (LA):** Leading integration arrangements for children and young people with SEND

**Local Concentration:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 10% within a Local Authority, compared to those in other areas.

**Local Offer:** Local Authorities in England are required to set out in their Local Offer information about provision they expect to be available across education, health and social care for children and young people in their area who have SEN or are disabled, including those who do not have Education, Health and Care (EHC) plans. Local authorities must consult locally on what provision the Local Offer should contain.

**Lower Layer Super Output Areas (LSOA):** These are small areas designed to be of a similar population size with an average of approximately 1,500 residents of 650 households. For ease of communication LSOA are sometimes referred to as neighbourhoods or small areas.

**Maintained School:** Schools who are maintained by a Local Authority any community, foundation or voluntary school, community special or foundation special school.

**Methodology:** Describes how research is carried out, including how information is collected and analysed, and why a particular method or methods have been chosen.

**National Curriculum:** This sets out a clear, full and statutory entitlement to learning for all pupils, determining what should be taught and setting attainment targets for learning. It also determines how performance will be assessed and reported.

**NHS England:** NHS England is an independent body, at arm's length to the government and held account through the NHS Mandate. Its main role is to improve health outcomes for people in England by providing national leadership for improving outcomes and driving up the quality of care; overseeing the operation of clinical commissioning groups; allocating resources to clinical commissioning groups, and commissioning primary care and specialist services.

**NHS Foundation Trust:** NHS foundation trusts are not-for-profit corporations that provide NHS hospitals, mental health and ambulance services. NHS foundation trusts are not directed by the Government, but are accountable to their local communities and governors, to their commissioners through contracts and to Parliament through their annual report and accounts. Foundation trusts are registered with and inspected by the Care Quality Commission.

**Ofsted:** Office for Standards in Education, a non-Ministerial government department established under section 342 of the Education Act 1996 to take responsibility for the inspection of all schools in England. Her Majesty's Inspectors (HMI) form its professional arm.

**Parent:** Under section 576 of the Education Act 1996, the term 'parent' includes any person who is not a parent of the child, but has parental responsibility (see below) or who cares for him or her.

**Population:** A group of people with a common link, such as the same medical condition, living in the same area or sharing the same characteristics.

**Prevalence:** How common a disease or condition is within a population, either at a point in time or over a given period of time (it includes new and existing cases). It is different from incidence.

**Primary Care:** Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians. It includes community clinics, health centres and walk-in centres.

**Public Health England (PHE):** An executive agency that delivers services to protect the public's health through a nationwide integrated health protection service, provides information and intelligence to support local public health services, and supports the public in making healthier choices.

**Pupil Referral Unit (PRU):** Any school established and maintained by a Local Authority under section 19 (2) of the Education Act 1996 which is specially organised to provide education for pupils who would otherwise not receive suitable education because of illness, exclusion or any other reason.

**Reliability:** The ability to get the same or similar result each time a study is repeated with a different population or group.

**Research Recommendations:** Recommendations for future research, covering questions relating to an uncertainty or lack of evidence that has been identified.

**Review of the Literature:** A summary of the evidence in a number of different individual studies, with conclusions about their findings.

**SEN Support:** Extra or different support that is provided in addition to the school's usual curriculum. The class teacher and SEN co-ordinator (SENCo) may receive advice or support from outside specialists.

**Social care:** Social care generally refers to all forms of personal care and other practical assistance for children, young people and adults who need extra support. This includes:

- Vulnerable children and young people (those who are at risk of, or who are already experiencing social and emotional problems).
- Children, young people and adults with learning or physical disabilities or mental health problems.

**Special Educational Needs (SEN):** A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she has a significantly greater difficulty in learning than the majority or others of the same age, or has a disability which prevents or hinders him or her from making use of educational facilities of a kind generally provided for others of the same age in mainstream or mainstream post-16 provisions.

**Special Educational Needs Co-ordinator (SENCo):** A qualified teacher in a school or maintained nursery school who has responsibility for co-ordinating SEN provision. In a small school, the head teacher or deputy may take on this role. In larger schools there may be a team of SENCos. Other early years settings in group provision arrangements are expected to identify an individual to perform the role of SENCo and childminders are encouraged to do so, possibly sharing the role between them where they are registered with an agency.

**Special Educational Provision:** Special educational provision is provision that is different from or additional to that normally available to pupils or students of the same age, which is designed to help children and young people with Special Educational Needs or Disabilities to access the National Curriculum at school or to study at college.

**Special School:** A school which is specifically organised to make special educational provision for pupils with special educational needs. Specialist schools maintained by the comprise community specialist schools and foundation specialist schools, and non-maintained (independent) specialist schools that are approved by the Secretary of State under Section 342 of the Education Act 1996.

**Stakeholder:** An organisation/individual with an interest in a topic, including public sector providers and commissioners of care or services.

**Standard Occupational Classification Hierarchy:** This hierarchy is used by the Office for National Statistics to classify a range of occupations.

**Statement of Special Educational Needs:** A pupil has a statement of SEN when a formal assessment has been made. It is a document that sets out the child's need and the extra help they should receive, all Statements of SEN should be converted to an Educational Health and Care plan by April 2018.

**Triangulation:** The use of two or more different research methods in combination; principally used as a check of validity. Generally, greater similarity of results produced by different methods indicates greater validity of the findings.

**Validity:** Whether a test or study actually measures what it aims to measure.

**Young person:** A person over compulsory school age (the end of the academic year in which they turn 16). From this point the right to make decisions about matters covered by the Children and Families Act 2014 applies to the young person directly, rather than to their parents.



## 7 Introduction

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Sunderland City Council commissioned the School of Education at the University of Sunderland to examine the prevalence of Special Educational Needs and Disabilities (SEND) identified in young people, aged 3-16, across the City of Sunderland. This research was requested to inform the strategic requirements in enabling effective provision for Sunderland's children and young people with SEND over the next five years.

With the recent changes in SEND policy, it is vital that Councils forward plan their SEND delivery strategies and funding arrangements, to better support schools and other education providers in navigating the challenges and opportunities posed by these changes (Children and Families Act 2014, DfE, 2015a). It is intended that this research will better place the City of Sunderland Council to challenge the DfE and EFA over funding arrangements for Sunderland, as it identifies specific potential pressures on the high needs block in the region. The Department for Education (DfE, 2016a) indicate the purpose of high needs funding is to provide the most appropriate support package for an individual with special educational needs (SEN) in a range of settings, taking account of parental and student choice. It is also intended to support good quality alternative provision for pupils who cannot receive their education in schools (ibid).

This research is taking place in a climate of ever-changing and extremely challenging financial pressures. This climate necessitates a targeted approach to delivery which maximises efficiency, effectiveness and innovative delivery routes to inform long term commissioning priorities.

## **8 Research methodology**

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BERA (2011) suggest that 'educational researchers aim to extend knowledge and understanding in all areas of educational activity and from all perspectives including learners, educators, policymakers and the public' (p.4).

### **8.1 The focus of the research**

The initial interview between the research team and Sunderland City Council identified the following foci for this research:

- To carry out analysis of existing data sets to gain insight into extent and nature of special educational needs and disability requirements for 3-16 year olds in Sunderland.
- To carry out qualitative research with key stakeholders from the National Health Service (NHS) and Clinical Commissioning Group (CCG).
- To produce a report with supporting evidence on findings to inform Sunderland City Councils 5-year strategy.

Following meetings with City of Sunderland Council the researcher team devised key themes to meet the research brief.

## 8.2 Key research themes

- Theme 1:** Analysis of the prevalence trends based on identified primary need: children and young people 5-16 years in Sunderland (2013-2017).
- Theme 2:** Analysis of the prevalence of identified primary need: children and young people 5-16 years based on school year and Key Stage in Sunderland (2017).
- Theme 3:** Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support in Sunderland (2017).
- Theme 4:** Analysis of national data compared to Sunderland City Council data based on primary type of need identified in children and young people 5-16 years (2016).
- Theme 5:** Analysis of Early Years data (reception year) by primary type of need and Good Level of Development in Sunderland (2014 – 2017).
- Theme 6:** Analysis of interviews with the NHS and CCG.
- Theme 7:** Analysis of the prevalence of Autism Spectrum Disorder in the City of Sunderland (3-16 years) (2017).
- Theme 8:** Analysis of high needs funding.
- Theme 9:** Analysis of the primary need of children missing from education in Sunderland.
- Theme 10:** Analysis of the primary need of children and young people in a Pupil Referral Unit (PRU).

## 8.3 The research approach

The research team approached this study from a social constructivist viewpoint. This approach centres on the idea that people play an active part in their own meaning-making and in the co-construction of knowledge in social interaction through dialogue (Vygotsky, 1978). This process of meaning making and knowledge construction is strongly influenced by social context – the situation in which a person finds themselves.

In this study, the qualitative data collected from participants is influenced by the social culture of the organisations in which they work (Fosnot, 2005). This also results in the researchers approaching this study from an interpretivist paradigm. The interpretivist approach emphasises the importance of social interaction as the basis of knowledge-building. From this perspective the individual and society are regarded as inseparable entities (O'Donoghue, 2007).

#### **8.4 Research methods**

The researcher team employed a mixed-method approach, involving both quantitative, qualitative data collection and analysis. Detailed descriptions of the methods undertaken in this study are given in the remainder of this section. Basit (2010) argues that the researcher should choose between qualitative or quantitative methods; however, Thomas (2013) draws attention to the need for a researcher to decide how the specific form of inquiry lends itself to the research question. As Higbee, Arendale and Lundell, 2005, p. 12 stated 'Qualitative research complements the more generalizable data that are gained through quantitative measures.' With the requirements of the Council in consideration this research project included both quantitative and qualitative methods.

#### **8.5 Qualitative methods**

Semi-structured interviews were undertaken by one member of the research team, with two purposively sampled participants in this study. Denscombe (2010) defines purposive sampling as: 'the researcher deliberately selects particular cases because they are seen as instances that are likely to produce the most valuable data' (p.17). Consequently, both participants were sampled for involvement in this study because it was deemed by the researchers and the Council that these participants would yield the most relevant data for analysis in meeting the aims of this research. One participant was an employee of the National Health Service (NHS) in Sunderland, employed as a Consultant Paediatrician; the other participant was an employee of the Clinical Commissioning Group (CCG) as a Joint Commissioning Officer.

Cohen et al. (2013) described interviews as a move from seeing humans as data to more of a social situation where an interchange of views can occur. Thomas (2013) agrees and adds that interviews enable the researcher to have face-to-face contact with the participants which will inevitably make them react in a different way to, for example, a questionnaire. Semi-structured interviews were undertaken due to the need to investigate the values, beliefs and motives behind individuals' experiences, in fully exploring the research questions of this study (Foddy, 1993). All interviews were undertaken inside the offices of the two participants. This was deemed to be conducive to effective data collection as, 'people talk more freely on their own ground' (Gillham, 2000, p.9). Exact locations of the individual interviews were chosen based on the availability of rooms at the time of the interview.

Wengraf (2001) argues that the greatest advantage of semi-structured interviewing as a research method is the flexibility. The relatively unstructured interview protocol enables both the researcher and the participant to exert control over the direction of the interview. Not only does this encourage interviewees to follow their interests within the parameters of the issues explored, but it also urges the participants to share their stories and extend their answers, due to the supportive culture that flexibility provides (Keats, 2000).

When conducting interviews, the researcher undertakes the role of the research instrument. Therefore, the researcher's 'biases, angers, fears and enthusiasms influence questioning style and how what is heard is interpreted' (Rubin and Rubin, 2004, p.12). This is recognised as a limitation of the research undertaken, however, the lead researcher who conducted these interviews did exercise self-reflexivity during data collection and data analysis, to reduce the bias that her personal values and beliefs may have presented.

Whilst it is widely accepted that interviewing produces rich data (Gillham, 2000; Siedman, 1998; Wengraf, 2001), the time consuming nature should not be ignored. Semi-structured interviews allow little scope for follow up (Basit, 2010 and Thomas, 2013). In order to afford effective data analysis, interviews require transcription. For this reason, it was decided that two interviews with key stakeholders were appropriate for the scope of this study.

Additionally, a transcriber was employed to undertake the transcription of the interviews. This also prevented any researcher bias during the transcription process.

The questions were designed to gather information about the intended outcomes across four themes, as agreed by the researchers and Sunderland City Council:

- Criteria and pathways - diagnosis
- Effectiveness of multi-agency involvement
- Joint commissioning provision
- Data sharing protocols to inform strategic decision across the local area
- The possibility of joint data base to inform decision making

Costa (1994) advocates the use of open-ended questions that require a recall of thinking and hypothesising. 'Would/if kinds of questions cause the brain to dream, visualize, evaluate, speculate, and imagine. Those two little words carry great power.' (p. 111). In light of this the interview questions were designed to be open-ended (appendix 1 and 2). Arksey and Knight (1999), McNiff (2013) and Thomas (2013) suggest that semi-structured interviews adopt a more open ended approach which allows researchers to follow up responses thus gaining greater insight into the topic being discussed. There were opportunities given in both interviews to elaborate on answers and to give additional clarification.

Prior to the interviews commencing the questions were discussed and approved, no modifications were required as it was agreed the questions were straightforward. As Fulcher and Scott (1999) suggested, 'unless the question is carefully worded, there will be scope for ambiguity and misunderstanding on the part of the respondents. As a result the answers that they give may be difficult to interpret' (p.77). The interviewer ensured that the questions were clear and that the participants felt at ease answering them. The justification for qualitative data was that it would examine the judgements or feelings of people key to multi agency working within Sunderland City Council (Verma, 1999).

## 8.6 Quantitative methods

This research utilised the data made available from Sunderland City Council to meet the aims of the study. The data was used to examine the primary need of children and young people with special educational needs and disabilities from 3-16 years. This included children who have a Statement of SEN, Education, Health and Care plans (EHC plans), and those who were identified as needing SEN Support from 3-16 years. This data was analysed to provide the Council with a detailed overview of the number of children and young people who have a primary need within the broad areas:

- Communication and Interaction
- Cognition and Learning
- Social, Emotional and Mental Health Difficulties
- Sensory and or Physical Needs

(DfE, 2015a).

To organise the data and to examine the prevalence of SEND across the City of Sunderland the following classifications and categories were used (DfE, 2015a; DfE 2016b)

- Statement of SEN
- Education, Health and Care plan
- SEN Support

**SpLD** Specific Learning Difficulty

**MLD** Moderate Learning Difficulty

**SLD** Severe Learning Difficulty

**PMLD** Profound and Multiple Learning Difficulty

**SEMH** Social, Emotional and Mental Health

**SLCN** Speech, language and communication needs

**HI** Hearing Impairment

**VI** Visual Impairment

<b>MSI</b>	Multi-Sensory Impairment
<b>PD</b>	Physical Disability
<b>ASD</b>	Autism Spectrum Disorder
<b>OTH</b>	Other Difficulty/Disability
<b>NSA</b>	No Specialist Assessment

## **8.7 Exploratory Geographical Analysis**

Bakian et al. (2015) recommend the use of mapping tools to identify any localised regions of heightened risk of ASD, this allows for the development of hypotheses based on findings in relation to factors such as familial risk or socio-economic status. For example in her study, using geographical mapping ASD hotspots were identified in four out of five birth cohorts. Exploratory geographical analysis was chosen as a method of data analysis to identify if there were any areas of Sunderland where there was a higher than average prevalence rate compared to other areas within the city. The maps produced were based on the children and young people aged 3-16 years with a diagnosis of ASD, identifying where they attend nursery/school and where they live in Sunderland or neighbouring area and whether they had a Statement of SEN/EHC plan or were identified as needing SEN Support. A ward map of Sunderland can be viewed in appendix 4.

To comply with the Data Protection Act 1998 legal guidance was sought on mitigating the chance of identifying an individual child or young person. The initial brief was to map where the children with Autism live by their home postcode.



To address the issue of inadvertently identifying children, the research and data protection team decided to map the children in multiple year groups:

- Map 1: All children with a diagnosis of Autism
- Map 2: Nursery and Reception children with a diagnosis of Autism
- Map 3: Key Stage One children with a diagnosis of Autism
- Map 4: Key Stage Two children with a diagnosis of Autism
- Map 5: Key Stage Three children with a diagnosis of Autism
- Map 6: Key Stage Four children with a diagnosis of Autism.

Furthermore, the research team would advise Sunderland City Council to refrain from making this document available to the public due to the aforementioned reasons.

#### **8.8 The data collection schedule**

The data collection for this research began in January 2017 through initial conversations with one of the key stakeholders. The quantitative and qualitative data was received following ethical approval from February- April 2017.

#### **8.9 Ethical considerations**

The principal researcher for this research project sought and gained ethical consent from the University of Sunderland Ethics Committee. Following this approval, voluntary and informed consent was sought for the interviews for Theme 6. As BERA (2011) advocate, researchers must take the steps necessary to ensure that all participants in the research understand the process in which they are to be engaged, including why their participation is necessary, how it will be used and how and to whom it will be reported. Cohen et al. (2013) acknowledge that an inevitable tension exists, between ensuring that research is ethical and ensuring that the data gathered is of optimum quality. Approval by the University of

Sunderland Ethics Committee was deemed by the researchers to effectively strike a balance in mitigating this tension.

The securing of participants' voluntary informed consent, before research gets underway, is considered the norm for the conduct of research, this was the process followed prior to the interviews taking place (Cohen et al., 2013). Ethical consent also ensured that participants were aware of their right to withdraw from this research at any time, if requested (McNiff, 2013). In accordance with ethics, information sheets and consent forms were circulated to the interview participants prior to the interviews taking place and the researcher clarified the purpose of the research. The participant information sheet distributed also adhered to both BERA (2011) Ethical Guidelines and met the expectations of the University of Sunderland Ethics Committee.

### **8.10 Reliability**

Reliability is defined by Kirk and Miller (1986) as, 'the degree to which the findings of a study are independent of accidental circumstances of their production' (p.26). Therefore, the reliability of a study deals with its replicability. Cohen, Manion and Morrison, (2007) clarify that the meaning of reliability varies in quantitative and qualitative research. Reliability in relation to quantitative research focuses on similar data from similar respondents over a period of time. In relation to this study reliability would occur if the interviews were carried out and repeated in a similar time frame then similar results would be obtained from similar respondents.

'Reliability is the extent to which a repetition of the research would result in the same data and conclusions – in other words, if the research were to be repeated, by you or another researcher, the same results would be achieved, assuming nothing has changed'

(Payne and Whittaker, 2006, p. 192).

Seidman (1998) argues that, 'to work most reliably with the words of participants, the researcher has to transform those spoken words into a written text to study' (p.97). However, in doing so, participants' responses may have been affected (Rubin and Rubin, 2004). The researcher team elected to employ an independent transcriber to avoid researcher bias during the transcription process.

### **8.11 Validity**

Validity is defined by Hammersley (1990) as, 'the extent to which an account accurately represents the social phenomena to which it refers' (p.57). Consequently, this research is regarded as valid if it accurately represents the extent and nature of SEND requirements of 3-16 year olds in Sunderland. Validity refers to the extent to which researchers are measuring what we set out to measure, if not the research is meaningless (Muijs, 2011). Consequently, research is valid when the research methods measure what they are intended to measure, with the result being the same if an alternative method of measurement was used (Cohen, Manion and Morrison, 2007). The data collected in this study is deemed to be valid, as the researcher team and the commissioners of the research worked together to identify the key data sets to be analysed. These data sets are routinely used by Sunderland City Council, therefore are highly relevant to the phenomena explored in this study (Higbee, Arendale and Lundell, 2005). In determining the validity of this research holistically, it is important to consider the internal and external validity of the methods employed.

Internal validity refers to the extent to which the data generated by the research relates to the aims, within a singular piece of research (Cohen, Manion and Morrison, 2007). Lincoln and Guba (1985) argue that triangulation of research methods promotes internal validity in qualitative research. Whilst it cannot be claimed that triangulation alone ensures internal validity, the multi-method nature of this research design does promote validity of this study. Yet, the small number of participants involved in the qualitative data collection process limits internal validity, to some extent.

In determining the external validity of a research project, the generalisability of the conclusions drawn to other contexts must be considered (Cresswell and Miller, 2000). It is important to address external validity, as the results of this study may not be representative of the wider learner population (Cohen, Manion and Morrison, 2007). The data for this piece of research are representative of Sunderland City Council with comparisons made where relevant to national data. Therefore, this research is predominantly valid only to Sunderland, with limited external validity on a national scale.

### **8.12 Analysis of data**

Smit (2002) defines data analysis as, 'a process of resolving data in its constituent components, to reveal its characteristic elements and structure' (p.66). Data gathered through qualitative methods were analysed separately, and using different data analysis techniques, to the data gathered through quantitative methods. Analysis of qualitative data is typically an iterative process; a framework of specific codes to be imposed on the data is not devised. Instead, codes and concepts arise from the data as they are continually analysed (Srivastara and Hopwood, 2009). Thus, the constant comparative method of analysis was deemed most appropriate for qualitative data.

### **8.13 Constant comparative method of data analysis**

This method required repeated comparison and contrast of new codes, categories and concepts as they arose (Denscombe, 2010). The process began with semi-structured interview one, drawing out codes from the interview transcripts to compare with interview two (see appendix 3). This comparison continued until both interviews had been fully analysed and definite themes running through the data had been identified. Two researchers were involved in the analysis of interview transcripts, thus the researchers were able to cross-check identified codes to ensure inter-rater reliability and that saturation of analysis had occurred.

## 8.14 Quantitative data analysis

IBM Statistical Package for the Social Sciences 23 (SPSS) was the main analytical tool used to analyse quantitative data and create a series of contingency tables for this research. As Muijs (2011) suggests it is probably the most common statistical data analysis software package used in educational research and it is widely used in Higher Education. Microsoft Excel 2016 and a 3D mapping add-on were used to create a series of maps for Theme 7. Sunderland City Council supplied all local (Sunderland specific) data for the research, whilst national or regional data was attained by the research team. The theme specific datasets that were analysed are given below:

- Themes 1-3            Pupil Level Annual School Census (PLASC)
- Theme 4             PLASC and SEND Local Authority Tables (DfE, 2016c)
- Theme 5             School Census data and PLASC
- Theme 6             NHS and CCG Interviews (No quantitative data analysis required)
- Theme 7             School Census data originally provided by Sunderland Autism Outreach Team
- Theme 8             High Needs Funding (No quantitative data analysis required)
- Theme 9             Children Missing out of Education (No data provided)
- Theme 10            Pupil Referral Unit and Alternative Provision census data.

## **9 Literature review: Part one**

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The following review of the literature supports exploration of the ten themes identified in the methodology chapter of this research. The review is split into three distinct sections: the first explores the legislation and policy surrounding Special Educational Needs and/or Disability (SEND) provision, with specific reference to Sunderland; the second examines Autism Spectrum Disorder; and, the third discusses Alternative Provision including Pupil Referral Units (PRUs) and Children Missing from Education.

### **9.1 Setting the scene: The City of Sunderland**

The City of Sunderland, lies on the North East coast of England and has a long and illustrious history of shipbuilding, heavy engineering and glass-making (Short and Fundinsland-Tetlow, 2012). Dodds (2011) writes that Sunderland lies at the mouth of the River Wear and is one of the principal water ways, and it is the regions second largest city. She adds that the south of the river is the most populated area of Sunderland. Sunderland grew from being a small trading port into a large industrial city due to rural-urban migration within the region, high birth rates and historic immigration from Ireland and Scotland (Cookson, 2015). Although the industrial greatness in now in the past, it did achieve city status in 1992 and it is now identified as a major conurbation in the North East of England (Meikle and Newman, 2007). City of Sunderland Council (2017) report that over the past five years, there have been around 200 strategic projects, creating more than 8,800 jobs and bringing about £1.3 billion of investment. BAE Systems is the latest world class manufacturing company to move into the City of Sunderland. BAE's new purpose built plant will house a forge, machining centre, and heat and surface treatment plants as it manufactures casing for Ministry of Defence ammunition orders.

See it do it Sunderland (2017) describes Sunderland as a welcoming, bustling city set right on the coast and at the mouth of the River Wear. It recommends visiting the wide sandy beaches and acres of relaxing and invigorating green spaces. Culturally Sunderland has a range of attractions, while its underground music scene is considered one of the most vibrant in the UK. Sunderland has recently bid to be the UK City of Culture (2021) which is supported by a host of key figures. Gareth Pugh, Fashion Designer quoted Sunderland as “representing a singular and compelling combination of post-industrial grit and charisma. It is home to a history of story-telling and a veritable cast of larger than life characters.” (Sunderland City of Culture bid, 2017).

The resident population of Sunderland in 2015 was 277,200 with 135,000 males and 142,200 females. From October 2015 to September 2016 the number of people 16-64 years who were economically active was 74.1% which is 0.9% lower than the regional average and 3.7% below the national average (Nomis, 2017). In Sunderland there are 45,900 people not in employment (25.9% of the population). From January to December 2015 in terms of workless households, Sunderland had (23.6%) compared to the regional average of (21.3%) and a national average of (15.3%) (ibid). According to employment by occupation data, in Sunderland there are a greater proportion of working age people 16+ employed in lower paid jobs such as plant and machinery work, caring, leisure and sales compared to the regional and national average. An example of this is in the Standard Occupational Classification group 6-7; lower paid roles in Sunderland equate to 23.9% compared to the regional at 19.8% and the national at 16.8% (see Table 1).

Table 1

*Employment across Sunderland, the North East and Britain by occupation (October 2015 - September 2016).*

Standard Occupational Classification Group	Sunderland		North East	Britain
	<i>N</i>	%	%	%
<b>SOC Group 1-3</b>	<b>37,200</b>	<b>29.8</b>	<b>38.7</b>	<b>45.1</b>
1 Managers, directors and senior officials	8,200	6.6	8	10.5
2 Professional occupations	15,900	12.6	18.2	20.2
3 Associate professional & technical	13,100	10.5	12.3	14.3
<b>SOC Group 4-5</b>	<b>32,700</b>	<b>26.1</b>	<b>21.9</b>	<b>20.9</b>
4 Administrative & secretarial	15,600	12.4	10.3	10.4
5 Skilled trades occupations	17,100	13.6	11.4	10.4
<b>SOC Group 6-7</b>	<b>29,900</b>	<b>23.9</b>	<b>19.8</b>	<b>16.8</b>
6 Caring, leisure and Other Service occupations	12,300	9.8	10.4	9.1
7 Sales and customer service occs	17,600	14	9.3	7.6
<b>SOC Group 8-9</b>	<b>25,200</b>	<b>20.2</b>	<b>19.7</b>	<b>17.2</b>
8 Process plant & machine operatives	9,500	7.5	7.4	6.4
9 Elementary occupations	15,800	12.6	12.2	10.7

*Note.* SOC refers to Standard Occupational Classification. Data includes individuals aged 16 and over (Office for National Statistics, 2016).

*Source: ONS annual population survey*

Sunderland City Council (2017) have announced current and future plans including a £100 million civil engineering project a new river Wear cable-stayed bridge and approach roads, due for completion by early 2018. Sunderland is also hosting the Tall Ships Race in July 2018 as well as bidding for the City of Culture.

## 9.2 The Index of Multiple Deprivation: Sunderland

The English Index of Multiple Deprivation (IMD) is the official relative measure of deprivation for neighbourhoods or Lower-layer Super Output Areas (LSOAs) in England and is based on 37 indicators from 7 domain indices (DfCLG, 2015a).



These indices are weighted and combined to produce the IMD for each LSOAs, they are:

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

(DfCLG, 2015a).

There are 32, 844 Lower-layer Super Output Areas (LSOAs) across England and are designed to have an average of 1,500 residents or 650 households living in them. The LSOAs are ranked where 1st is the most deprived and 32, 844th is the least deprived (DfCLG, 2015a). The individual LSOAs for Sunderland Local Authority for 2015 are given in Figure 1 overleaf. It can be seen from the figure below that the most deprived areas of Sunderland are within the wards: Redhill, Southwick, Pallion, St Annes, Sandhill, Hetton and Copt Hill, small areas within Washington North and Central.

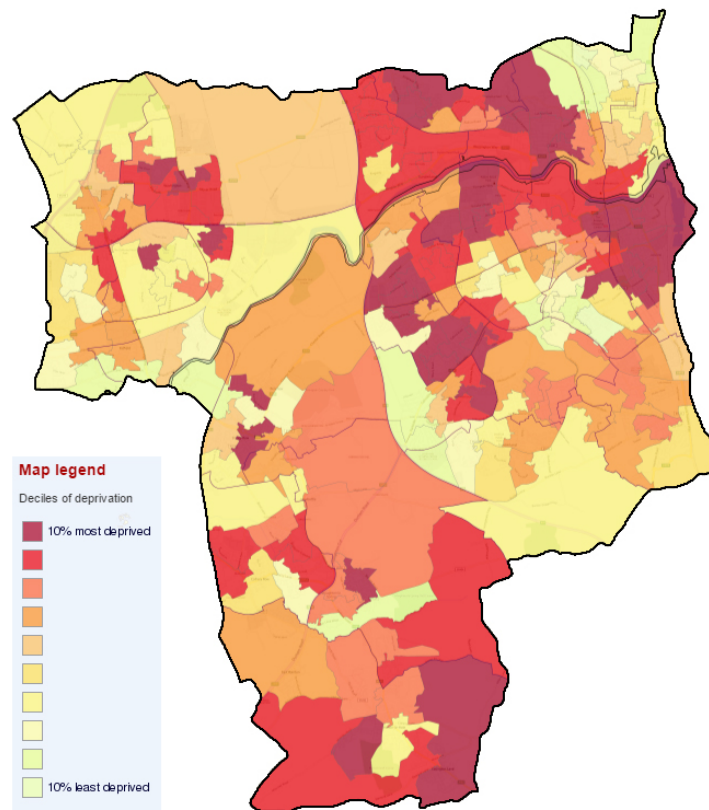


Figure 1: The Index of Multiple Deprivation rank for each LSOA in Sunderland (2015) (Open Data Communities, 2017).

The individual IMD ranks can be combined to produce an overall IMD rank for Local Authority districts. Out of 326 Local Authorities in England, Sunderland is ranked as 38th overall (DfCLG, 2015b). There is no single measure of deprivation that is the most suitable when comparing higher-level areas such as Local Authorities due to the spread of deprivation, size, population and geographical differences. Instead several deprivation measures should be used to present a fuller account. In light of this, the IMD rank, extent rank and local concentration measures have been used, and are given in Table 2 overleaf.

Table 2

*The Index of Multiple Deprivation (IMD) by Local Authority area in Tyne and Wear.*

Local Authority	IMD Rank	Extent Rank	Local Concentration
Sunderland	38	37	46
Gateshead	80	73	67
Newcastle upon Tyne	92	45	13
North Tyneside	138	106	112
South Tyneside	31	23	71

*Note . IMD Rank, Extent Rank and Local Concentration are ranked where 1 is the most deprived (DfLG, 2015b).*

**\*Extent Rank:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 30% in the country.

**\*Local Concentration:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 10% within a Local Authority, compared to those in other local authorities.

### 9.3 Deprivation versus educational outcomes in Sunderland

Social inequalities and their influence on the educational experiences of young people have been highlighted by many researchers, both historically and in recent years. The challenge is often characterised by a lack of physical resources for families to afford quality educational experiences for their children, but it can also include indirect inequality, stemming from parental attitudes to education (Morris, Dorling and Davy Smith, 2016). Research by Crawford, Macmillan and Vignoles (2014) into social inequalities in education highlighted that socially disadvantaged children are far less likely to experience high academic attainment, across a range of academic phases. Additionally, this research indicated that high-attaining socio-economically disadvantaged children are often overtaken by their average-attaining, more economically advantaged peers. Therefore, the effects of social inequality on the educational experiences of young people are likely to be enduring, requiring longitudinal intervention.

The Department of Health (2013) acknowledge that social disadvantage and adversity increase the risk of developing mental health problems. Furthermore, children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes.

#### **9.4 Academic attainment nationally and in Sunderland**

The Office for National Statistics (2017) show that pupils in Sunderland achieving 5+ A\* -C GCSEs, or equivalent, including English and Mathematics between September 2013 and August 2014 was 50.9%. This is 3.7% lower than the regional average for the North East and 5.7% less than the national average.

Wilshaw (2017) stressed that not a single child on free school meals from the North East and Yorkshire and Humber regions had gone to Oxbridge University after leaving school in 2010. Amanda Brown, Assistant General Secretary at the National Union of Teachers added in the report that ‘cuts to Local Authority budgets, which had been at their most severe in areas with the highest levels of child poverty, had reduced the funding available to sustain and develop vital child and family services.’

Table 3 below shows the proportion of children with SEND eligible for free school meals (FSM) nationally for each primary need and SEND provision. It highlights that most of the children and young people on SEN Support are categorised as having a Moderate Learning Difficulty (MLD) as their primary need. Social Emotional and Mental Health Difficulties (SEMH) are identified as the second most prevalent need for children on SEN Support. In terms of those children and young people with a Statement of SEN or on Education, Health and Care plans the predominant need is Autism Spectrum Disorder (ASD) followed by SEMH. This analysis relates to children eligible for free school meals.

Table 3

*Prevalence of pupils with identified Primary Needs and Free School Meal (FSM) eligibility (2016).*

Primary Need	Pupils on SEN support		Pupils with SEN with statements or EHC plan	
	<i>Total Population</i>	<i>% FSM</i>	<i>Total Population</i>	<i>% FSM</i>
Specific Learning Difficulty	26,561	18.7	2,196	24.6
Moderate Learning Difficulty	71,358	29.2	10,915	36.8
Severe Learning Difficulty	934	28.3	10,088	34.8
Profound & Multiple Learning Difficulty	215	22.4	2,811	28.2
Social, Emotional and Mental Health	51,988	33.0	11,592	42.5
Speech, Language and Communications Needs	48,020	25.2	8,873	28.7
Hearing Impairment	2,744	18.8	1,579	26.6
Visual Impairment	1,795	21.7	848	25.5
Multi- Sensory Impairment	300	18.0	156	24.7
Physical Disability	4,564	22.8	3,474	27.0
Autistic Spectrum Disorder	9,117	21.3	15,635	27.3
Other Difficulty/Disability	11,842	23.7	1,398	26.7
SEN Support but No Specialist Assessment	9,044	25.3	70	26.1
<b>Total</b>	<b>238,482</b>		<b>69,635</b>	

*Note.* Excludes pupil referral units, general hospital schools and independent schools. Percentages are rounded to the nearest 0.1 (DfE, 2016d).

*Source: School Census*

In 2010, Ofsted acknowledged that pupils identified as having SEN were disproportionately from disadvantaged backgrounds. They were also far more likely to be absent or excluded from school and achieve, academically, at a lower rate than expected compared with more affluent peers, both in terms of their attainment at any given age and in terms of their progress over time. Additionally, it is recognised that pupils identified with special educational needs and/or disabilities have fewer friends, are less popular and are more likely to be the victims of bullying than their peers not diagnosed with a special educational needs (Frostad and Pijl, 2007; McLaughlin, Byers and Peppin-Vaughan, 2010; Nowicki, 2012).

## 9.5 What are Special Educational Needs and/or Disabilities (SEND)?

The legislative document which presents the current definition of SEND is the 'Special Educational Needs and Disability Code of Practice: 0 to 25 years' (DfE, 2015a). This document also provides statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities.

The current definition of SEND in the 2015 Code of Practice (DfE, 2015a) arose from changes in legislation enshrined in the Children and Families Act 2014. This legislation replaces previous legislation including the Special Educational Needs and Disability Act 2001, the new legislation has far reaching implications for children and young people, families and other agencies working alongside them (Ko, 2015). The reforms will be explored in detail in the following section. The SEND code of practice (DfE, 2015a) defines Special Educational Needs and Disabilities as when:

- A child or young person has a learning difficulty or disability which calls for special educational provision to be made for him or her.
- A child of compulsory school age or a young person has a learning difficulty or disability if he or she:
  - has a significantly greater difficulty in learning than the majority of others of the same age, or
  - has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions

The SEND Code of Practice (DfE, 2015a) also offers a definition of disability, which draws upon the Equality Act (2010). This Act explains that children have a disability if they present with ‘... 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’ (p135).

This definition provides a relatively low threshold for disability and includes more children than many realise: ‘long-term’ is defined as ‘a year or more’ and ‘substantial’ is defined as ‘more than minor or trivial’. This definition includes Sensory Impairments such as those affecting sight or hearing, and long-term health conditions such as Asthma, Diabetes, Epilepsy, and Cancer (DfE, 2015a).

Cheminais (2015, p. 15) stresses the importance of teachers being aware of the diversity of children and young people who, under the Equality Act (2010) are considered to have a disability. These include:

- Sensory Impairments, e.g. Visual Impairment (VI), Hearing Impairment (HI) and Multi-Sensory Impairments (MSI)
- Physical impairments or illness that affects mobility, dexterity or control of movement e.g. Arthritis, Multiple Sclerosis and Stroke
- Developmental conditions, e.g. Dyslexia, Dyspraxia, Autism Spectrum Disorders
- Progressive diseases, e.g. Motor Neurone Disease, Muscular Dystrophy, Dementia and Lupus
- Illnesses with impairments with fluctuating or recurring effects, e.g. Myalgic Encephalitis (ME), Chronic Fatigue Syndrome (CFS), Epilepsy, Diabetes
- Mental health conditions and mental illnesses, e.g. Depression, Eating Disorders, Obsessive Compulsive Disorder (OCD), Schizophrenia, Bipolar Affective Disorders and Self-Harm
- HIV infection
- Cancer
- Facial disfigurements.

The SEND code of practice (DfE, 2015a) indicates that many children identified with SEN may also be identified as having a disability. It explains that there is a significant overlap between children with disabilities and young people and those with SEN. Where a child with a disability or young person requires special educational provision they will also be covered by the SEN definition. Ko (2015) stresses that where a health body identifies a child under school age has an SEN or disability they must inform the child's parents and inform the Local Authority where appropriate.

## **9.6 Special Educational Needs and Disability Policy**

Edward Timpson MP launched the Children and Families Act in March 2014; it was billed by the Department for Education as the biggest education reform in a generation for children and young people identified with SEND (DfE, 2014a; Martin-Denham, 2015). Many of the reforms to SEND provisions, contained in the Children and Families Act, were introduced on 1 September 2014. These reforms stipulated a range of changes to the classification and categorisation systems, with respect to the needs presented by children identified with SEND. These changes are discussed later in this chapter.

The rationale for the Children and Families Act (2014) was to bring together disparate strands of legislation and embed the principles of inclusivity, agency and equality into policy aimed at meeting the needs of children identified with SEND. The rationale was to ensure relevant public bodies provided all children and young people with SEND access to integrated, multi-agency provision through new Education, Health and Care Plans (EHC plans).

The reforms also strongly advocated for the voices of young people and their parents to be better taken account of in choosing and funding the provision that best meets their needs. The principles of the Children and Families Act (2014) shaped the SEND Code of Practice (DfE, 2015a), as they set out the legal framework governing SEND and provided practical advice to organisations and bodies (such as Local Authorities, schools and colleges) in meeting their statutory obligations as set out in the Act.



The Driver Youth Trust released a report in 2015, highlighting the recent challenges and opportunities associated with the SEND reforms, from the authors' professional experiences of running charities focused on supporting children identified with SEND. The report presented many examples of high quality practice, emerging from the reforms. However, it argued that the system was still fragmented, with high quality practice appearing in 'pockets,' rather than across the system as a whole. This has led to difficulties in sharing information and knowledge. The report also indicated that one of the key causes of fragmentation was the lack of communication and support available to Local Authorities in navigating the changes to their role. Specifically, support for Local Authorities in developing their 'Local Offer' to children identified with SEN and their families was lacking. Additionally, the authors suggested that a disparate funding system was also exacerbating the difficulties associated with fragmentation in the system. The current funding models associated with SEND are explored later in this chapter.

The remainder of this chapter gives information on specific and relevant reforms to SEND policy, stemming from the Children and Families Act of 2014, as well as presents national data on the prevalence of SEND and explores current funding models associated with support for children identified with SEND.

## **9.7 National data overview**

Figure 2 overleaf highlights the national picture in terms of the primary need of pupils and their SEN classifications. It can be seen that Moderate Learning Difficulties are the most prevalent primary need for those identified as SEN support. In terms of Statement of SEN or EHC plan ASD is the most common need at 25.9% of this group.

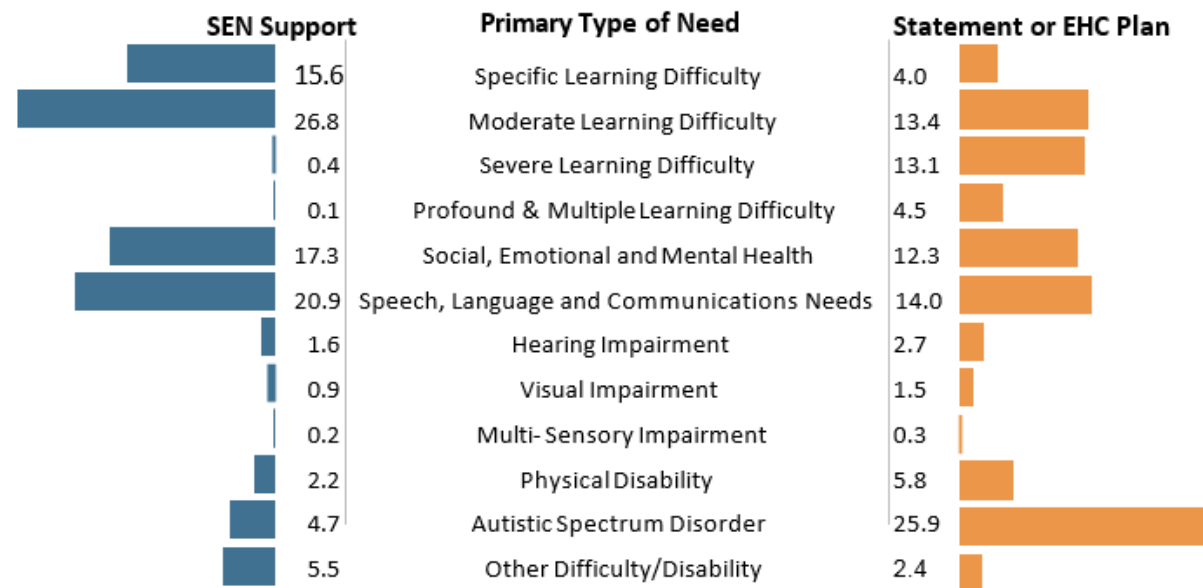


Figure 2: Percentages of pupils with identified Primary Needs and SEN classifications in the United Kingdom (DfE, 2016b). Pupils with SEND in state funded primary, secondary and specialist schools.

The DfE (2016b) presents that the number and proportion of pupils classified with SEN has been in decline since 2010. It clarifies that there are now 1.23 million pupils with SEN in schools in England. This represents 14.4 % of all pupils. Of these, 237,000 have a statement of SEN or EHC plan (2.8% of all pupils) and 992,000 have SEN Support (11.6% of all pupils). Ofsted (2016a) report that the proportion of pupils who have special educational needs and/or disabilities is at the lowest level since 2007. This decline is due to a fall in the proportion of pupils identified as having special educational needs without a statement or EHC plan (those in receipt of SEN Support). In 2016, this group declined to 11.6% of all pupils. This is the lowest on record and down 6.7 percentage points from its peak in 2010. Almost half of the reduction in the proportions of pupils identified as requiring special educational needs support has occurred since 2014, a 3.5 percentage point fall, when the revised SEND Code of Practice (DfE, 2015a) and Children and Families Act 2014 came into force. The proportion of the total pupil population with a statement or EHC plan has remained constant, at 2.8%, since 2007 (DfE, 2016b).

## 9.8 Statements to Education, Health and Care plans

The previous SEND Code of Practice (DfES, 2001) advised that children whose SEND needs required specialist input from various professionals should to be issued with a Statement of SEN. This was intended to detail the specific support offered for an individual, usually with associated funding. One of the most radical changes initiated by the Children and Families Act 2014 was that the Statement of SEN was to be replaced by Educational Health and Care plans (EHC plans) by April 2018. These EHC plans are to focus, not only on education provision for children identified with SEND (previously covered in Statements of SEN), but also on health and social care needs (DfE, 2015a). Ko (2015) adds that the EHC is a statutory process with parents, a young person over the age of 16 but under the age of 25 or a person acting on behalf of the school or post 16 institution being able to request an EHC assessment.

The Education, Health and Care plan (EHC plan) was introduced with the principle of a person-centred approach to supporting children and their families (Martin-Denham, 2015). The rationale behind the change was to stimulate more joined up multi-agency working between public services working with individuals and their families. The SEND code of practice (DfE, 2015a) details that a pupil may be given an EHC plan once a formal assessment of a child's needs has been made. If a child is successful in applying for an EHC plan, the resultant document produced sets out the child's need(s) and the additional support they should receive; thus, better enabling families to hold public agencies to account in meeting their child's needs (DfE, 2016d). All children must have transferred from a Statement to an EHC plan by the 1st April 2018 (ibid).

Ofsted (2016a) stated that the proportion of boys (4%) who have an EHC plan or statement is more than twice that of girls (1.5%). Thirty per cent of boys who have a statement or EHC plan have Autism Spectrum Disorder identified as their primary need, compared with just under 15% of girls with an EHC plan or a statement.

The 20 week process is presented below:

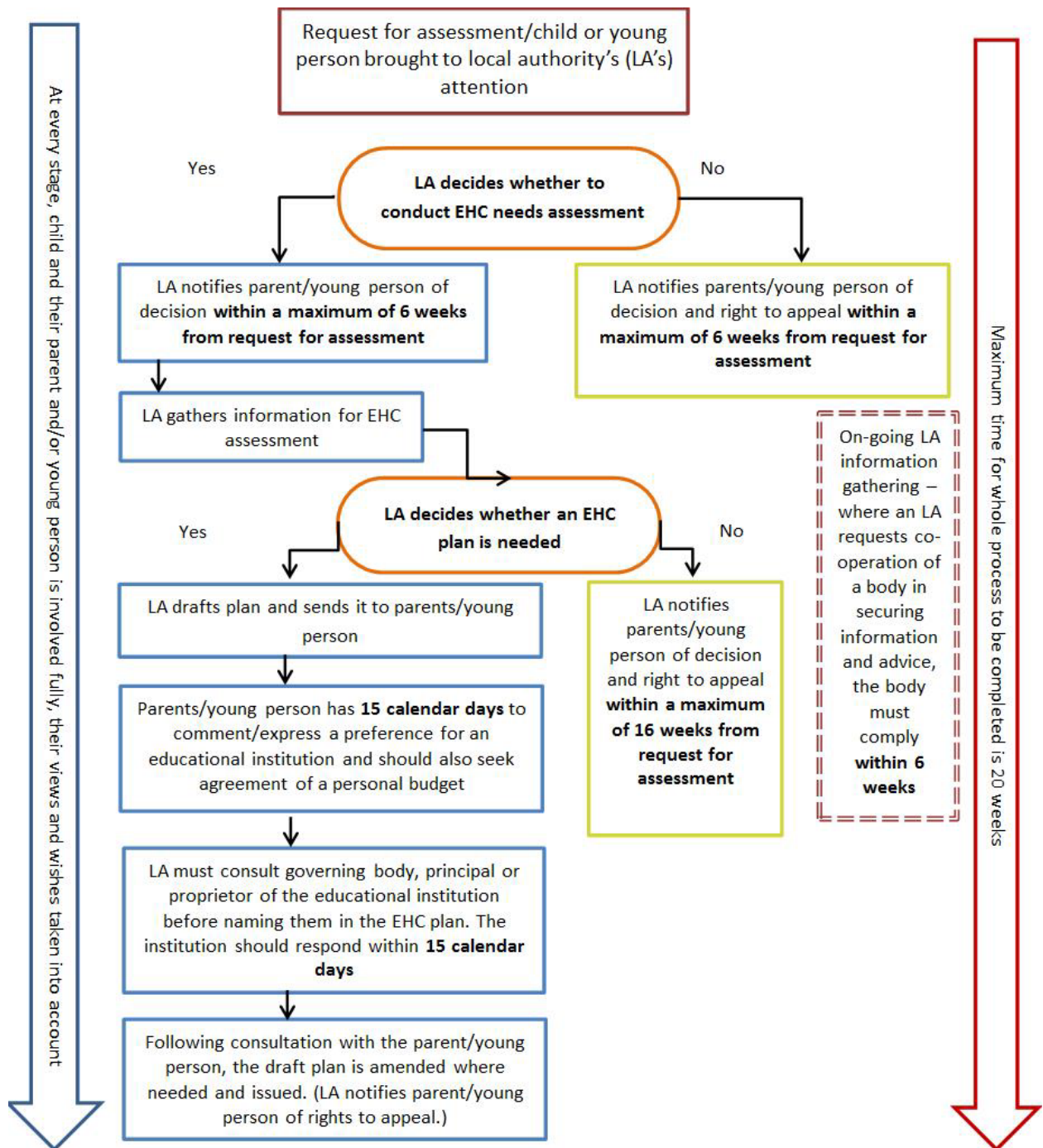


Figure 3: Statutory timescales for EHC needs assessment and EHC plan development (DfE, 2015a).

## 9.9 SEN Support

In addition to the Statement of SEN, the 2001 Code of Practice (DfES) detailed two additional layers of support for children identified with SEN; prior to applying for a Statement, children could be placed on 'School/Early Years Action,' or 'School/Early Years Action Plus.' The Children and Families Act (2014) eradicated this approach, instead replacing the two layers of support with one, entitled 'SEN Support.' Cowne (2015) clarifies that where children are in receipt of additional support, a record must be kept of the additional resources provided and progress made as a result of these.

SEN Support is defined by (DfE, 2016b, p. 4) as those children and young people where extra or different help is given from that provided as part of the school's usual curriculum. The SEND code of practice (DfE, 2015a, p. 100) is explicit that 'where a pupil is identified as having SEN, they should take action to remove barriers to learning and put effective special educational provision in place.' The class teacher and/or the special educational needs co-ordinator (SENCo) in a school may receive advice or support from outside specialists for children categorised as requiring SEN Support, if deemed appropriate by all agencies. The pupil on SEN Support does not have a Statement or Education, Health and Care Plan (EHC plan), as their needs are not deemed 'additional' enough to warrant the level of support afforded by one.

In their annual report 2015/16 Ofsted (2016a) shared that in some parts of the country, less than 40% of pupils in receipt of special educational needs support are progressing well. The report found that local areas were tracking the progress of these pupils less systematically, compared to pupils with statements or education, health and care plans. On a positive note they reported that local areas were becoming more accurate in their identification of children and young people who have special educational needs and/or disabilities. As a result of this the proportion of pupils identified as needing special educational needs support was at the lowest point in almost a decade (ibid).

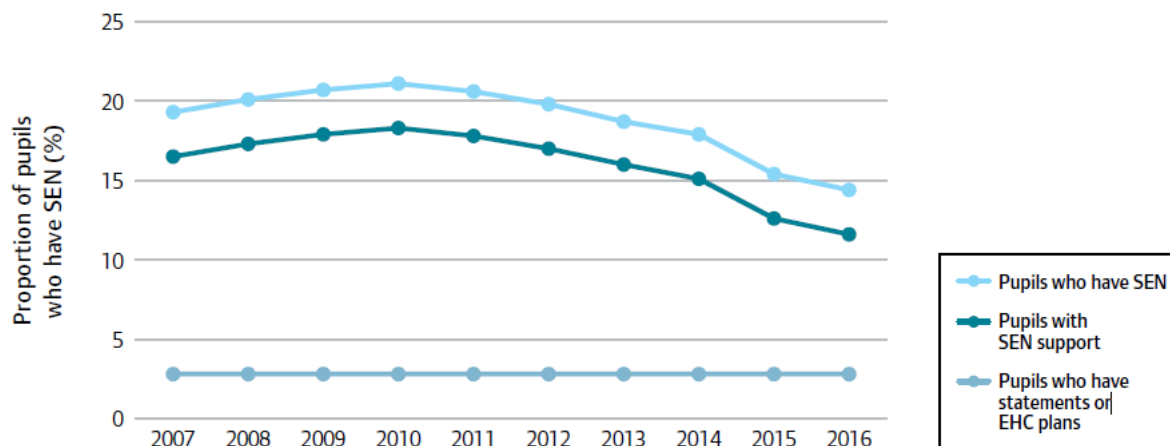


Figure 4: The proportion of pupils who have special educational needs (SEN) and SEN provision in schools, January 2007 - 2016 (Ofsted, 2016a).

### 9.10 Broad areas of need

The Children and Families Act 2014 also brought about changes to the categorisation of SEND. The previous category of ‘Behaviour, Emotional and Social Difficulties (BESD)’ was removed (DfES, 2001); a new classification ‘Social, Emotional and Mental Health (SEMH)’ was introduced, although this was not intended to be a direct replacement. The rationale for this change was to ensure that practitioners assessed the reason for their behaviour in order to meet the underlying need (Martin-Denham, 2015). The SEND code ‘SEN Support but no specialist assessment of type of need’ was also introduced in 2015. The introduction of four broad areas of need, are discussed in detail below; all definitions have been adapted from the DfE (2015a) Special Educational Needs and Disability Code of Practice. The following definitions include introductions to various primary types of need, which will be expanded in greater detail later in this chapter.

### **9.10.1 Communication and Interaction**

One of the most prevalent primary types of need nationally is speech, language and communication needs (SLCN). Children identified with SLCN display difficulties in communicating with others. This may be because they have difficulty in saying what they want to do, understanding what is being said to them or they do not understand or use social rules of communication. The profile for every child identified with SLCN is different and their needs may change over time. They may have difficulty with one, some, or all of the different aspects of speech, language or social communication at different times of their lives. Children and young people who are identified with Autism are likely to present specific difficulties with social interaction. They may also experience difficulties with language, communication and imagination, which can impact on how they relate to others.

### **9.10.2 Cognition and learning**

Difficulties with cognition and learning are often experienced as young people learning at a slower pace than their peers, even with appropriate differentiation. Special Educational Needs that affect learning covers a wide range of needs, including Moderate Learning Difficulties (MLD), Severe Learning Difficulties (SLD), where children are likely to need support in all areas of the curriculum and associated difficulties with mobility and communication, through to Profound and Multiple Learning Difficulties (PMLD), where children are likely to have severe and complex learning difficulties as well as Physical Disability or Sensory Impairment. The broad area of cognition and learning may also include children identified with specific learning difficulties (SpLD), which affect one or more specific aspects of learning, such as dyslexia, dyscalculia, dyspraxia and ADHD.

### **9.10.3 Social, Emotional and Mental Health difficulties**

This category represents a radical change in SEND policy, as it acknowledges mental health needs as special educational needs for the first time (Kennedy, 2015). The SEND code of practice (DfE, 2015a) explains that children and young people may experience a wide range of social and/or emotional difficulties throughout their childhood and adolescence, which may manifest themselves in different ways. This may include becoming withdrawn or isolated, as well as displaying challenges, disruptive or disturbing behaviour. These behaviours may reflect underlying mental health difficulties such as Anxiety or Depression, Self-harming, Substance Misuse, Eating Disorders or physical symptoms that are medically unexplained. Other needs that fall under the broad area of social, emotional and mental health difficulties may include Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder or Attachment Disorder. The SEND code (DfE, 2015a) also highlights the importance of schools and colleges implementing clear processes for effectively managing behaviour, with the primary focus being to avoid disruption to other students.

### **9.10.4 Sensory and/or physical needs**

Children with needs that fall under 'sensory and/or physical needs' require additional provision because they have been identified with a disability which prevents or hinders them from making use of the educational facilities generally provided in their place of learning. The SEND code of practice (DfE, 2015a) explains that these difficulties are often age-related and can fluctuate over time. Many children with a Visual Impairment (VI), Hearing Impairment (HI), or a Multi-Sensory Impairment (MSI) will require specialist support and/or equipment to access their learning. Children identified with MSI have a combination of visual and hearing difficulties. Children identified with a Physical Disability (PD) also fall under this broad area of need, as they often require additional ongoing support and equipment to access all of the opportunities available to their peers.



### **9.11 The graduated approach**

The SEND code of practice (DfE, 2015a) advocates a graduated approach to meeting the needs of children that have been identified as requiring SEN Support. This support requires schools/colleges to implement practices that act to remove barriers to learning for that child and enable effective SEND provision to occur. There is a strong emphasis in early identification of children requiring SEN Support, therefore, it is anticipated that, in many cases, needs assessment takes place in the early years. Additionally, it explains that the graduated approach must emanate at whole school level and that the overall responsibility for the pupil identified with SEND lies with the class/subject teacher and not with the SENCo/learning support department.

In 2014, as a response to the Children and Families Act, 2014 earlier that year, NASEN (2014) released a report that distilled the graduated approach for practitioners in line with the SEND Code of Practice (DfE, 2015a). This report echoed the SEND code explaining that SEN Support should arise from a four-part cycle, known as the graduated approach, ‘through which earlier decisions and actions are revisited, refined and revised, leading to a growing understanding of the pupil’s needs and of what supports the pupil in making good progress and securing good outcomes’ (p.2). The graduated approach draws on personalised methods of support, with more frequent reviews and more specialist input. It is intended that this approach will better enable teachers to tailor interventions in meeting individuals’ needs. There are four distinct stages to the graduated approach, which form a cycle of effective practice in meeting the needs of children identified as needing SEN Support. These stages are entitled:

- Assess
- Plan
- Do
- Review

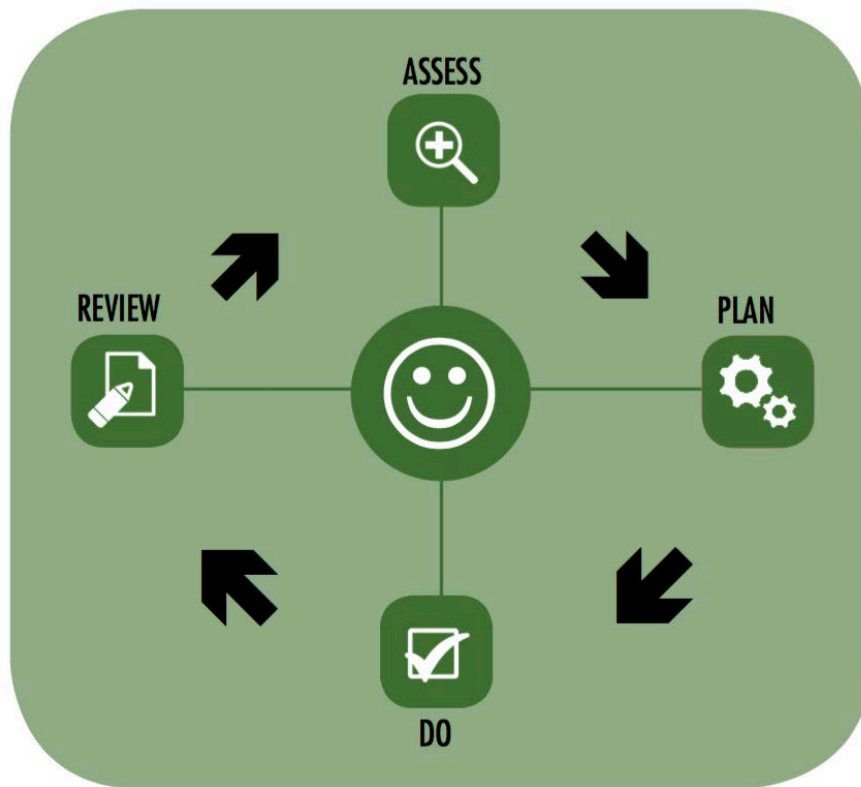


Figure 5: Graduated approach to SEND identification (NASEN, 2014, p.2).

### 9.11.1 Assess

The DfE (2015a) code of practice details the ‘assess’ stage as an early years practitioner carrying out an analysis of a child’s needs, with support from the SENCo and the child’s parents/carers. This initial assessment should be reviewed regularly to ensure that support is matched to need. Where there is little or no improvement in the child’s progress, more specialist assessment may be called for from specialist teachers or from health, social services or other agencies beyond the setting. Where professionals are not already working with the setting, the SENCo should contact them, with the parents’ agreement. As Farrell (2017) suggests identification and assessment across the range of special educational needs and disabilities will relate to the definitions and related criteria used. It is expected these will be supplemented by various other assessments including psychometric tests, observations and discussions with parents and carers.

### **9.11.2 Plan**

When professionals have decided that SEN Support is required, and having formally notified the parents, the practitioner and the SENCo should agree, in consultation with the parent, the outcomes they are seeking, the interventions and support to be put in place, the expected impact on progress, development or behaviour, and a clear date for review. Plans should take into account the views of the child and involve parental input. The support and intervention should be selected to meet the outcomes identified for the child, based on reliable evidence of effectiveness, and provided by practitioners with relevant skills and knowledge. Any related staff development needs should be identified and addressed.

### **9.11.3 Do**

This is the implementation phase of SEN Support. During this phase, the early years practitioner, usually the child's key person, remains responsible for working with the child on a daily basis. With support from the SENCo, they should oversee the implementation of the interventions or programmes agreed as part of SEN Support. The SENCo should support the practitioner in assessing the child's response to the action taken, in problem solving and advising on the effective implementation of support.

### **9.11.4 Review**

The DfE (2015a) code of practice explains that regular reviews of the effectiveness of support provided and its impact on the child's progress should occur. The impact and quality of the support should be evaluated by the practitioner and the SENCo working with the child's parents, taking into account the child's views. They should agree any changes to the outcomes and support for the child in light of the child's progress and development. Parents should have clear information about the impact of the support provided and be involved in planning next steps.

## **9.12 Primary types of need, prevalence and definitions**

The Department for Education (DfE) collect what is called a primary type of need for those pupils on SEN Support or with a Statement or EHC plan (2016b). This section presents each primary type of need and gives a research-informed definition of the needs. It should be noted that many of these needs are inter-connected and can present simultaneously in individuals, therefore, primary needs should not be thought of as entirely distinct from one another. This will be discussed in greater detail later in this chapter. It is also important to note that for many of these types of needs there isn't one agreed definition and that the severity of each type of need is not able to be categorised.

The legislative changes in the Children and Families Act (2014) resulted in changes to collection of primary need data between 2015 and 2016. Pupils who were previously categorised as being on School Action were not required to have a primary type of need recorded. From 2015, pupils who were on School Action and have transferred to SEN Support have been recorded as having a primary type of need. This has led to an increase in the number of pupils recorded as having a primary type of need. There may have been some pupils who were still on School Action in the 2015 collection who did not provide a primary type of need, however there were no pupils recorded as School Action in 2016.

The prevalence of a special educational need or a disability, for example ASD, refers to the proportion of a population estimated to have that type of need which is often given as a percentage or the number of individuals found in the population studied (Farrell, 2017). The incidence of a special educational need or a disability is important to allow for future planning in health providers and in educational contexts. It needs to be noted that determining prevalence is not straightforward due to the range of assessments used in diagnosis, the subjective nature of diagnosis and the variation in consideration of co-morbidity (Martin-Denham, 2015).

All figures presented in the remainder of this section have been taken from the DfE's (2016b) latest statistical first release, based on data gathered in January 2016, published in July 2016, which presents the national prevalence for each separate primary SEND need. The figures represent the percentages of primary need identification, within the national SEND population. The national percentages include all types of school. It should be noted that percentages have been rounded up; therefore, there may be discrepancies between total numbers of children and the sum of constituent parts.

Interestingly within the SEND code of practice (DfE, 2015a) definitions of primary needs are not provided. For the purposes of this research it was important to provide clarity by defining the range of special educational needs and disabilities referred to in the data sets and in the literature reviews. As Farrell (2017) notes, defining some disabilities is challenging. It is important not to be rigid within these definitions as there is overlap between mild, moderate and severe which is often reliant on interpretation and individual judgement.

### **9.12.1 SpLD: Specific Learning Difficulty**

**Definition:** Specific Learning Difficulties (or SpLDs), affect the way information is learned and processed. They are neurological (rather than psychological), usually run in families and occur independently of intelligence. They can have significant impact on education and learning and on the acquisition of literacy skills (British Dyslexia Association, 2017).

**Overview:** Zakopoulou et al. (2014) acknowledge that the term Specific Learning Difficulties (SpLD) integrates a number of difficulties which may affect communication, such as Dyspraxia, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Dysphasia, Asperger's Syndrome, Dyscalculia and Dyslexia. The British Dyslexia Association (2017) agree adding that SpLD is an umbrella term used to cover a range of frequently co-occurring difficulties. They also clarify that SpLDs can also co-occur with difficulties on the Autism Spectrum such as Asperger Syndrome (British Dyslexia Association, 2017).

**National prevalence:** The Driver Youth Trust (2015) suggest that nationally there are 13% of children and young people with Specific Learning Difficulties. The Department for Education present that SpLD are more prevalent in secondary aged pupils with SEN Support than primary aged pupils (DfE, 2016b). They add that 25.0% of 15 year olds on SEN Support had this primary type of need compared with 10.8% of 7 year olds of which Dyslexia is the most common need (British Dyslexia Association, 2017). In relation to Dyslexia and persistent literacy difficulties, identification is a barrier to accurate estimates of the number of young people with these difficulties in schools. Dyslexia Action estimates that 10% of children in the UK are dyslexic (Dyslexia Action, 2012). In addition, 15.6% of children on SEN Support have Specific Learning Difficulties; 4% of children identified with SEND have been issued a Statement/EHC plan for SpLD.

#### **9.12.2 MLD: Moderate Learning Difficulty**

**Definition:** Farrell (2017) refers to previous government guidance which states that students with 'moderate learning difficulties' will have attainments 'significantly below expected levels in most areas of the curriculum, despite appropriate interventions.' Also he adds that their needs will not be able to be met by usual differentiation and the flexibility of the National Curriculum (DCSF, 2009). Norwich et al. (2013) states that MLD is currently understood in the English school census definition to refer to significant general difficulties in literacy and numeracy learning and in understanding concepts. Furthermore, it is an important category to represent general learning difficulties and so acts as the reference point for specific learning difficulties (SpLD), which are understood as being distinct from MLD.

**Overview:** Norwich et al. (2012) comments that MLD is a term used to describe a group of pupils who continue to be the largest proportion of those identified as having a Special Educational Needs since 2010. Deforges (2006) suggested that compared to other areas of SEN, MLD is a neglected area for educational research and initiatives. Norwich and Kelly (2005) identify that one of the key questions to be considered is whether children and young people identified with MLD are simply those at the lowest end of the range of pupils with low attainment or whether they also have an intellectual disability. Farrell (2017) discusses the challenges of identification of children and young people with MLD because of a lack of agreed definitions.

**National prevalence:** MLD remains the most common primary type of need overall. 24.2% of pupils with special educational needs have this primary type of need. This percentage has increased since last year, from 23.8%. 26.8% of pupils on SEN Support have MLD as a primary type of need and 13.4% of all statements are allocated to children with Moderate Learning Difficulties. The large numbers of children identified with MLD may be explained by the ambiguous nature of the term; effective identification of this primary need can be challenging, as was discussed in the previous paragraph. This may be leading to significant over-diagnosis of this primary need, as many educational and health-focused needs could be identified under the umbrella term that is 'Moderate Learning Difficulty.'

### **9.12.3 SLD: Severe Learning Difficulty**

**Definition:** MacKay (2009) highlighted that the terminology and interpretation associated with severe and complex learning difficulties has been subject to ongoing debate and change across a range of professions. This has led to considerable diversity in the terminology used to denote the concepts involved in defining Severe Learning Difficulties. Historically, the definition of SLD was strongly rooted in the medical model of disability; a model in which within-child deficits was a prominent focus.

The rejection of the medical model of disability has inevitably resulted in the use of psychological and educational constructs in definitions. This has led to some disparity between medical diagnoses and educational concepts and, thus, has made a common definition of Severe Learning Difficulties across multi-agencies difficult. Additionally, there exists some widespread confusion, amongst educationalists and psychologists, as to what denotes the differences between the concepts of 'moderate' and 'severe' when diagnosing learning difficulties (MacKay, 2009).

**Overview:** It has been suggested that children identified with Severe Learning Difficulties take longer to process information than their non-SEN peers and often engage in the learning process passively, rather than actively participating (Lee, McGee and Ungar, 2001). They may also experience difficulties with attention or memory, reinforcing the argument made earlier in this paper, that Special Educational Needs and Disabilities are complex and involve a number of inter-related concepts. Furthermore, children with Severe Learning Difficulties are likely to experience significant barriers to effective communication, which can often lead to difficulties in forming attachments to their parents, teachers and/or peers (Goss, 2006).

**National prevalence:** Severe Learning Difficulties represent 0.4% of children on SEN Support nationally. Yet, 13.1% of children granted a Statement or EHC plan are identified with a Severe Learning Difficulty. This makes SLD the third most common primary need of children allocated a Statement of SEN/EHC plan. There are, therefore, many more children identified with SLD who have been given a Statement/EHC plan than those who are receiving SEN Support. This is likely explained by the fact that children with Severe Learning Difficulties likely require significant support to access learning; this support usually warrants a Statement/EHC plan, as the provision warranted under SEN Support does not meet the complexity of needs presented by a child/young person with SLD.



#### 9.12.4 PMLD: Profound and Multiple Learning Difficulty

**Definition:** Bellamy et al. (2010) suggest the following components as defining PMLD: 'extreme delays in intellectual and social functioning, limited verbal skills but responsive to environmental cues, dependence on familiar others to interpret communicative intent, frequent associated medical, physical or sensory impairments.' The DSM-5 (American Psychiatric Association, 2013, p.33) defines PMLD as 'deficits in both intellectual and adaptive functioning in conceptual social and practical domains' which start during the developmental period.

**Overview:** Glover et al. (2011) explain that PMLD is a description rather than a diagnostic category. Farrell (2017) describes how in terms of the conceptual domain the conceptual skills generally involve, 'the physical world rather than the symbolic processes.' He explains that the child or young person may use objects in a goal-orientated way for self-care, work and recreation. They may encounter challenges with motor and sensory impairments impacting on their ability to use objects functionally. In the social domain they may have very limited understanding of speech and gesture but may have some understanding of simple instructions and gestures. Finally, in the practical domain they will be depend on others for all aspects of physical care, health and safety. Male (2015) reflects that PMLD often co-occurs with physical difficulties sensory impairments or severe health conditions. She suggests causal factors as genetic syndromes and influences such as alcohol and drugs prior to birth. In addition, there are factors around the time of birth and difficulties with labour or delivery which can lead to problems with brain functioning in the new born child.

**National prevalence:** The percentages of children identified with SEN, whose primary need is categorised as PMLD is 4.6%. 4.5% of children have been allocated a Statement of SEN/EHC plan. Only 0.1% of children identified with SEND, with the primary need of Profound and Multiple Learning Difficulties are on SEN Support. As with MLD, there is some ambiguity surrounding the identification of PMLD, which may explain the low percentages of children in this category. This will be discussed in greater detail later in this chapter.

### 9.12.5 SEMH: Social, Emotional and Mental Health Difficulty

**Definition:** The World Health Organization (2011) describes mental health as:

‘A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.’

**Overview:** Department of Health (2013) state that there is a lack of nationally collated current data on the present extent of mental health problems and service provision. The report added that a total of 1 in 10 children and young people aged 5–15 years had a clinically diagnosable mental disorder and that self-harm is common, particularly in adolescence and those with a mental disorder. Mental health is described as being paramount to having a good quality of life, with children and young people who are happy and confident more likely to carry this into adulthood thus providing resilience in the face of adversity (WHO, 2012). The annual report of the Chief Medical Officer (2013) adds that psychiatric disorders among children and young people are common and persistent, the concern is they may increase in times of austerity due to increasing pressures on families and shrinking support available to them. She added that child mental health should be a high policy priority and that there was a desperate need for high-quality data on which to further develop services and to base the next generation of child mental health research programmes. Further to this there is a need for rigorous evaluations of different service models as well as more randomised trials of interventions and their implementation with fidelity into routine clinical practice. Also, improved co-ordination across children’s services and between child and adult mental health services is essential.

**National prevalence:** The percentage of children identified with SEND, whose primary need is recorded as Social, Emotional and Mental Health Difficulties is 19.6%. As was discussed earlier in this literature review, the Children and Families Act (2014) introduced this new categorisation of primary need. This was a significant reform as, for the first time; mental health was accepted as an area of SEND, requiring additional educational support. 17.3% of children identified with SEND are accessing SEN Support for their Social, Emotional and Mental Health Difficulties and 12.3% have been granted a Statement/EHC plan for this primary need. This makes Social, Emotional and Mental Health Difficulties the second most common primary need for children with a Statement/EHC plan, and third most common for children on SEN Support.

The Department of Health (2013), in their annual report, noted that the prevalence of psychiatric disorder among 5-15 year olds was 10% in two large national population-based surveys. The report acknowledged that the prevalence of disorder in this group has been overlooked internationally; it also highlighted that the combined data from these surveys revealed half of the 5-15 year olds with at least one psychiatric disorder also had a psychiatric disorder 3 years later.

Interestingly Social, Emotional and Mental Health Disorders are by far the most common primary need of children identified with SEND who are educated in Sunderland PRUs, yet there is no national data that details primary needs of children educated in PRUs so national comparison is limited.

As will be discussed in greater detail, later in this literature review, PRUs are a frequent place of education for children who have been excluded from mainstream schools. This suggests that a large number of exclusions are of children who are identified with Social, Emotional and Mental Health Disorders (McLaughlin, 2010).

Eames and Shippen (2017) SEMH argue joint working is essential if services are to survive, especially in times of financial hardship. However, this work is not always straightforward; each organisation has a different culture, language, and goals.

### 9.12.6 SLCN: Speech, Language and Communication Needs

**Definition:** Kersner (2015) defines speech as 'the mechanism by which most people communicate' requiring the use of the voice to make sounds. She explains it is not synonymous with language adding that speech is only one form of language, the spoken form, other being writing or signs.

**Overview:** Speech, Language and Communication Needs are one of the main primary needs within the board area of need entitled 'Communication and Interaction,' which was discussed earlier in this chapter. Public Health England (2015) identify that strong speech, language, and communication skills are associated with school readiness, and positive social and academic outcomes throughout childhood. The DfE (2016b) profile results show that for the aspect of speaking there is a year on year improvement in the percentage of children achieving at least the expected level. Ofsted (2014) highlight that, overall, children from low income backgrounds have fewer skills in language and communication. The preschool years therefore represent a prime opportunity to promote the language and communication of all children, but particularly those who may need additional input.

Farrell (2017) suggest a range of factors which may result in children and young people encountering challenges with speech, these include: physical difficulties with articulation, and /or problems with controlling pitch and or making sound contrasts that convey meaning. He adds that these difficulties are aspects respectively of phonetics, prosody and phonology. Just as the aspects are interrelated, so difficulties can co-exist.

**Phonetics:** Wright and Kersner (2015) refer to the study of articulation, which is explained as 'mastery of the sounds of the language.' They describe how it is a form of motor skill learning which lead to the automatic moving of speech articulators in the mouth in a fast and exact co-ordinated sequence.

**Prosody:** Farrell (2017) outlines how this refers to speech volume, patterns of intonation and changes in pitch. This involves rhythm and fluency of speech to convey meaning, enabling understanding from the listener.

**Phonology:** Wright and Kersner (2015) state that the definitions of phonology can be very broad, however, they suggest it concerns the differences in speech sounds carrying meaning and has been defined as 'the way in which individual sounds are put together to make words within a given language, such that changing a sound within a word will change meaning' p. 102.

**National Prevalence:** 34.9% of children identified with SEND have Speech, Language and Communication Needs listed as their primary need. 20.9% of children identified with SEND are on SEN Support to meet their Speech, Language and Communication Needs and 14% have been given a Statement/EHC plan for this primary need. Speech, Language and Communication Needs are the second most prevalent need of children on SEN Support, following Moderate Learning Difficulties (DoH, 2013).

### 9.12.7 HI: Hearing Impairment

**Definition:** Farrell (2017) outlines that hearing loss rarely affects all frequencies equally, so hearing is often distorted.

**Overview:** The newborn hearing screening programme for England (NHSP England) was introduced between 2002 and 2006 with full implementation achieved in March 2006. The aim of the programme is to screen eligible babies within the first few weeks of life and by three months of age at the latest, and to identify cases of congenital moderate to profound Permanent Childhood Hearing Loss (PCHI) by six months of age. Farrell (2017) clarifies that most deaf children are born to hearing parents.

**National prevalence:** 4.3% of children identified with SEND present with a Hearing Impairment. 2.7% of children identified with SEND have been granted a Statement of

SEND/EHC plan for Hearing Impairment; this is likely children who are profoundly deaf and require significant support in accessing learning. 1.6% of children identified with SEND and have a Hearing Impairment are on SEN Support; these children are likely to have their learning needs successfully met by schools following the four part cycle of SEN Support, as explained earlier in this chapter.

### **9.12.8 VI: Visual Impairment**

**Definition:** Gray (2005) suggests that the term 'Visual Impairment' encompasses a broad spectrum of eye conditions and visual acuity levels. Visual acuity is defined as a person's central vision which they use to see detail. The World Health Organisation (2016) states that in terms of visual function there are four levels; normal vision, moderate Visual Impairment, severe Visual Impairment and blindness. They add that moderate Visual Impairment combined with severe Visual Impairment are grouped under the term 'low vision:' low vision taken together with blindness represents all Visual Impairment. In addition to this the Royal institute of Blind People (RNIB, 2016) highlight that there are over thirty different types of Visual Impairment conditions. This view is shared by Willings (2017) who adds that there is such a wide range of Visual Impairments and that children and young people will have their own individual visual needs. It is widely accepted that there are a range of medical causes and that due to variation in the cause, type and severity the needs of children will vary accordingly (Salisbury, 2007; Gray, 2009; Glazzard et al. 2015 and Willings, 2017). It can be concluded that there are multiple causes of Visual Impairment which can include being genetically determined and can arise during the development of the foetus, during birth and throughout childhood stemming from a range of factors such as illness and trauma.

**National prevalence:** Children with a Visual Impairment comprise 2.4% of all children identified with SEND. The majority of children identified with a primary need of Visual Impairment have been successful in gaining a Statement of SEND/EHC plan, at 1.5% of the overall population of children identified with SEND. 0.9% of children identified with SEND are receiving SEND Support for a Visual Impairment.

### 9.12.9 MSI: Multi-Sensory Impairment

**Definition:** Multi-sensory impairment is the term used for a spectrum of conditions, including, but not limited to, individuals who are deafblind or have hearing and Visual Impairments as well as physical impairments and learning disabilities (Aitken, 2000).

**Overview:** It has been identified that children and young people with MSI experience numerous difficulties in many areas of daily life. McInnes and Treffry, 1982; McInnes, 1999 and Aitken, 2000 suggest that the characteristic areas of difficulty in MSI can be broadly summarised and grouped as follows:

- communication
- accessing and finding out information
- relationships
- mobility and orientation
- use of senses
- cognitive abilities

Aitken and Millar (2002) identify the impact that a Visual Impairment as well as additional difficulties can have on the communication skills of children and young people. The challenges can include: a reduced and confused experience of the world, becoming passive and isolated, and the tendency to be echolalic or repeating the last word said to them, all of which may limit their ability to make choices. Aitken and Millar (2002) highlight the effects of hearing impairment on individuals, including potential isolation from information and from other people. They add that a physical impairment in association with communication difficulties will also present additional challenges.

**National prevalence:** Multi-Sensory Impairment is the least prevalent primary need of children identified with SEND. A total of 0.5% of children identified with SEND present with a Multi-Sensory Impairment as their primary need. 0.3% of all children identified with SEND have been granted a Statement/EHC plan for a Multi-Sensory Impairment and 0.2% are accessing SEND Support for this primary need.

#### **9.12.10 PD: Physical Disability**

**Definition:** The term 'Physical Disability' covers a wide range needs and is challenging to define. The 2010 Equality Act defines a person with a physical, or mental, disability as one whose impairment has a long-term effect on their ability to carry out normal day-to-day activities (TSO). Research by Horridge et al. (2016) highlighted the multifaceted needs of physically disabled children and, indeed, their families. The authors conducted research in Sunderland, analysing over 8000 consultations with disabled children and young people attending paediatric disability clinics. The aim of the research was to develop a systemised and accepted nomenclature that encapsulated the multi-faceted and inter-related needs of disabled children. The researchers termed this nomenclature a Disabilities Terminology Set (DTS). The researchers identified a terminology set that included 296 terms to describe physical disabilities, highlighting the complexity of this primary need. The authors also identified that different physical disabilities can present different patterns of complexity, influenced by personal resilience, vulnerabilities, living and system environments as well as by the passage of time.

Ireland et al. (2016) argue that this devised terminology set should be used to better inform the discussions between health professionals, the child and their family. The Disabilities Terminologies Set was used by the authors in further research, to develop a Health, Functioning and Wellbeing Summary Traffic Light tool, which was given to children and their families immediately before their consultation with a health professional. This tool encouraged families to identify the key features of a child's physical disability that they required support with, and thus would prioritise in their forthcoming consultation. 60 families were involved in this study, again in Sunderland, and 87.1% of the resulting



consultations were thought to better address the needs of families than those in which the tool was not used.

Hinton and Kirk (2014) suggest there is a comparable lack of research on teachers' knowledge and perceptions of other conditions such as Arthritis, HIV and Cystic Fibrosis, for example, and research in these areas may identify additional and/or disease-specific issues, which have not been discussed here. A large scale national survey of teachers' knowledge of and attitudes towards pupils' long-term conditions may be useful to identify teachers' training needs in relation to pupils' long-term health conditions.

**National prevalence:** A total of 8% of children identified with SEND have a Physical Disability as their primary need. 5.8% of children identified with SEND have been successful in gaining a Statement/EHC plan for a Physical Disability; 2.2% are accessing SEND Support for a Physical Disability.

#### **9.12.11 ASD: Autism Spectrum Disorder**

**Definition:** Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them (National Autism Society, 2017). The DSM-5 specifies diagnostic criteria for Autism Spectrum Disorder (American Psychiatric Association, 2013). It specifies that Autism involves 'persistent deficits in social communication and social interaction, which occur in many contexts' (p. 50). Furthermore it adds that there may be limitations in social and emotional sharing, non verbal communication used in social interaction and being able to develop, sustain and understand relationships (ibid).

**National Prevalence:** ASD remains the most common primary type of need for pupils with a statement or EHC plan; 25.9% of pupils with a statement or EHC plan were categorised as having this primary need. This has increased slightly from 24.5% in 2015 (DfE, 2016b). 4.7% of pupils identified with SEN were receiving SEN Support for ASD. Therefore, the vast majority of children identified with ASD require the specialist co-ordinated support afforded by a Statement/EHC plan. This suggests that schools and colleges experience significant difficulties in educating children identified with ASD by following the graduated approach associated with SEN Support (DfE, 2015a).

#### **9.12.12 OTH: Other Difficulty/Disability**

**Definition:** There is no definition.

**National Prevalence:** The DfE's latest statistical first release (2016b) indicates that 7.9% of all children identified with SEND have a difficulty/disability that does not fall into the accepted diagnoses already explored in this chapter, and must be labelled as 'other.' 5.5% of children identified with SEND are accessing SEN Support for a difficulty/disability labelled as 'other,' and 2.4% have been given a Statement of SEND/EHC plan to meet their needs.

#### **9.13 A Consideration of Co-morbidity**

As was presented above, the DfE (2016b) collect a primary type of need for those pupils on SEN Support or with a Statement of SEN/EHC plan. However, there is a wealth of evidence that highlights the multi-faceted nature of children's needs. Many children identified with SEND are likely to experience needs that fall under multiple categories and not simply that which is identified as their primary need (Kendall and Taylor, 2016; Riddick, 2012; Taylor et al., 2015). This is particularly common in children with ASD.

Horridge (2016a) suggests that population profiling to inform care pathways development and service design is essential. She proposes that by prompting families and clinicians to seek out associations, identifying them early and manage them in a timely way, ultimately results in better outcomes. This will impact positively on service planning and resource allocation as you are able to ensure there is sufficient capacity to meet needs within the NHS. It is suggested that it needs to be explored how this information can be securely shared with the Council to support service planning in education.

Gooch et al. (2014) outline that in recent years, there has been growing interest and research into the frequent co-occurrence of developmental disorders. Hulme and Snowling (2009) and Williams (2013) highlight that it is now well recognised that pure disorders are rare in development and that 'co-morbidity' is common.

Taylor et al. (2015) identified that one of the most common examples of co-morbidity is in relation to ADHD which is thought to be present in 30-60% of individuals whose primary needs has been identified as ASD. Pearson (2006) suggested that, for parents and teachers, these co-existing conditions can be of equal or greater concern than the core features of Autism and can have a significant impact on behaviour management, learning acquisition and the development of social relationships. Bradley and Bolton (2006) and Simonoff et al. (2008) reinforce that there is a very high prevalence of co-morbid mental health conditions associated with ASD, including ADHD, learning disabilities, emotional disorders, anxiety and phobic disorders. Furthermore, Murray et al. (2014) raise concerns that there is an under-reporting of neuropsychiatric co-morbidities within the British population of those with a diagnosis of ASD.

Those with ASD often experience additional health and mental health conditions and behavioural problems that can impact on their lives and on their families (Dominick et al. 2007; Hurtig et al. 2009). It is likely that the complexity of managing a child's ASD needs together with behaviour and mental health problems contributes to the higher levels of stress and distress seen in families of children with ASD compared to other families (Allik et al. 2006a; Lecavalier et al. 2006; Manning et al. 2010).

### 9.14 Identification/assessment of Special Educational Needs and/or Disabilities

Figure 6 below shows the opportunities to assess and record information about all children in England (Ofsted, 2014). Ofsted outline that when children are born, their birth is recorded and Health Visitors also visit immediately after the birth and assess the child's family environment to identify possible information and support that may be needed. There are further checks as part of the Healthy Child Pathway at six weeks, three to four months, five to eight months and one year. At around the age of two, all children should be assessed again by health services, and there should also be a check within the EYFS if the child is in an EYFS registered setting. Data on outcomes are critical to ensure that providers can be held to account for the impact they have.

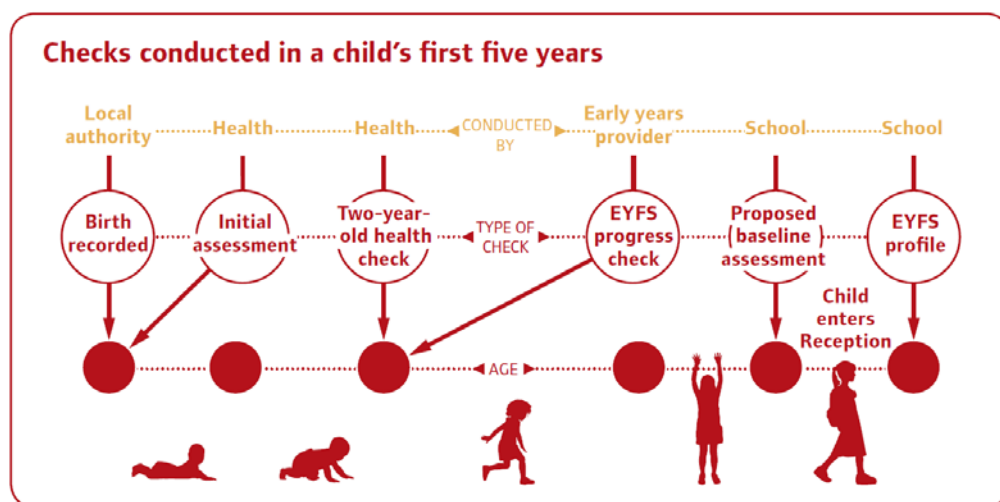


Figure 6: Checks carried out by early years providers and school within the child's first five years (Ofsted, 2014).

The current SEND code of practice (DfE, 2015a) repeats the previous recommendations of the earlier codes that SENCos and teachers should work collaboratively in identifying and assessing the special needs of children and young people (DfEE, 1994; DfES, 2001). In the 2015 guidance it states 'where a pupil is identified as needing SEN Support, the class teacher or subject teacher, working with the SENCo, should carry out a clear analysis of the pupils needs.'

Wedell (2017) discussed the issue of the term 'a clear analysis' proposing that this understates the complexity of achieving this. It was identified by SENCOs that there are insufficient tools available to identify needs accurately or reliably at school level. The identification of SEND should be built into the overall approach to monitoring the progress and development of all pupils (NASEN, 2015). Laija-Rodriguez et al. (2013) raise the concern that the primary issue of assessment in school is to identify deficits, especially when applying for support. They do acknowledge that strengths are noted on Individual Education Plans (IEPs)

The Driver Youth Trust (2015) highlighted that reforms to LA provision and regional variation have led to inconsistency in identifying pupils' needs. As a result several interviewees in the research suggested that parents are paying for private diagnostic assessments if they suspect their children have Dyslexia.

### **9.15 Special Educational Needs and/or Disability in the EYFS**

Ofsted (2014) describe the early years, otherwise known as the foundation years as the time between birth and the 31 August following their fifth birthday. They add that Local Authorities must now offer all children a place in a school Reception class from the September following their fourth birthday. Robert-Holmes (2012) wrote that the Early Years Foundation Stage (EYFS) framework, was published in March 2007 and implemented in September 2008 it built on and replaced the non-statutory Birth to Three Matters guidance (DfES 2003) and the Foundation Stage curriculum for three and four year olds (QCA 2000), and the National Standards for Day Care (Sure Start, 2003). Rogers (2011) described the EYFS as providing a 'long-awaited and distinctive educational phase' for children in English early years settings through a play based and developmentally relevant framework, designed with a focus on education and care.

The Tickell Review (2011) states that the earliest years in a child's life are absolutely critical. There is overwhelming international evidence that foundations are laid in the first years of life which, if weak, can have a permanent and detrimental impact on children's longer term development. A child's future choices, attainment, wellbeing, happiness and resilience are profoundly affected by the quality of the guidance, love and care they receive during these first years.

HM Government (2010) stated that the evidence was clear that children's experiences in their early years strongly influence their outcomes in later life, across a range of areas from health and social behaviour to their employment and educational attainment. It added that the most recent neuroscientific evidence highlights the particular importance of the first three years of a child's life. A strong start in the early years increases the probability of positive outcomes in later life; a weak foundation significantly increases the risk of later difficulties.

As Martin-Denham (2015) explained when it is becoming apparent that a child in the early years is not meeting expected levels of progress, practitioners and the SENCo need to gather information on the child's learning and development to allow early intervention to begin. It is important to consider causal factors such as the home environment, poverty and family circumstances. Ofsted (2016a) reported that good early years education, particularly for children from low-income backgrounds, is crucial to longer term academic success. In 2010/11, in some deprived areas of the country, less than half the early education provision available was good or outstanding. They have shared that in the last five years there have been considerable changes for the better:

- Across the country, 91% of early years providers are now good or outstanding: a 22 percentage point increase since 2010.
- The proportion of good and outstanding nurseries and pre-schools is now almost identical in the least and most deprived areas.
- This year, in every Local Authority area in the country, at least eight out of 10 childcare places are in registered providers of early education judged good or outstanding.

- In 2016, over two thirds of young children reached the government’s ‘good level of development’ compared with just over a half in 2013 (ibid).

Nutbrown (2012) raised the concern of qualifications for early years professionals. Her concerns were that currently, early years group settings must be managed by someone with at least a relevant level 3 qualification but that at the time half the staff were only qualified to level 2. But many level 3 qualifications currently on offer are insufficient in content and standard. She recommended that the content of level 3 qualifications be strengthened, to include more child development and play, more on special educational needs and disability. More recently, Ofsted (2014) have recognised that children from low income families make the strongest progress when supported by highly qualified staff, particularly with graduate level qualifications.

### **9.16 The prime and specific areas of learning**

The DfE (2017) framework states that there are seven areas of learning and development that must shape educational programmes in early years settings. All areas of learning and development are important and inter-connected. Three areas are particularly crucial for igniting children’s curiosity and enthusiasm for learning, and for building their capacity to learn, form relationships and thrive. The prime areas of learning are explored below:

#### **9.16.1 Communication and language**

**Listening and Attention:** children listen attentively in a range of situations. They listen to stories, accurately anticipating key events and respond to what they hear with relevant comments, questions or actions. They give their attention to what others say and respond appropriately, while engaged in another activity.

**Understanding:** children follow instructions involving several ideas or actions. They answer 'how' and 'why' questions about their experiences and in response to stories or events.

**Speaking:** children express themselves effectively, showing awareness of listeners' needs. They use past, present and future forms accurately when talking about events that have happened or are to happen in the future. They develop their own narratives and explanations by connecting ideas or events.

### **9.16.2 Physical development**

**Moving and handling:** children show good control and co-ordination in large and small movements. They move confidently in a range of ways, safely negotiating space. They handle equipment and tools effectively, including pencils for writing.

**Health and self-care:** children know the importance for good health of physical exercise, and a healthy diet, and talk about ways to keep healthy and safe. They manage their own basic hygiene and personal needs successfully, including dressing and going to the toilet independently.

### **9.16.3 Personal, social and emotional development**

**Self-confidence and self-awareness:** children are confident to try new activities, and say why they like some activities more than others. They are confident to speak in a familiar group, will talk about their ideas, and will choose the resources they need for their chosen activities. They say when they do or don't need help.



**Managing feelings and behaviour:** children talk about how they and others show feelings, talk about their own and others' behaviour, and its consequences, and know that some behaviour is unacceptable. They work as part of a group or class, and understand and follow the rules. They adjust their behaviour to different situations, and take changes of routine in their stride.

**Making relationships:** children play co-operatively, taking turns with others. They take account of one another's ideas about how to organise their activity. They show sensitivity to others' needs and feelings, and form positive relationships with adults and other children.

The specific areas of learning are explored below:

#### **9.16.4 Literacy**

**Reading:** children read and understand simple sentences. They use phonic knowledge to decode regular words and read them aloud accurately. They also read some common irregular words. They demonstrate understanding when talking with others about what they have read.

**Writing:** children use their phonic knowledge to write words in ways which match their spoken sounds. They also write some irregular common words. They write simple sentences which can be read by themselves and others. Some words are spelt correctly and others are phonetically plausible.

#### **9.16.5 Mathematics**

**Numbers:** children count reliably with numbers from 1 to 20, place them in order and say which number is one more or one less than a given number. Using quantities and objects, they add and subtract two single-digit numbers and count on or back to find the answer. They solve problems, including doubling, halving and sharing.

**Shape, space and measures:** children use everyday language to talk about size, weight, capacity, position, distance, time and money to compare quantities and objects and to solve problems. They recognise, create and describe patterns. They explore characteristics of everyday objects and shapes and use mathematical language to describe them.

#### **9.16.6 Understanding the world**

**People and communities:** children talk about past and present events in their own lives and in the lives of family members. They know that other children don't always enjoy the same things, and are sensitive to this. They know about similarities and differences between themselves and others, and among families, communities and traditions.

**The world:** children know about similarities and differences in relation to places, objects, materials and living things. They talk about the features of their own immediate environment and how environments might vary from one another. They make observations of animals and plants and explain why some things occur, and talk about changes.

**Technology:** children recognise that a range of technology is used in places such as homes and schools. They select and use technology for particular purposes.

#### **9.16.7 Expressive Arts and Design**

**Exploring and using media and materials:** children sing songs, make music and dance, and experiment with ways of changing them. They safely use and explore a variety of materials, tools and techniques, experimenting with colour, design, texture, form and function.

**Being imaginative:** children use what they have learnt about media and materials in original ways, thinking about uses and purposes. They represent their own ideas, thoughts and feelings through design and technology, art, music, dance, role-play and stories.

Table 4

*Key differences between the prime and the specific areas (Tickell, 2011).*

Prime areas	Specific areas
Are time-sensitive. If not securely in place by the age of 5, they will be more difficult to acquire and their absence may hold the child back in other areas of learning.	Are less time-sensitive. Specific areas of learning reflect cultural knowledge and accumulated understanding. It is possible to acquire these bodies of knowledge at various stages through life.
Are characterised by their universality. They occur in all socio-cultural contexts.	Are skills and knowledge which are specific to priorities within socio-cultural contexts.
Are not dependent on the specific areas of learning, although the specific areas of learning provide the context for their development.	Are dependent on learning in the prime areas – the specific learning cannot easily take place without the prime.

The DfE (2017) statutory guidance states that educational programmes must involve activities and experiences for children, as follows:

**Communication and language** development involves giving children opportunities to experience a rich language environment; to develop their confidence and skills in expressing themselves; and to speak and listen in a range of situations.

**Physical development** involves providing opportunities for young children to be active and interactive; and to develop their co-ordination, control, and movement. Children must also be helped to understand the importance of physical activity, and to make healthy choices in relation to food.

**Personal, social and emotional development** involves helping children to develop a positive sense of themselves, and others; to form positive relationships and develop respect for others; to develop social skills and learn how to manage their feelings; to understand appropriate behaviour in groups; and to have confidence in their own abilities.

**Literacy development** involves encouraging children to link sounds and letters and to begin to read and write. Children must be given access to a wide range of reading materials (books, poems, and other written materials) to ignite their interest.

**Mathematics** involves providing children with opportunities to develop and improve their skills in counting, understanding and using numbers, calculating simple addition and subtraction problems; and to describe shapes, spaces, and measure.

**Understanding the world** involves guiding children to make sense of their physical world and their community through opportunities to explore, observe and find out about people, places, technology and the environment.

**Expressive arts and design** involves enabling children to explore and play with a wide range of media and materials, as well as providing opportunities and encouragement for sharing their thoughts, ideas and feelings through a variety of activities in art, music, movement, dance, role-play, and design and technology.

### **9.17 The progress check**

The DfE (2017) framework advises that:

'When a child is aged between two and three, practitioners must review their progress... If there are significant emerging concerns, or an identified special educational need or disability, practitioners should develop a targeted plan to support the child's future learning and development p. 13.'

The EYFS framework adds that practitioners should encourage parents and/or carers to share information from the progress check with other relevant professionals, including their health visitor and the staff of any new provision the child may transfer to. Practitioners must agree with parents and/or carers when will be the most useful point to provide a summary. Where possible, the progress check and the Healthy Child Programme health and development review at age two (when health visitors gather information on a child's health and development) should inform each other and support integrated working. This will allow health and education professionals to identify strengths as well as any developmental delay and any particular support from which they think the child/family might benefit. Providers must have the consent of parents and/or carers to share information directly with other relevant professionals.

#### **9.18 Assessment in the Early Years Foundation Stage (EYFS): The EYFS Profile**

The Standards and Testing Agency (2016) confirmed that the EYFS profile was due to become non-statutory from September 2016. The DfE (2016f) has now confirmed that the EYFS profile will remain statutory for the 2016 to 2017 and 2017 to 2018 academic years. Wormwell (2016) shares that the current main method of assessment in reception is the EYFS Profile. Teachers assess a child's attainment against the 17 Early Learning Goals (ELGs) using a best fit judgement for each pupil. Pupils are judged as 'emerging' – not yet achieving the ELG, 'expected'- achieving the ELG, and 'exceeding'- achieving beyond the ELG and working within the National Curriculum. Points are awarded on a scale of 1-3, with 1 being the point for 'emerging'.

### **9.19 Good Levels of Development nationally and in Sunderland**

Ofsted (2014) detail that the only outcomes data for ages 0–5 that are consistently recorded and published are in the Early Years Foundation Stage Profile (EYFSP). They explain that the EYFSP is an assessment conducted by schools at the end of the Reception year. As well as individual judgements about the development of each child in different areas of learning, the EYFSP includes an assessment of whether each child has reached a ‘good level of development’, based on criteria set by the government.

Ofsted (2016a) reported that, the proportion of children achieving a good level of development in the early years was 69.3%, this was an increase of three percentage points since 2015. They acknowledged that the rate of improvement was not as rapid as in the previous two years. However, overall, the proportion of children achieving a good level of development has risen by 17.6 percentage points since 2013. In the last three years, each region in England has seen an increase in the percentage of children achieving a good level of development, with the North East showing the greatest improvement (ibid).

Table 5 overleaf shows a comparison of regional Local Authorities (LAs) in terms of the percentage of children on free school meals who achieve a good level of development at the end of reception year. Sunderland is the highest achieving LA in comparison to neighbouring areas. A Good Level of Development (GLD) is defined as the number and proportion of children achieving at least the expected level within the three prime areas of learning: communication and language; physical development and personal, social and emotional development; and the early learning goals within the literacy and mathematics areas of learning.

Table 5

Percentage of children on Free School Meals (FSM) achieving a Good Level of Development (GLD) at the end of EYFS (Ofsted, 2014).

Local Authority	% GLD
Sunderland	34
Northumberland	30
Newcastle upon Tyne	28
Stockton on Tees	22
Durham	26
South Tyneside	33

### 9.20 The Role of Special Educational Needs Co-ordinator (SENCo)

Oldham and Radford (2011) write that historically the position of SENCo was made statutory by the 1993 Education Act and the SEN Code of Practice set out its purpose (DfEE, 1994). Cheminais (2015) highlights that the SEN regulations (2014), the SEND code of practice (0-25) (2014) and Part 3 of the Children and Families Act (2014), formed the new SEND statutory framework, and these represented the biggest reforms in just over three decades. These changes have impacted on the role of the SENCo how is now seen as central in leading improvement for SEND.

The SEND Code of Practice (DfE, 2015a) requires governing bodies of maintained mainstream schools and the proprietors of academy schools (including free schools) to ensure that there is a qualified teacher designated as Special Educational Needs (SEN) co-ordinator (SENCo) for the school. The National award for SEN co-ordination is a mandatory award that must be accredited by universities, and individual courses may be chosen by local authorities or schools. The courses are designed to support professional development and help improve practice (NCTL, 2015). Wedell (2014) The most recent SEND code of practice (DfE, 2015a) increased the emphasis that previous versions placed on class teachers' responsibility for responding to the diversity of children's learning needs, through quality first teaching.

Done et al. (2016) discusses the shift in the SENCo role over recent years and suggests that instead of functioning as an 'in-house expert' to whom responsibility for inclusion could be delegated, the SENCo is now more likely to be engaged in whole-school organisational-level initiatives including, performance evaluation, the identification and leading of continuing professional development (CPD) requirements. The challenge with this is that the SEND code of practice (DfE, 2015a) states that the SENCo 'should' not 'must' be on the Senior Leadership Team. In light of this many SENCos remain unable to be a key leader in terms of co-ordinating provision and practice. It is evident from research that the role of the SENCo is challenging, stressful and demanding due to limited time to do the role.

Related to this, there has been concern raised nationally by university providers of the Post Graduate Certificate National Award for Special Educational Needs Co-ordination that some Head Teachers are changing their SENCo every three years to avoid funding their SENCos to complete the required qualification. It is recommended that the City Council keep a register of which schools have a qualified SENCo in post to develop expertise in identifying needs with stringent policies, processes and procedures, a lack of resources, funding and fear of litigation (Cole and Johnson, 2004).

The SENCo role includes the following duties (DfE, 2015a, NCTL, 2014).

- Overseeing the day-to-day operation of the school's SEN policy
- Coordinating provision for children with SEN
- Liaising with the relevant designated teacher where a looked after pupil has SEN
- Advising on a graduated approach to providing SEN Support
- Advising on the deployment of the school's delegated budget and other resources to meet pupils' needs effectively; Liaising with parents of children with SEN
- Liaising with other schools, educational psychologists, health and social care professionals, and independent or voluntary bodies
- Being a key point of contact with external agencies, especially the LA and LA support services



- Liaising with potential next providers of education to ensure a young person and their parents are informed about options and a smooth transition is planned
- Working with the head teacher and school governors to ensure that the school meets its responsibilities under the Equality Act (2010) with regard to reasonable adjustments and access arrangements
- Ensuring that the school or maintained nursery keeps the records of all children with SEN up to date

### **9.21 The Role of National Health Service (NHS) and Clinical Commissioning Groups (CCGs)**

Clinical Commissioning Groups (CCGs) were created following the 2012 Health and Social Care Act, and replaced Primary Care Trusts on 1 April 2013. CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. There are now 209 CCGs in England. NHS England is the statutory body responsible for overseeing the commissioning of health services by CCGs (Compact Voice, 2015).

The main role of CCGs is to ensure that the best possible health outcomes for the local population are supported, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc. It is an ongoing process, and CCGs must constantly respond and adapt to changing local circumstances. CCGs are responsible for the health of their entire population, and are measured by how much they improve outcomes.

CCGs are:

- Membership bodies, with local GP practices as the members
- Led by an elected Governing Body made up of GPs, other clinicians including a nurse and a secondary care consultant, and lay members
- Responsible for approximately 2/3 of the total NHS England budget; or £71.9 billion in 2016/17

- Responsible for healthcare commissioning such as mental health services, urgent and emergency care, elective hospital services, and community care
- Independent, and accountable to the Secretary of State for Health through NHS England
- Responsible for the health of populations ranging from under 100,000 to 900,000, although the average population covered by a CCG is about a quarter of a million people (NHS Clinical Commissioners, 2017)

Local Authorities are now responsible for public health, therefore, CCGs work closely with them through health and wellbeing boards to achieve the best possible outcome for the local community, by developing a joint needs assessment and strategy for improving public health. The figure below gives a visual representation of the different health bodies involved in health service commissioning.

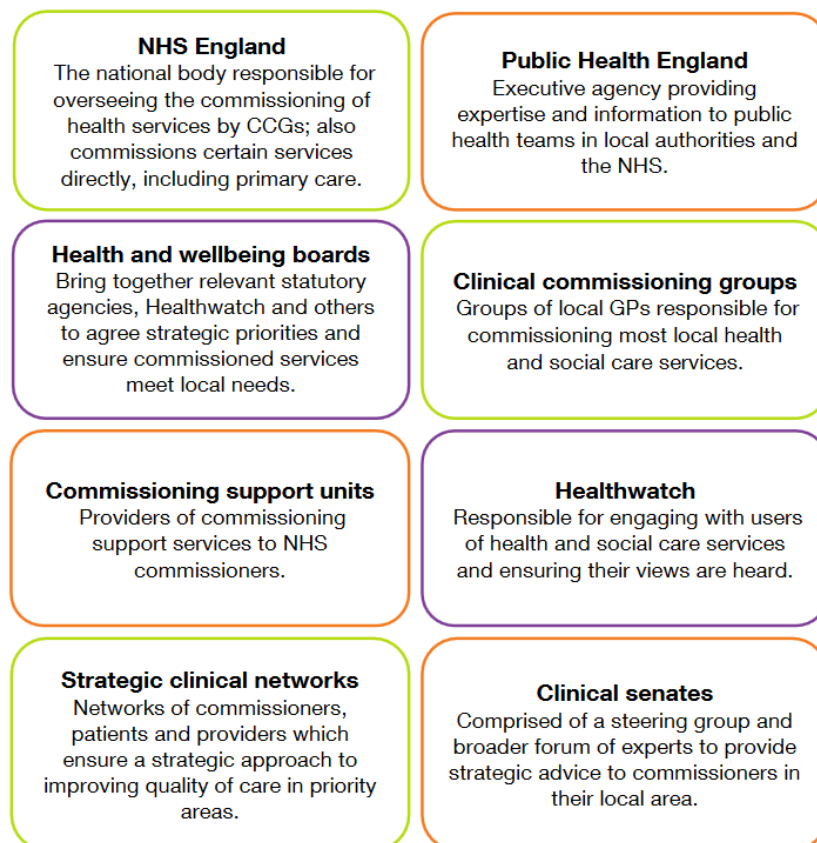


Figure 7: Health bodies involved in commissioning of services (Compact Voice, 2015).

NHS Sunderland Clinical Commissioning Group (CCG) is the statutory health body responsible for the planning and buying of local NHS care and services to meet the needs of the local community. Their vision is stated on their website as, 'to improve the health, wellbeing and life expectancy of the residents of Sunderland, by providing joined up health and social care, underpinned by effective clinical decision-making, reducing the disparities in health across the city and achieving 'better health for Sunderland.'

### **9.22 The Designated Medical Officer (DMO) role**

The Designated Medical Officer (DMO) plays a key role in supporting boroughs with implementing the SEND reforms initiated by the 2014 Children and Families Act. The DMO works to support children and young people aged 0-25 with SEND and provides the point of contact for local authorities, schools and colleges seeking health advice on children and young people who may have SEN or disabilities. They also provide a contact point for Clinical Commissioning Groups (CCGs) or health providers, so that appropriate notification can be given to the Local Authority of children who they think may have SEN or disabilities.

This is a non-statutory role which would usually be carried out by a Paediatrician, but there is local flexibility for the role to be undertaken by a suitably competent qualified and experienced nurse or other health professional (in which case the role would be the Designated Clinical Officer - DCO).

The Council for Disabled Children produced a handbook in September 2016, which set out practical advice and support for DMOs, DCOs and other professionals involved in implementing the health focused reforms presented in the 2014 Children and Families Act. The report highlighted that whilst the DMO has a clear role to play in supporting joined up working across Education, Health and Social Care, the appointment of a DMO cannot be viewed as an independent solution to ineffective multi-agency working. The report explained that the DMO must be supported by all stakeholders to support children identified with SEND. In order for optimally effective multi-agency working to occur, the DMO role must have clear and realistic expectations associated with it. This must translate to reasonable and carefully considered responsibilities, within the role descriptor.

These responsibilities should also reflect the specific logistical arrangements and requirements of the local area.

The Council for Disabled Children (2016) suggested the following key responsibilities of the DMO role, as informed by workshops held involving over 600 health professionals from across England:

1. **Oversight** across all health professionals delivering healthcare to individual disabled children, young people and those with special educational needs. This may include a focus on:
  - Processes for identification of disabled children and young people and those with special educational needs, particularly pre-school children
  - The process for securing health assessment and key principles for health advice in EHC plans
  - Oversight and assurance of health provision specified in EHC plans
  - Provision of information and advice in the Local Offer on available health services for children and young people with SEN and disability, their parents and those who may care for them or want to refer them for assessment
  - The assessment of health needs and provision of services to young offenders with EHC plans
  - Working with schools to support pupils with medical conditions.
  
2. **Coordination** to ensure:
  - All health services are reflected in the Local Offer and that health providers are co-operating with the Local Authority in its development/review
  - A clear process for mediation arrangements regarding the health element of EHC plans
  - Co-ordination of EHC assessments with other key health assessments e.g. Children and Young People's Continuing Care assessment, Looked-after Children's Health Assessment.

3. **Strategic** contribution to the development of:

- A joint commissioning strategy that works towards the integration of services to improve outcomes
- A participation and engagement strategy with children and young people with SEN and disability and their families

### **9.23 Care co-ordination: NHS Digital**

In 2016 the current Health Secretary, Jeremy Hunt, announced that £4.2bn had been set aside for digital and technology projects in the NHS; this was to be for the duration of the current parliament (Thornton, 2016). The key aim of this technology project (NHS Digital) is to drive improvements in care co-ordination, with a secondary aim to be the use of data in health research and service planning.

As stated in the King's Report by Honeyman et al. (2016), data sharing is described as essential for conducting research and improving patient care. The Wachter Review (2016) presented that the goal of digitalisation of health systems was to promote the 'healthcare's triple aim:' better health, better healthcare and lower cost. It added that IT, data systems and information sharing are critical to delivering integrated care and can help to co-ordinate care delivered by professionals across different organisations.

Imison et al. (2016) stated that it is also critical that information governance is not a barrier to progress. Data captured by digital technologies could improve service planning, and to support the alignment of capacity more closely with demand. Wachter (2016) agrees, explaining that privacy and safeguarding is extremely important but this should not hinder data sharing as it adds value to patient care and research. He suggests that with regulation and governance, where patient's rights are respected, there could be enormous benefits to data sharing.

It is evident that much of the literature around NHS digital focuses on data sharing within health organisations, solely on an internal basis. Department of Health (2012), in a report for the NHS Future Forum, argued that there is a poor flow of information within the NHS about individuals and this is a key barrier to ensuring that there is effective joined-up service working, particularly for those with multiple and complex disabilities who care crosses organisational boundaries. The overwhelming view in this report was that with appropriate consent, all individuals involved in caring for a patient should have access to their records to share and communicate information; at this time the argument does not extend to sharing information with City Councils.

Horridge (2016b) piloted data collection at the point of care using a defined terminology set to examine the feasibility of data collection during paediatric clinic consultations. The outcome of the study was that paediatricians felt this data collection at the point of clinical care was possible without being disruptive. They were able to count the number of needs and quantify complexity in a way which then informed clinical care. She reported that this system was effective at the mapping of needs and suggested that knowing how many children are dependent on specific technologies or have specific needs in a school population will, once the issues of data sharing across agencies are resolved, permit planning for their need to be met in the early years, schools and into adult services. If it were possible to share this information with the Council this would actively support the forward planning of services as the multifaceted needs will be clearly defined.

#### **9.24 The Healthy Child Programme (HCP)**

- By the 12th week of pregnancy;
- The neonatal examination;
- The new baby review (around 14 days old);
- The baby's six to eight-week examination;
- By the time the child is one year old;
- Between two and two-and-a-half years old.

One of the HCP's core functions is to recognise disability and developmental delay. This includes a responsibility to provide information, support, referral and notification to others, and in particular there is a duty to inform the local education authority if it is suspected that a child may have special educational needs.

The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children, through health and development reviews, health promotion, parenting support, and screening and immunisation programmes. Its goals are to identify and treat problems early, help parents to care well for their children, change health behaviours, and protect against preventable diseases.

### **9.25 Funding models**

In December 2016, the National Audit Office gave notice to schools that they would be facing 'real-term cuts in funding and would have to make savings of 8 per cent by 2019-2020' (NAO, 2016). It would therefore appear that schools are facing increasing financial challenges, as the number of schools in deficit has risen by 10 percentage points between 2015 and 2017 to 18 per cent (NAHT, 2017). This will undoubtedly affect the pupils within the commissioning Local Authority including those with SEND and may lead to increase in requests for EHCs and SEN Support in the education sector. The NAHT report also highlighted a statistic that a 66% proportion of respondents had reduced the number of support hours available to pupils in school due to funding pressures.

The Children and Families Act 2014 significantly changed the role of Local Authorities by ensuring that needs of all young people with SEND are met in a way that is outcome focussed. It also broadened the remit of LAs to ensure that needs are met from birth-25 years. There is a transitional funding system in place for children with high level needs until a National Funding Formula is introduced in 2018-2019. The current system is based on a series of 'top-up' payments that are provided for pupils with the most significant need who require an EHC plan (with Statements of SEN being phased out on a rolling programme until April 2018 (DfE, 2016a). The current system for top-up funding works as shown in Figure 8.

	Mainstream settings	Specialist Settings	
10k -	Top-up funding for individual pupils determined by LA	Top-up funding for individual pupils determined by LA	Funding Bands
	School contributes up to £6k for additional needs from its SEN budget	Base funding of £10k per planned pupil place	
	Core funding for all pupils (approximately £4k per pupil)		

**Proposed SEN funding arrangements (pre-16)**

Figure 8: The current system for top up funding (DfE, 2012a).

The allocation of top-up funding varies between local Authorities with Sunderland City Council utilising a banding system based on costed provisioning mapping. Local Authorities utilise various banding systems based on different criteria with Sunderland City Council using a 4 point banding system, North Tyneside City Council a 5 point system and Northumberland City Council a 15 point banding system. The reason for the differing banding systems is due to individual Local Authorities determining their own systems.

A difficulty that schools are currently experiencing is around the ‘up to £6,000 contribution from the schools SEND budget’ in terms of meeting the needs of pupils with SEND including provision and resources. In order to provide an inclusive learning environment in mainstream schools they ‘have had to make huge compromises’ financially due to limited budgets (Smith, 2017). This will undoubtedly impact on the number of requests for EHC plan and High Needs Funding and ultimately alternative provision.



There is a risk that schools will be unable to meet the needs of children on SEN Support due to decreases in budgets. When this is considered alongside the NAHT Report (2017) there will be increasing pressures placed on the system going forwards that will require strategic leadership and considered provision planning.

An initial DfE (2014a) consultation of the High Needs Funding Block which relates to the funding of pupils with the most significant SEND who require an EHC plan was conducted with a view to introducing a National Funding Formula in 2017-2018. This target has since been extended to begin 2018-2019 based on the outcomes of a second consultation which closed December 2016 (no date for feedback has been provided at time of publication).

In December 2016, the government stated that their, 'proposals ensure that no Local Authority would see any reduction in funding as a result of the proposed 2018-2019 funding formula' (DfE, 2016a). This further secures financial support to meet high needs within a Local Authority during this period. This can provide some stability in terms of provision planning but may mean that LAs may find difficulty in meeting emerging increases in need while, as stated previously, schools struggle to deal with real-terms financial cuts (NAO, 2016). As part of the proposed formula 72 LAs would see an immediate increase of High Needs Funding in their 2018-2019 allocation (ibid). The DfE are currently looking at a formula which will distribute funding for High Needs in a more equitable manner based on deprivation and the evidential link between hardship and High Needs. They will be conducting research alongside LAs producing their own strategic SEND which will be used to shape funding levels going forward.

Inclusion, 'while not a simple concept' (NASEN, 1998) has been proven to be effective when considered as the provision rather than placement for pupils with SEND which will include a range of needs for the pupils discussed in this report. Some concerns are raised about the effect of SEND pupils being taught alongside mainstream peers; however, Farrell et al. (2007) conducted an in-depth systematic review placing learners in mainstream has no adverse consequences for all pupils' achievement, attitudes and behaviours which is worth further consideration. Although it is also worth considering the evidence suggesting that for some learners segregated education (specialist provision) may be the most beneficial

practice for the individual (Wang, 2009). Considering inclusive practices across the Local Authority and sharing of best practice may lead to more pupils with high SEND needs being successful in mainstream schools or prevent them from even becoming pupils with High Needs.

## 10 Literature Review: Part Two

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### A critical discussion on the prevalence of Autism

#### 10.1 What is Autism?

Bakian et al. (2015) described Autism as a neurodevelopmental disorder with a complex aetiology, which is characterised by challenges with social, communicative and behavioural functioning. The most frequent variations in symptoms presented included: levels of social interaction; patterns of verbal and non-verbal communication; repetition in behaviours; sensory processing deficits; specific and rigid interests; and, severity of needs (American Psychiatric Association, 2013). Molteni and Maggiolini (2014) recognised that children identified with ASD often experienced challenges with interaction and communication, frequently due to low levels of social competence. Children often present with behaviours that are easily attributed to the condition, often accompanied by sensory issues; this can engender stereotyping from peers and may have life-long effects. DeBooth and Reynolds (2017) agreed, describing Autism as a complex and multi-faceted neurological disorder which often impacts on those affected in a range of ways. The American Psychiatric Association (2017) highlighted that Autism often engenders repetitive behaviours in children identified with the condition, as well as restricted interests and persistence on sameness. Anagnostou et al. (2014) suggested that the varied nature in presentation of ASD, particularly varying levels of social interaction, patterns of verbal and non-verbal communication, repetitive behaviours, sensory processing difficulties, restricted interests and severity of need, are problematic for both research and clinical practice.

## 10.2 What are the known causes of Autism?

Historically, it was thought that parenting styles were responsible for Autism (Kanner, 1943). However, Wing (2007) later identified that Autism was caused by irregularities in brain development, prior to birth. DeBooth and Reynolds (2017) highlighted that there is no single cause or biomarker which has been identified related to Autism. It is believed that genetics play a role in the aetiology of Autism (Sutcliffe, 2008; Geschwind, 2008). A recent study led by the University of North Carolina found that altered distribution of cerebrospinal fluid (CSF) in high risk infants can predict whether or not they will develop ASD (Observatory, 2017). The authors explained that the fluid was once considered a shock absorber, protecting the brain from the skull.

The North Carolina study confirmed earlier research that suggested infants with increased CSF in the subarachnoid space have an increased risk of Autism. The project included 343 infants at 6, 12 and 24 months. It was also identified that 221 of the babies had older siblings with a diagnosis of ASD, suggesting that ASD may have genetic links. The conclusion was that those children who went on to later develop ASD had significantly more subarachnoid CSF at six months of age compared to those who did not develop Autism (ibid). Building on this study, Patra (2017) explored brain images of high risk infants, which revealed expansion of cortical surface to be highly associated with later diagnosis of Autism Spectrum Disorders. Children diagnosed with Autism at 24 months of age showed cortical surface overgrowth at six months and increased brain volume in MRI scans at one year of age (Hazlett et al., 2017). These MRI images can be understood as early predictors of social and communication deficits which appear much later and hence are potential biomarkers for Autism. Patra (2017) suggested identification of at risk infants before two years of age to increase the effectiveness of early interventions.

Swartz (2016) highlighted that 'genome sequencing' has already found mutations in 65 genes that increase the risk of developing Autism. He suggested that some are passed from the DNA of the mother, the father or, sometimes, from both parents to the child. Others arise spontaneously, meaning they aren't present in either parent's genetic makeup. To date, genetic causes have been pinpointed in only about 20 percent of Autism cases, usually those that are associated with certain rare diseases, such as Fragile X syndrome, Phelan-McDermid syndrome or Williams syndrome. It is still largely unknown which genes drive the development of the disorder (ibid). However, London and Etzel (2000) and Hallmayer et al. (2011) suggested that genetic factors in isolation do not fully explain the occurrence of Autism, although the evidence highlights that genetics do play a central role (Sutcliffe, 2008; Abrahams and Geschwind, 2008).

Farrell (2017) summarised that there are no definite causes of ASD currently known. The heritability of ASD are thought to range from 37-90%, based on concordance rates in twins. Farrell reported that as much as 15% of instances of ASD seem to be associated with a known genetic mutation (American Psychiatric Association, 2013, p.57). Farrell (2017) cites strong evidence that ASD has a biological basis and a major genetic component. This is supported by twin studies which examine the co-occurrence of Autism in identical and non-identical twins and other siblings. He summarised that there may be several genes which act with environmental factors leading to ASD.

ASD is more prevalent in males than females (National Autism Society, 2017). Although the gender disparity in prevalence has often been mentioned, only few studies examine differences in the clinical presentation of males and females with ASD (Kauschke et al., 2016). The Simons Foundation Autism Research Initiative SPARK (2017) has recently launched a landmark Autism research project in the United States due to the significant increase in prevalence over the last two decades. They recognised that the rise in ASD may be due to a recently broadened diagnostic criteria and an increase in awareness; though the authors believe that a better understanding is needed due to recent research indicating genes playing a role. This is a long term study which aims to advance understanding of Autism. They are aiming to collect 50,000 DNA samples and medical information to allow

scientist to analyse genetic changes and understand more about the gender prevalence of the condition.

In addition to the genetic factors previously discussed, there has been consideration of environmental risks, such as prenatal and perinatal factors, that have been associated with the development of Autism. These can include parental age, breech position, maternal pregnancy, weight gain and maternal fever during pregnancy (Croen et al., 2007; Bilder et al., 2009; Grether et al., 2009; Bilder et al., 2013 and Zerbo et al., 2013). Other environmental factors have been suggested such as chemical and pollutant exposures, heavy metals and pesticides (Windham et al., 2006, Roberts et al., 2007. Kalkbrenner et al., 2010; and Volk et al., 2013). Furthermore, links between Autism and prescription medications including valproic acid, thalidomide and selective serotonin reuptake inhibitors have also been suggested (Bromley et al., 2008, Croen et al., 2011).

There have been many research projects into environmental causes of ASD. Croen et al. (2011) examined whether prenatal exposure to antidepressants medications was associated with increased risk of ASD. They suggested that prenatal exposure to antidepressants during the first trimester may increase the risk of ASD, although they stated that their results needed to be considered with caution until there are further studies to provide a comparison. Bakian (2015) noted that the links to these environmental factors requires further exploration, as many studies examining environmental Autism risk factors have been proven to be inconclusive. Gardener et al., (2011) reviewed multiple studies investigating this phenomenon which all showed inconsistent results that were not statistically significant. These studies examined: abnormal foetal presentation, umbilical-cord complications, foetal distress, birth injury or trauma, multiple birth, maternal haemorrhage, summer birth, low birth weight, low Apgar score, feeding difficulties and neonatal anaemia. However, the authors were able to conclude that exposure to multiple neonatal complications could increase the risk of ASD.

### **10.3 What are the prevalence rates of Autism internationally, nationally and regionally?**

Baren-Cohen et al. (2009) proposed that prevalence estimates for ASD have steadily increased over the past four decades. In 1978, the accepted estimate for classic Autism prevalence was 4 in 10 000; Autism (including classic Autism) is thought to currently affect approximately 1% of the population. Karim, Cook and O'Reilly (2012) specifically noted the apparent increase in the prevalence of ASD in children. In the late 1970s it was estimated that the prevalence of ASD in children was thought to be 20 in 10 000 (Wing and Gould, 1979). More recently this is believed to have increased to one in 100 children in the UK (Baird et al., 2006; National Autism Society, 2017; and, Farrell, 2017). When specifically considering Tyne and Wear school aged children, the prevalence rate is 1.32%, based on deductions from the DfE (2016b) special educational needs in England data set. This indicates a higher than average prevalence of ASD in Tyne and Wear, compared to national figures. In the US there is a higher prevalence rate than the UK (Bakian, 2015) with 1 in 68 children being diagnosed by the age of eight (CDC, 2014). Bakian (2015) noted the sharp rise in ASD diagnoses over the past three decades in the US. This is comparable with the situation in the UK where there is a rising prevalence of ASD diagnosis, which, as previously highlighted, affects approximately 1% of children (Baird et al., 2006; Baron-Cohen et al., 2009; National Autism Society, 2017).

### **10.4 Possible causes of an apparent increase in ASD prevalence**

Farrell (2017) suggested possible reasons for an apparent increase in prevalence of ASD could include: widening of the definition; increased awareness; and, differences in research methods used in studies of ASD (American Psychiatric Association, 2013). He also acknowledged that the increase in prevalence could be due to an increase in real terms. This view is supported by National Institute of Mental Health (2012), who suggested that the increase in the prevalence of children identified with ASD may be attributed to several factors, including the growing awareness of the condition, the expanded definition of Autism, or, indeed, a true increase in incidence of Autism. Charman (2002) theorised that since Kanner's (1943) criteria for diagnosis, the diagnostic boundary of the core

presentation of Autism has broadened over the decades. Hoffman et al. (2014) presented a number of reasons for the increasing ASD prevalence, highlighting that they are multi-faceted and challenging to measure. Yet, greater Autism awareness among parents, educators, and clinicians, along with increased access to diagnostic and treatment services, is believed to be one of the most significant contributing factors (Charman, 2002; Blaxil, 2004; Fombonne, 2005; Williams et al., 2006; Newschaffer et al., 2007; Matson and Kozlowski, 2011). Murray et al. (2014) also highlighted that UK primary care has experienced an increase in prevalence of ASD between 1992 and 2008. The authors suggested that this is likely to be due to widening diagnostic criteria, alongside increased awareness and acceptance of Autism. More recently, Atladottir et al. (2015) indicated that the increasing prevalence of ASD in Denmark, Sweden, Finland and Western Australia was due to non-etiological factors, such as improved availability to services, the broadening of diagnostic criteria and increased awareness of neuropsychiatric difficulties in professional communities. With similar findings Bakel (2015) suggested an increase in prevalence in France could be due to changes in classification and diagnostic procedures, improved service availability, alongside better acceptance and increased awareness.

### **10.5 Co-morbidity in Autism Spectrum Disorders**

It is widely recognised that ASD can co-exist with co morbid disorders, including Down's Syndrome, Cerebral Palsy, Tourette's Syndrome, Turner Syndrome and individuals with Hearing and Visual Impairments (Charman, 2012). In a study by Simonoff et al. (2008), it was reported that 70% of the sampled population of 112 children aged 10 - 14 years displayed at least one co-morbid psychiatric disorder alongside ASD. Salazar (2015) further highlighted additional, recent studies which have demonstrated that psychiatric disorders commonly co-occur in children with ASD; many studies have reported high aggregated rates of co-morbidity, with some as high as 70–90 % (Leyfer et al., 2006; de Bruin et al., 2007; Simonoff et al., 2008; Mattila et al., 2010; Mukaddes and Fateh 2010).



Maskey (2013) emphasised that co-existing conditions can include a range of emotional and behavioural difficulties such as aggression, self-injury, issues with sleep, feeding, eating problems, sensory sensitivities, intellectual disabilities, as well as co-morbid health and mental health diagnosis including Epilepsies, ADHD, Anxiety, Obsessive and Tic Disorders. Further studies have reported that there are common co-occurring disorders with ASD, often identified in later childhood, including Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Anxiety Disorders, with the emergence of Depression and Obsessive Compulsive Disorder in adolescence/adult life (Mazefsky et al., 2008; Simonoff et al., 2008; Skokauskas et al., 2010; van Steensel et al., 2013).

Autism and associated co-morbid disorders often significantly impact on social outcomes, education and health of children and adults (Bolton et al., 1998). This is primarily due to the frequent early onset of Autism, its lifelong persistence and associated pervasive impairments (Simonoff et al., 2008). The annual societal cost in the UK of supporting children identified with Autism has been calculated as £2.7 billion; these costs amount to £25 billion per annum for adults identified with ASD, with estimated lifetime costs of £1.7 million for those with intellectual disabilities and £0.8 million for those without (Knapp et al., 2009).

Lane et al., (2010); Lane et al., (2011) and Lane et al., (2014) suggested that grouping children with ASD based on similar traits could lead to more focused treatment groups for practitioners to direct their efforts, and allow targeted intervention for the symptoms of greatest severity and that impact on functional performance.

## **10.6 Identification of Autism Spectrum Disorders**

Molteni and Maggiolini (2015) in their research claimed that the majority of parents (71%) noticed the indicators of Autism within the first two years of a child's life; in (72%) of the cases it was the mother who initially raised concerns. The authors added that a third of parents observed the initial differences between the third and fourth year. These findings have been echoed in international studies, which suggest concerns being noted between

twelve and twenty four months of age, particularly when the child is not the parents' first (Ozonoff et al., 2002 and Morgan et al., 2008). As Frenette et al., (2011) and DfE (2015a) acknowledge, early identification of Autism facilitates diagnosis, therefore allowing timely access to educational and therapeutic services.

Mandell (2012); Nealy et al., (2012) and Pozo et al., (2011) highlighted the challenges that families who take care of children and young people with Autism can often face. There can be high levels of stress and anxiety for families and the child due to misunderstandings from society about Autism (Autism Europe, 2001 and Brennan, 2011). Additionally, due to the natural spectrum of characteristics experienced by children identified with Autism, families can find it difficult to strike an effective balance between under and over-support for children.

### **10.7 Socio-economic factors**

It is possible to undertake geographical mapping of ASD prevalence in a given locality, to determine any socio-economic factors that may be associated with ASD prevalence. Bakian's (2015) US-based study utilised spatial analysis and mapping tools to identify localised regions of heightened risk, in being diagnosed with ASD, which he termed 'residential segregation.' These regions were then used to generate hypotheses concerning aetiology. This study highlighted that higher than expected ASD prevalence was identified in 4/5 areas in Utah. The findings of this study were consistent with California-based studies, which highlighted 'hotspots' of ASD prevalence; areas in which ASD prevalence was much higher than that expected when compared to the population concentrations in those areas (Hoffman, et al., 2014).

These studies were; therefore, able to highlight that children who are born into particular communities were three times more likely to have Autism. The authors suggested that increased Autism prevalence was linked to higher socio-economic status (SES) in the majority of hotspots, as parents in the 'hotspot' communities were of elevated socio-economic status. This link was tentatively explained by the authors; they suggested that parents of higher socio-economic status possessed the skills to push for formal diagnoses for their children, therefore explaining the higher prevalence of ASD in these areas. Fombonne (2003) and Newschaffer et al. (2007) suggested that the increase in prevalence of ASD in areas of elevated socio-economic status may reflect better identification and knowledge of Autism in these areas.

Research by Rai et al. (2012); Larsson et al. (2005) and Bilder (2009) also highlighted a heterogeneous relationship between Autism and elevated socio-economic status. However, findings have shown inconsistencies, with one study finding no association between ASD and higher maternal education. Hoffman et al., (2014) investigated differences in geographical distribution of ASD in North Carolina made an interesting observation that regions with low risk in the early years of surveillance became similar to those with high risk in later years. This suggested to the researchers that practices in remote regions caught up with those in resource-rich areas, or that clinicians and educators were becoming better trained to identify children with Autism.

## **10.8 Summary**

In summary, it is clear that there is no one single cause of Autism; however, there is significant evidence that suggests ASD has a biological basis. As Glazzard (2015) highlighted, 'Autism is explained as a product of nature rather than a product of nurture, although this does not exclude the possibility of environmental factors at the pre-natal stage' (p. 90). As Bakian (2015) summarised, there are studies examining environmental ASD risk factors, which tentatively indicate that there may be a link between ASD prevalence in communities of elevated socio-economic status. However, it is important to note that these studies have

not been consistent in their findings. Therefore, there is a need for further research into the link between socio-economic status and ASD prevalence.

As SPARK (2017) identified, the prevalence of Autism has increased significantly over the past two decades. There are indications that ASD may be more prevalent in the North East of England, than in the UK as a whole. This increase in prevalence is largely attributed to broader diagnostic criteria for ASD and an increase in overall awareness of Autism.

Researchers have highlighted that there has never been a greater need to gain a better understanding of ASD, as it affects so many children, young people and adults that early intervention to meet needs is essential (DeBoth and Reynolds, 2017 and Gardener et al., 2017).

## 11 Literature Review: Part Three

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### 11.1 Types of provision

There is clear policy guidance for local authorities provided by the DfE (2013a) regarding ensuring a good education for children who cannot attend school due to health needs. The Government's policy intention is that all children, regardless of circumstance or setting should receive a good education to enable them to shape their own futures. Therefore alternative provision and the framework surrounding it should offer good quality education on par with that of mainstream schooling, along with the support pupils need to overcome barriers to attainment. This support should meet a pupil's individual needs, including social and emotional needs, and enable them to thrive and prosper in the education system (p.3).

Ko (2015) concluded that special educational provision is defined according to the age of the young person:

- For children aged two or more: Educational or training provision that is additional to or different from that is generally available in mainstream settings.
- For a child under 2 years of age: Special educational provision means educational provision of any kind.

The percentage of pupils with a statement or EHC plan attending maintained special schools has gradually increased each year DfE (2016b). In 2010, 38.2% of pupils with statements attended maintained special schools and this has increased to 42.9% of pupils with statements or EHC plans in 2016. The percentage of pupils with statements or EHC plans attending independent schools has also increased between 2010 and 2016, from 4.2% to 5.7%.

## 11.2 Alternative Provision (AP)

The definition of Alternative Provision was provided by the DfE in (2013b) as 'education arranged by local authorities for pupils who, because of exclusion, illness or other reasons, would not otherwise receive suitable education; education arranged by schools for pupils on a fixed period exclusion; and pupils being directed by schools to off-site provision to improve their behaviour.' More recently alternative provision is commonly defined as education outside school, arranged by local authorities or schools themselves (Ofsted, 2016b). They have highlighted that 'alternative provision remains a largely uninspected and unregulated sector'. The most recent School Inspection Handbook (Ofsted, 2016c) suggested that inspectors should make every effort to telephone or meet staff in the institutions where pupils are taught off-site to help assess the school's quality assurance arrangements. Inspectors are required to evaluate the rigour with which the school monitors the attendance, behaviour, learning and progress of the pupils who attend them. Ofsted added that units dealing with pupils' behaviour may exist away from the school site, but be run by the school. Sometimes, this provision may be shared by one or more schools. It is important to find out how this is monitored and evaluated, both day to day and over time. An inspector should visit the unit briefly to assess safeguarding procedures, the quality of teaching and how effectively the unit helps to improve pupils' behaviour, learning and attendance. The visit should be proportionate to the number of pupils who attend and the length of time they spend there. This can be full-time provision for a number of pupils over several weeks, so it is important to evaluate it thoroughly (ibid).

Beyond pupil referral units and other full-time provision, there is no requirement for the majority of alternative providers to register with any official body and no formal arrangements to evaluate their quality (Ofsted, 2016b). Historically, Ofsted (2011) was critical of the format and quality of the information that schools gave to providers about the pupils' needs. A quarter of the schools in that survey gave only oral information to the providers. Even where the information was written, too many providers did not receive any information about the pupils' literacy and numeracy skills, health needs or special educational needs, or specific behavioural difficulties.

### **11.3 What are Pupil Referral Units (PRUs)?**

The 1996 Education Act gave local authorities (LAs) the duty to provide suitable education for excluded children (DfEE, 1996, section 19). PRUs are Local Authority establishments which provide education for children unable to attend a mainstream school including children who are excluded (Bruder and Spensley, 2015). Harrison (2008) suggested that the most common alternative provision in the UK is the PRU. It is intended that a PRU provides alternative education provision for a short time to prepare children for a successful re-integration into mainstream education (Pirrie and Macleod, 2009). Pirrie et al. (2011) highlights that amongst the research and policy related literature in the previous decade there is widespread consensus that young people who have been permanently excluded from school are at a far greater risk of a range of negative outcomes than young people who have not had this experience. They added that these negative outcomes include prolonged periods out of education and/or employment; poor mental and physical health; involvement in crime; and homelessness. Lawrence (2011) argued that understanding the factors that support successful re-integration of young people from PRUs to mainstream education can contribute to increasing positive outcomes for this vulnerable group.

The Department for Children, Schools, and Families strategy *Back on Track* (2008) reported that just under half of the pupils in PRUs were there because they had been excluded and over half of children go to their first Alternative Provision placement via a PRU.

### **11.4 Who are PRUs for?**

Swann (2013) agreed that PRUs cater for a diverse range of children and young people. This includes predominantly those who are excluded from school on a fixed term or permanent basis but also those who are unable to attend school for medical reasons, pregnant teenagers, those who are school phobic, school refusers and those awaiting a school place. Roffey (2016) shares that most pupils have access to social and emotional resources that facilitate their learning and development but adds that significant numbers of children in the UK do not. She adds that this can be due to them living with chronic adversity or

experiencing acute stress due to family breakdown and trauma. As theorised by (Bradley and Crowyn, 2002; Farah et al., 2006 and Mani et al., 2013) we know that highly stressful experiences and/or negative life situations will be detrimental on self-worth, concentration, attendance, behaviour and mental health. In light of this Roffey (2016) stresses that schools are working with children whose life experiences make learning and compliance difficult. Therefore, it is imperative that schools focus on building relationships through a whole school focus on wellbeing and care.

### **11.5 What are fixed and permanent exclusions?**

Permanent exclusions refer to a pupil who is excluded and who will not come back to that school (unless the exclusion is overturned) (DfE, 2016g). As DfE (2012b) explained a decision to exclude a pupil permanently should only be taken: in response to a serious breach, or persistent breaches, of the school's behaviour policy; and where allowing the pupil to remain in school would seriously harm the education or welfare of the pupil or others in the school. As the DfE (2013a) guidance clarifies 'LAs are responsible for arranging suitable full-time education for permanently excluded pupils, and for other children who, because of illness or other reasons – would not receive suitable education without such provision.'

Fixed Term exclusions refer to pupils who are excluded from a school for a set period of time. This can involve a part of the school day and it does not have to be for a continuous period. A pupil may be excluded for one or more fixed periods up to a maximum of 45 school days in a single academic year. This total includes exclusions from previous schools covered by the exclusion legislation (DfE, 2016g).

### **11.6 How many children and young people are excluded from school and why?**

In their annual report 2015/16 Ofsted (2016a) stated that a small number of young children (under the age of 4) are permanently excluded from schools for serious misbehaviour, totalling 30 children in 2015. They reported that the number of younger children who were



given fixed period exclusions each year has been increasing steadily. While proportions of children remain very small (less than 1%) this is an increase of over 1,000 exclusions a year compared with five years ago.

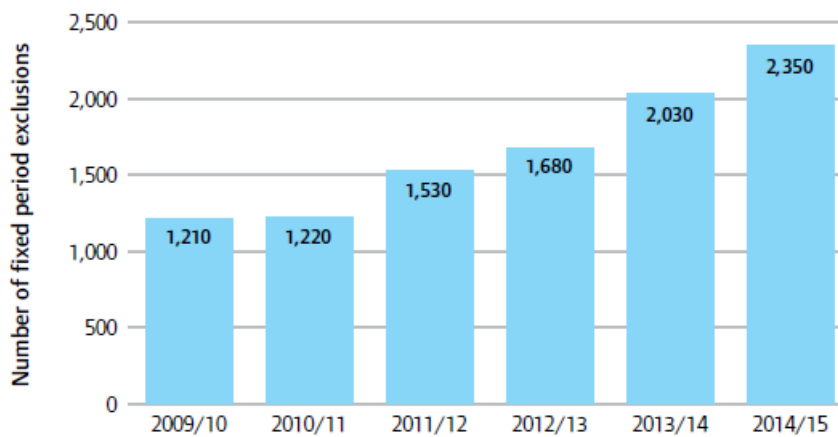


Figure 9: Fixed period exclusions for children aged four and under (2009/10 to 2014/15).

The number of permanent exclusions across all state funded primary, secondary and special schools has increased from 4,950 in 2013/14 to 5,800 in 2014/15 (DfE, 2016g). This corresponds to an average of around 31 permanent exclusions per day in 2014/15, up from an average of 26 per day in 2013/14. Re-integration to mainstream school was concluded to be successful where the receiving school was highly inclusive, the LA gave high levels of support to the school and the young person wanted to make a success of their re-integration (Lawrence, 2011).

The DfE (2016g) reported that pupils identified with Special Educational Needs (SEN) accounted for just over half of all permanent exclusions and fixed period exclusions. Persistent disruptive behaviour is still the most common reason for both permanent and fixed period exclusions in state funded primary secondary schools and special schools. It accounts for just under a third of all permanent exclusions and just over a quarter of all fixed period exclusions (DfE, 2016g).

The DfE (2016h) data stated that Sunderland City Council was ranked first out of all LAs in the North East for the highest number of permanent exclusions in primary schools (10 children). In terms of fixed period exclusions, Sunderland has the second highest in the

region at 200 primary aged children in 2014/15. In secondary schools it is evident that Sunderland are performing well in comparison to other Local Authorities in the region in terms of the number of permanent and fixed period exclusions. In state-funded Secondary schools, Sunderland is seventh at 21 permanent exclusions and eleventh at 578 fixed period exclusions in 2014/15.

Table 6

*Permanent and fixed period exclusions in North East LAs by type of school (2014/15).*

Area	State-funded primary schools				State-funded secondary schools				Special schools			
	Permanent		Fixed period		Permanent		Fixed period		Permanent		Fixed period	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>ENGLAND</b>	<b>920</b>	<b>0.02</b>	<b>49,650</b>	<b>1.10</b>	<b>4,790</b>	<b>0.15</b>	<b>239,240</b>	<b>7.51</b>	<b>90</b>	<b>0.09</b>	<b>14,080</b>	<b>13.54</b>
<b>NORTH EAST</b>	<b>30</b>	<b>0.01</b>	<b>1,470</b>	<b>0.68</b>	<b>270</b>	<b>0.18</b>	<b>12,230</b>	<b>7.84</b>	<b>10</b>	<b>0.12</b>	<b>660</b>	<b>9.78</b>
Darlington	-	-	72	0.78	-	-	703	12.14	-	-	69	25.65
Durham	6	0.01	547	1.32	73	0.26	2,058	7.44	-	-	234	18.50
Gateshead	x	x	62	0.39	54	0.46	580	4.91	-	-	25	5.08
Hartlepool	-	-	20	0.21	x	x	348	6.34	-	-	7	3.63
Middlesbrough	x	x	79	0.53	33	0.43	3,227	42.36	x	x	123	25.73
Newcastle upon Tyne	x	0.00	117	0.55	5	0.03	1,070	6.86	x	x	51	7.16
North Tyneside	-	-	45	0.27	13	0.10	499	3.81	-	-	7	1.02
Northumberland	x	x	144	0.75	37	0.14	1,350	5.14	x	x	59	8.77
Redcar and Cleveland	-	-	73	0.56	-	-	890	10.77	-	-	0	0.00
South Tyneside	x	x	23	0.19	19	0.23	242	2.94	-	-	17	3.81
Stockton-on-Tees	-	-	91	0.48	15	0.14	681	6.55	-	-	19	3.52
Sunderland	10	0.04	200	0.84	21	0.13	578	3.69	-	-	51	7.61

*Note.* National and regional totals and totals across each local authority have been rounded to the nearest 10. *Source: School Census*  
There may be discrepancies between totals and the sum of constituent parts. 'x' denotes less than 5, or a percentage based on less than 5. '-' denotes zero values. (DfE, 2016j).

The national data for special school permanent exclusions shows there were no permanent exclusions across the North East for children in a specialist school. However, there were a number of fixed period exclusions with Sunderland ranking fifth overall with 51 fixed period exclusions.

Table 7

*Permanent and fixed period exclusions in North East LAs by type of school (2013/14).*

Area	State-funded primary schools				State-funded secondary schools				Special schools			
	Permanent		Fixed period		Permanent		Fixed period		Permanent		Fixed period	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>ENGLAND</b>	<b>870</b>	<b>0.02</b>	<b>45,010</b>	<b>1.02</b>	<b>4,000</b>	<b>0.13</b>	<b>210,580</b>	<b>6.62</b>	<b>70</b>	<b>0.07</b>	<b>13,890</b>	<b>13.86</b>
<b>NORTH EAST</b>	<b>30</b>	<b>0.01</b>	<b>1,390</b>	<b>0.66</b>	<b>200</b>	<b>0.13</b>	<b>9,610</b>	<b>6.11</b>	<b>10</b>	<b>0.08</b>	<b>800</b>	<b>12.44</b>
Darlington	-	-	72	0.78	-	-	428	7.41	-	-	73	28.63
Durham	12	0.03	606	1.48	70	0.25	1,714	6.13	-	-	207	16.82
Gateshead	x	x	67	0.43	18	0.15	503	4.22	-	-	16	3.43
Hartlepool	-	-	13	0.14	x	x	321	5.78	-	-	x	x
Middlesbrough	x	x	87	0.60	23	0.30	1,819	23.50	x	x	169	36.74
Newcastle upon Tyne	x	x	62	0.30	x	x	1,001	6.54	x	x	33	5.08
North Tyneside	-	-	40	0.25	11	0.08	501	3.77	-	-	19	2.88
Northumberland	9	0.05	132	0.70	29	0.11	1,196	4.46	x	x	108	17.06
Redcar and Cleveland	-	-	61	0.48	-	-	602	7.18	-	-	x	x
South Tyneside	-	-	5	0.04	12	0.15	212	2.57	-	-	35	8.64
Stockton-on-Tees	-	-	70	0.37	19	0.18	676	6.52	-	-	23	4.34
Sunderland	6	0.03	178	0.76	14	0.09	637	4.02	-	-	112	17.81

Note. National and regional totals and totals across each local authority have been rounded to the nearest 10.

Source: School Census

There may be discrepancies between totals and the sum of constituent parts. 'x' denotes less than 5, or a percentage based on less than 5. '-' denotes zero values. (DfE, 2015c; 2015d).

### 11.7 What are the outcomes for children in PRUs?

Research studies by Sameroff, et al. (1993) and Hall-Lande et al. (2007) indicated links between exclusion and social isolation, youth offending, drug and alcohol misuse, crime, susceptibility to mental health problems and reduced cognitive functioning. Hayden (1998) added that those excluded are argued to be the most vulnerable young people in society therefore it is essential that organisations support effective re-integration of these pupils to mainstream education.

Table 8

*Number of children and young adults attending PRUs and Alternative Provision academies (2013 – 2016) in the North East.*

Local Authority	Year			
	2013	2014	2015	2016
	N	N	N	N
<b>NORTH EAST</b>	<b>544</b>	<b>565</b>	<b>618</b>	<b>803</b>
Darlington	4	8	9	9
Durham	105	97	88	98
Gateshead	77	56	41	88
Hartlepool	6	x	4	7
Middlesbrough	64	54	63	84
Newcastle upon Tyne	156	199	225	280
North Tyneside	9	45	46	73
Northumberland	7	x	12	9
Redcar and Cleveland	17	8	16	19
South Tyneside	17	16	8	19
Stockton-on-Tees	28	32	39	42
Sunderland	54	50	67	75

*Note.* National and regional totals have been rounded to the nearest 5. 'x' denotes less than 5, or a percentage based on less than 5. There may be discrepancies between the sum of constituents and the totals as shown (DfE, 2013c; 2014b; 2015d; 2016k).

*Source School Census*

From Table 8 (above) and Figure 10 (overleaf) it can be seen that the number of children and young adults in pupil referral units is at its highest in 2016. The data set for this does not include children who are dual placed and so these children do not appear on these representations.

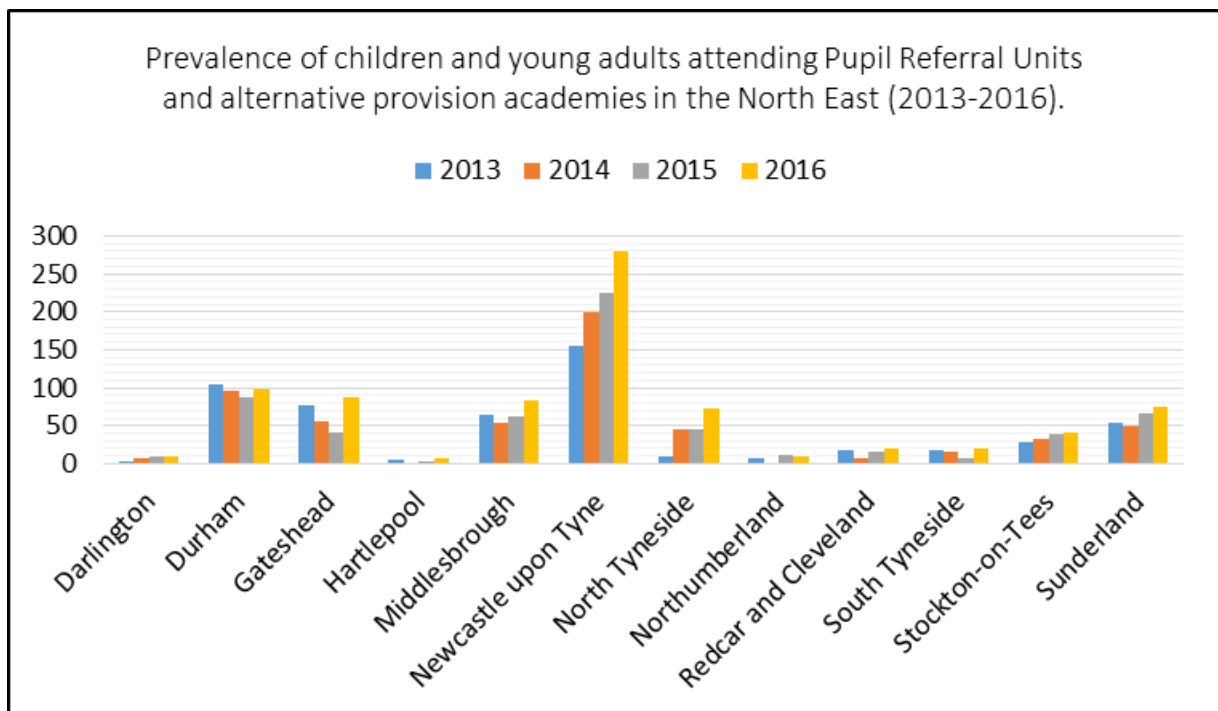


Figure 10: Prevalence of children and young adults attending PRUs and alternative provision academies in the North East (2013-2016).

The DfE (2012b) reported that in some areas PRU provision is of poor quality. Once placed there, children rarely return to mainstream school, the curriculum is narrow, the teaching poor and pupils do not achieve academic success. Rather than improving behaviour, the atmosphere of the worst PRUs feeds their pupils' behavioural difficulties. Some of the most vulnerable children, with a range of differing needs, end up in bleak one-size-fits-all provision. The DfE added that the most effective PRUs have strong, authoritative leaders who are respected partners of their mainstream colleagues. These PRUs are seen as a local resource, where the expertise of staff is used to help mainstream schools to improve their practice.

Lawrence (2011) carried out research examining the process of re-integration of secondary aged pupils from a PRU to mainstream education. The concern was raised that some have successful re-integration and others do not. The research outcomes of a one year pilot by Bruder and Spensley (2015) demonstrated that providing a clinical psychologist to a PRU for one day a week supported the mental health of the young people. Those who participated

in the study reported that they had an experience of being listened to, were taken seriously and felt able to express themselves to somebody. In addition, teaching staff reported that they felt better equipped to understand the complexities around their pupils' presentation of needs and, if necessary, felt supported in adjusting the way that they managed and supported some pupils.

### **11.8 Implications of findings for the place of Pupil Referral Units**

The findings of this research should be utilised by the LA to develop a guidance document for schools and PRU staff regarding the factors contributing to successful re-integration or "a good practice guide", which can be considered to be "evidence based". In addition, the resulting research report could facilitate a discussion between the PRU and mainstream schools regarding the wider issue of working relationships, communication systems and perceptions of role and function. More generally, the results could also be used to demonstrate the importance of an inclusive ethos and approach in mainstream schools. There are also numerous implications for the educational psychologist and educational psychology practice.

### **11.9 Children missing or out of education**

The DfE (2013b) guidance for Local Authorities clarified that:

'The law does not define full-time education but children with health needs should have provision which is equivalent to the education they would receive in school. If they receive one-to-one tuition, for example, the hours of face-to-face provision could be fewer as the provision is more concentrated' (p.6).

Furthermore, 'Where full-time education would not be in the best interests of a particular child because of reasons relating to their physical or mental health, LAs should provide part-time education on a basis they consider to be in the child's best interests. Full and part-time education should still aim to achieve good academic attainment particularly in English, Maths and Science (ibid)'.

Ofsted (2016b) have proposed that when children go missing from education or have poor attendance, this can be an indicator that they are at risk of abuse or neglect. This is why it is so important for schools to keep accurate attendance records and take action when children go missing.

Wilshaw claimed that 'many thousands of children and young people in England do not attend full-time education' (Ofsted, 2013) which undoubtedly impacts on their outcomes and causes significant safeguarding concerns. They even go as far to say that 'too often, children and young people who receive only a part-time education, or who have none at all, can become invisible to the Local Authority' (ibid). This report 'pupils missing out on education' highlighted the key role of LAs in monitoring pupils who receive less than full time education and secure provision for those pupils who have been removed from roll through permanent exclusion for example. Ofsted, as of August 2016, now are required to 'evaluate the rigour with which the school [they are inspecting] monitors the attendance, behaviour, learning and outcomes of the pupils' who attend partnership or off-site arrangements which strengthens the accountability for pupils who may be at risk from missing out on education (Ofsted, 2016c).

## **12 Data presentation, analysis and recommendations**

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This chapter presents the key themes to have emerged from analysis of the data gathered. The data are presented alongside the findings for ease of navigation and comparison. Details on the data analysis process are given in the methodology chapter of this report. Recommendations are presented in this chapter, according to the ten themes identified by the stakeholder. The data analysis has enabled the research team to formulate 35 recommendations. While the large number of recommendations are necessary it must be acknowledged these have been produced to support a five year plan.

### **12.1 Theme 1: Analysis of the prevalence trends based on identified primary need: children and young people 5-16 years in Sunderland (2013-2017).**

Theme 1 explores the prevalence of identified primary needs in Sunderland across 2013-2017. Data are presented in Table 9 and Figure 11 (overleaf) highlight that Moderate Learning Difficulties, Social Emotional Mental Health, Speech Language and Communication, Autism Spectrum Disorders and Specific Learning Difficulties are the most prevalent primary needs in Sunderland.



Table 9

Prevalence of identified Primary Needs in Sunderland: children and young people 5-16 years (2013-2017).

Primary Need	Year									
	2013		2014		2015		2016		2017	
	N	%	N	%	N	%	N	%	N	%
SpLD	482	1.51	420	1.30	423	1.30	460	1.40	424	1.28
MLD	2454	7.68	2179	6.74	1665	5.11	1498	4.56	1445	4.37
SLD	113	0.35	103	0.32	89	0.27	79	0.24	78	0.24
PMLD	8	0.03	7	0.02	8	0.02	7	0.02	4	0.01
SEMH	1337	4.18	1337	4.14	1217	3.74	1124	3.42	1228	3.71
SLCN	1064	3.33	1161	3.59	1009	3.10	1014	3.09	1037	3.13
HI	84	0.26	88	0.27	91	0.28	94	0.29	103	0.31
VI	40	0.13	42	0.13	42	0.13	42	0.13	44	0.13
MSI	5	0.02	4	0.01	6	0.02	4	0.01	4	0.01
PD	170	0.53	182	0.56	184	0.57	172	0.52	192	0.58
ASD	378	1.18	413	1.28	497	1.53	572	1.74	653	1.97
OTH	221	0.69	205	0.63	152	0.47	147	0.45	136	0.41
NSA	-	-	-	-	19	0.06	38	0.12	36	0.11
Not SEND Identified	25602	80.11	26190	81.01	27156	83.41	27594	84.01	27718	83.74
Total	31958	100.00	32331	100.00	32558	100.00	32845	100.00	33102	100.00

Note. Data includes state-funded primary schools, secondary schools, special schools and Pupil Referral Units. '-' denotes zero values. Boxed values highlight figures of interest.

Source: PLASC

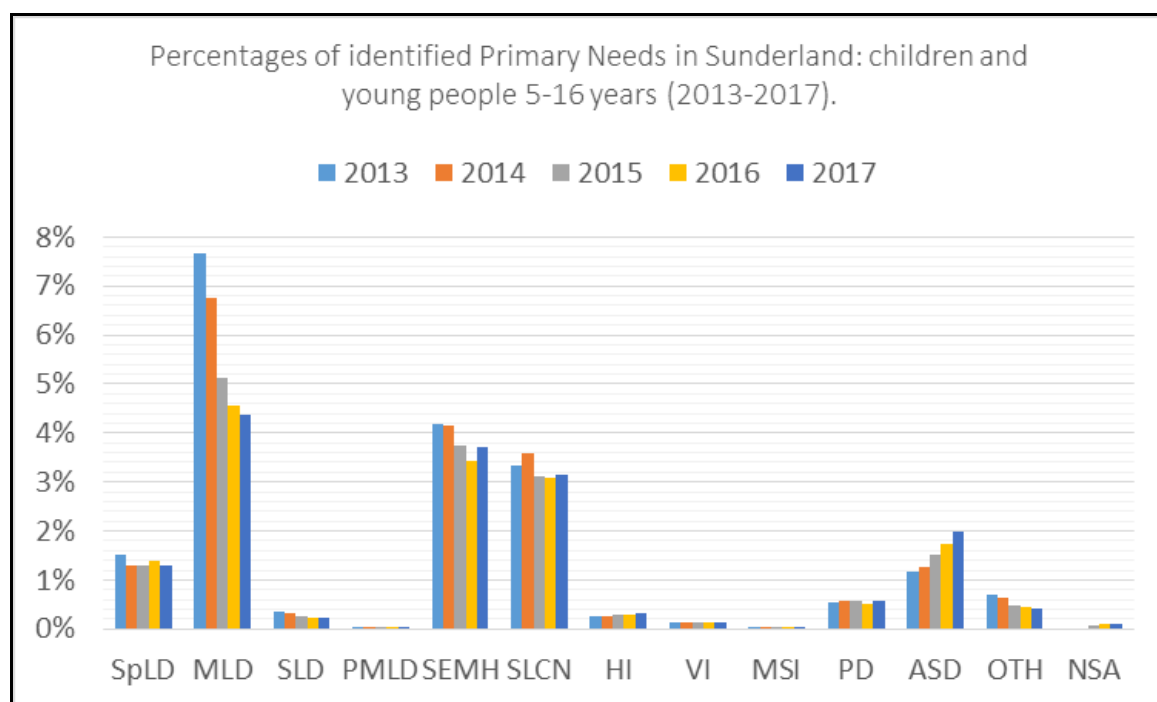


Figure 11: Percentages of identified Primary Needs in Sunderland: children and young people 5-16 years (2013-2017).

- **Moderate Learning Difficulties:** There has been a notable decrease in the prevalence of MLD across Sunderland, falling from 7.68% in 2013 to 4.37% in 2017, as a percentage of all children educated in Sunderland. However, MLD remains the most prevalent SEND in Sunderland. The notable decrease in the prevalence of MLD between 2013 and 2017 suggests that this primary need will continue to decrease in prevalence. This decrease may be explained by what Norwich et al. (2013) explained as the misunderstood nature of MLD as a primary need, in terms of what constitutes effective diagnosis of this need and the definition of the need itself. This phenomenon is also confirmed by the lead researcher's professional experiences of working with SENCos. Many have identified that their understanding of MLD, both definition and characteristics, is very limited. Additionally, there is a significant lack of current specific guidance on what constitutes an effective definition of MLD in the SEND Code of Practice (Norwich and Kelly, 2005; Farrell, 2017).

**Recommendation 1:** For the Council to examine with SENCos their knowledge and understanding of Moderate Learning Difficulties and to use this information to plan CPD to support educational contexts in accurate assessment and identification to meet the needs of children and young people with MLD.

**Recommendation 2:** For the Council to carry out a random audit of children and young people identified with MLD to understand the range of needs within the sample and to assess the accuracy of the identification.

The vision for the Sunderland Clinical Commissioning Group is 'We want to improve the mental health and emotional wellbeing of all children, young people living in Sunderland and to narrow the gap in outcomes between those who do well and those who do not.'

- **Social Emotional Mental Health:** SEMH is the second most prevalent primary need of children identified with SEND in Sunderland. As was explored in the literature review, the 2014 Children and Families Act introduced the category SEMH, which was not intended as a direct replacement for the previous category BESD, however, for the purposes of this research SEMH was deemed the most appropriate category for direct comparison. Between 2013 and 2014, when BESD was in place, the numbers of children identified with this need was similar. After the introduction of SEMH as a broad area of need there was an initial decrease in numbers of children identified with this need. This has been followed, in recent years, by fluctuations in rates of identification. There are currently 1228 children and young people identified with SEMH in Sunderland, which is an increase since 2016 and are indicative of effective implementation of the SEND reforms. It is likely that the numbers of children identified with SEMH will rise over the coming years, in light of trends identified in the Chief Medical Officer's report (DoH,2013), which highlighted that one in ten children of ages 5 to 15 are likely to experience a clinically diagnosable medical disorder.

**Recommendation 3:** Due to increase in prevalence of SEMH between 2016 and 2017, it is recommended that the Council support a focus on early identification of SEMH and ensure that all educational settings in Sunderland are equipped to support children and young people with this primary need. This can be achieved by providing high quality, accredited CPD to relevant stakeholders, both in schools and within core services.

- **Speech Language Communication Needs:** The rates of identification for SLCN have remained fairly constant over the last 5 years. SLCN remains the third most prevalent primary need of children identified with SEND in Sunderland. Support for children identified with SLCN is particularly important; given both the high numbers of children identified with SLCN as a primary need and the strong prevalence of SLCN within other primary needs, as was identified in the Code of Practice (DfE, 2015a). Consequently, it is likely that the prevalence of children displaying SLCN

characteristics in Sunderland is far greater than that represented by primary need data. Recommendations for this primary need are presented within Theme 2.

- **Autism Spectrum Disorder:** ASD is the third most diagnosed primary need of children identified with SEND in Sunderland. The rates of ASD diagnosis have steadily increased between 2013 and 2017. It is important to note that an anomaly has been identified between numbers of children identified with ASD from the PLASC data and those recorded on the postcode data shared by the Autism Outreach Team to Sunderland Council.

**Recommendation 4:** As there has been an increase in the number of children diagnosed with Autism, it is advised that the Council reviews all recording and tracking procedures for these children to ensure their needs are optimally met. The local offer should include service provision, quality information, guidance and signposting to support children and families.

- **Specific Learning Difficulty:** Based on estimations made by the Driver Youth Trust, Sunderland presents with a significant under-identification of SpLD (2015). Estimates suggest that approximately 13% of children and young people in Britain experience SpLD (Driver Youth Trust, 2015). In 2017, 424 children and young people in Sunderland were identified with SpLD; this represents 1.28% of the population. This figure is significantly lower than the national estimates, which suggests that there is an under-identification of SpLD in Sunderland.

**Recommendation 5:** For the Council to work closely with nursery/school leaders and SENCos to ensure that all children with SpLD have their needs assessed and identified by an Educational Psychologist or other trained professional.

**Recommendation 6:** For the Council to respond to the under identification of SpLD by evaluating the effectiveness or impact of arrangements for identifying and assessing the needs of specific groups of children and young people with SpLD across provision in Sunderland. This will require the Council to provide school based training on neurodiversity.

## 12.2 Theme 2: Analysis of the prevalence of identified primary need: children and young people 5-16 years based on school year and key stage in Sunderland (2017).

Theme 2 explores the prevalence of identified primary need in more detail, by examining the data across the following age phases:

- Primary Phase (Year 1 to Year 6)
- Secondary Phase (Year 7 to Year 11)
- All phases combined, primary and secondary
- By Key Stage (KS1,KS2,KS3 and KS4)

The analysis identifies the most prevalent primary needs based on year groups.

### Primary Phase

Table 10

*Prevalence of identified Primary Needs in Sunderland: children and young people 5-11 years based on school year (2017).*

Primary Need	School Year											
	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6	
	N	%	N	%	N	%	N	%	N	%	N	%
SpLD	11	0.34	14	0.44	21	0.67	32	0.98	40	1.25	46	1.49
MLD	86	2.68	124	3.91	121	3.88	158	4.82	171	5.33	171	5.55
SLD	3	0.09	2	0.06	4	0.13	7	0.21	5	0.16	18	0.58
PMLD	-	-	1	0.03	1	0.03	1	0.03	1	0.03	-	-
SEMH	75	2.34	86	2.71	69	2.21	90	2.74	129	4.02	125	4.06
SLCN	197	6.14	174	5.49	134	4.30	150	4.57	105	3.27	75	2.43
HI	8	0.25	2	0.06	9	0.29	7	0.21	7	0.22	14	0.45
VI	4	0.12	4	0.13	3	0.10	3	0.09	2	0.06	5	0.16
MSI	1	0.03	-	-	1	0.03	-	-	-	-	2	0.06
PD	24	0.75	20	0.63	21	0.67	25	0.76	24	0.75	19	0.62
ASD	53	1.65	72	2.27	75	2.41	65	1.98	63	1.96	60	1.95
OTH	11	0.34	26	0.82	18	0.58	12	0.37	15	0.47	14	0.45
NSA	6	0.19	6	0.19	3	0.10	5	0.15	3	0.09	2	0.06
Not SEND Identified	2730	85.07	2640	83.25	2638	84.61	2725	83.08	2642	82.38	2531	82.12
Total	3209	100.00	3171	100.00	3118	100.00	3280	100.00	3207	100.00	3082	100.00

Note. Data includes state-funded primary schools, special schools and pupil referral units. '-' denotes zero values. Boxed values highlight figures of interest.

Source: PLASC

## Secondary Phase

Table 11

*Prevalence of identified Primary Needs in Sunderland: children and young people 11-16 years based on school year (2017).*

Primary Need	School Year									
	Year 7		Year 8		Year 9		Year 10		Year 11	
	N	%	N	%	N	%	N	%	N	%
SpLD	35	1.21	56	1.96	52	1.84	50	1.90	67	2.38
MLD	152	5.24	125	4.38	136	4.81	92	3.49	109	3.87
SLD	10	0.34	6	0.21	10	0.35	6	0.23	7	0.25
SEMH	105	3.62	117	4.10	141	4.99	121	4.59	170	6.03
SLCN	49	1.69	47	1.65	33	1.17	39	1.48	34	1.21
HI	8	0.28	8	0.28	17	0.60	13	0.49	10	0.35
VI	4	0.14	5	0.18	2	0.07	3	0.11	9	0.32
PD	13	0.45	12	0.42	10	0.35	14	0.53	10	0.35
ASD	63	2.17	54	1.89	55	1.95	46	1.74	47	1.67
OTH	15	0.52	10	0.35	3	0.11	5	0.19	7	0.25
NSA	-	-	6	0.21	1	0.04	2	0.08	2	0.07
Not SEND Identified	2445	84.34	2407	84.37	2366	83.72	2246	85.17	2348	83.26
Total	2899	100.00	2853	100.00	2826	100.00	2637	100.00	2820	100.00

*Note.* Data includes state-funded secondary schools, special schools and pupil referral units. '-' denotes zero values. Boxed values highlight figures of interest.

*Source: PLASC*

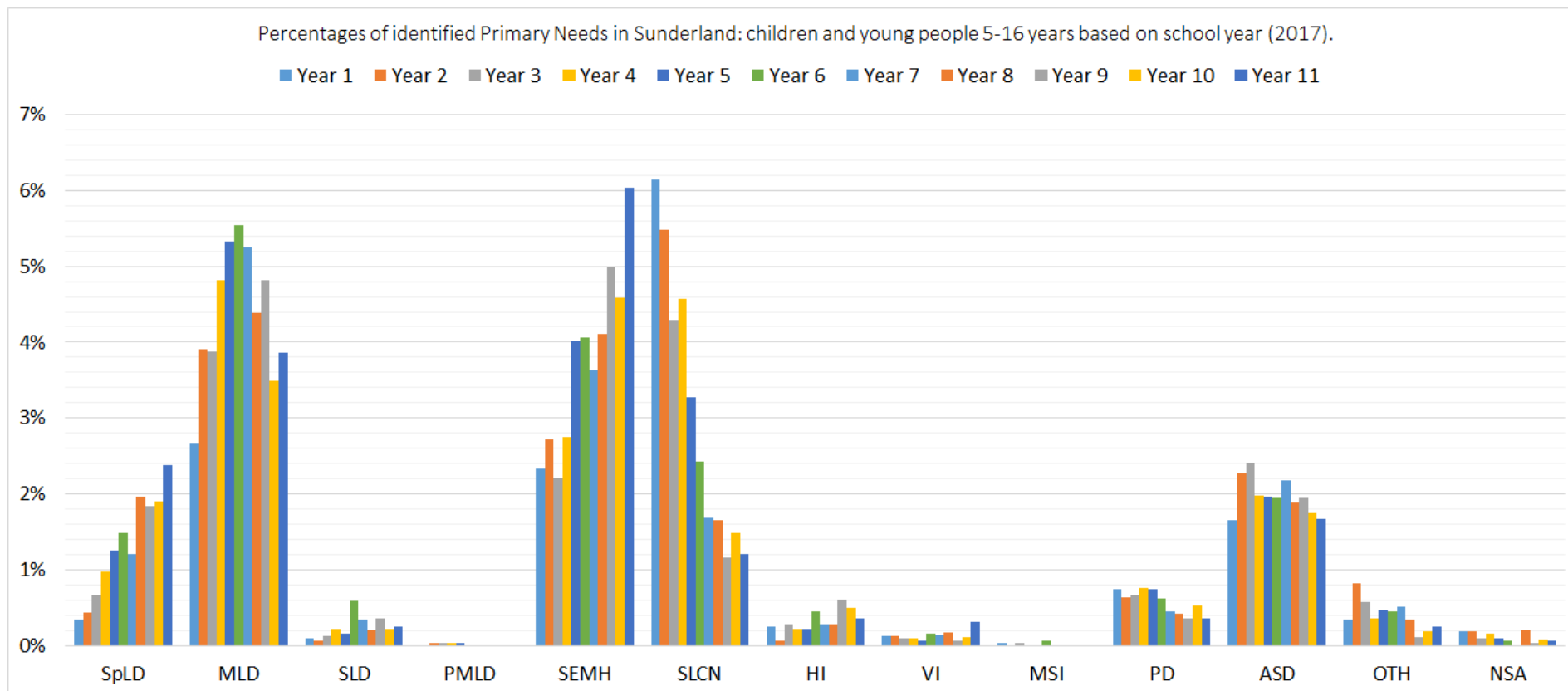


Figure 12: Percentages of identified Primary Needs in Sunderland: children and young people 5-16 years based on school year (2017).



## By Key Stage

Table 12

*Prevalence of identified Primary Needs in Sunderland: children and young people 5-16 years based on Key Stage (2017).*

Primary Need	Key Stage							
	KS1		KS2		KS3		KS4	
	N	%	N	%	N	%	N	%
SpLD	25	0.39	139	1.10	143	1.67	117	2.14
MLD	210	3.29	621	4.89	413	4.81	201	3.68
SLD	5	0.08	34	0.27	26	0.30	13	0.24
PMLD	1	0.02	3	0.02	-	-	-	-
SEMH	161	2.52	413	3.26	363	4.23	291	5.33
SLCN	371	5.82	464	3.66	129	1.50	73	1.34
HI	10	0.16	37	0.29	33	0.38	23	0.42
VI	8	0.13	13	0.10	11	0.13	12	0.22
MSI	1	0.02	3	0.02	-	-	-	-
PD	44	0.69	89	0.70	35	0.41	24	0.44
ASD	125	1.96	263	2.07	172	2.01	93	1.70
OTH	37	0.58	59	0.47	28	0.33	12	0.22
NSA	12	0.19	13	0.10	7	0.08	4	0.07
Not SEND Identified	5370	84.17	10536	83.05	7218	84.15	4594	84.19
Total	6380	100.00	12687	100.00	8578	100.00	5457	100.00

Note. Data includes state-funded primary schools, secondary schools, special schools and pupil referral units. Boxed values highlight figures of interest.

Source: PLASC

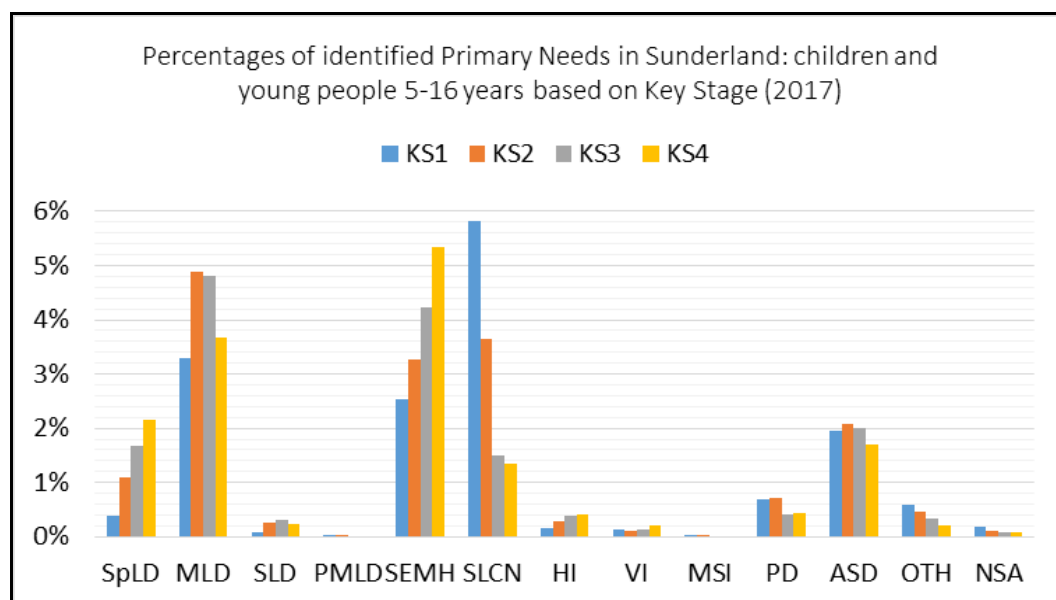


Figure 13: Percentages of identified Primary Needs in Sunderland: Children and Young People 5-16 years based on Key Stage (2017).

- **Social, Emotional and Mental Health (SEMH):** The PLASC data indicates that the numbers of children identified with SEMH in Sunderland steadily increases, ending as the most prevalent primary need by Year 11. There is a notable rise in children identified with SEMH from Year 5 to Year 6, in Year 9 and in Year 11. These are the points in the education system at which standardised and summative testing occurs. It is also possible that the peaks seen across Key Stages 3 and 4 could be explained by a range of social pressures, including puberty and digital technology. The steady increase in prevalence of SEMH as children get older highlights the importance of early intervention in supporting children and young people with this primary need by qualified and well trained staff and pastoral teams. This requires effective multi-agency working to implement.

Prevalence note: In the current academic year, the highest rates of SEMH prevalence, as a percentage of all children and young people in Sunderland are in: Year 5 (4.02%), Year 6 (4.06%), Year 8 (4.10%), Year 9 (4.99%), Year 10 (4.59) and Year 11 (6.03%).

**Recommendation 7:** For the Council to review existing models for effective multi-agency working and explore means by which greater collaboration between clinical teams, educational psychologists, SENCos and CAMHS can work together to support early intervention in educational contexts, by identifying geographical and age related hotspots (DfE, 2015a; Eames and Shippen, 2017).

**Recommendation 8:** Due to the high rate of SEMH prevalence in Year 11 at 6.03% of all children in Sunderland, the Council should analyse the number of children in education, employment and training 16-18 years to identify the level of need and inform provision planning based on findings.

- **Moderate Learning Difficulties:** In the primary age phase, there is a notable increase from 2.68% of all children in Year 1 to 5.55% in Year 6 of MLD identification. As explained in Theme 1 data analysis, this could be due to a lack of understanding of the definition of MLD prior to identification. MLD peaks between the Key Stage Two and Key Stage Three transition, we recommend that the Council explore this via further research. Suggested triggers for this peak in identification could include, curriculum changes and increased demands or standardised testing. There is a general trend of reduction in identification of MLD between Key Stage 3 and 4. This supports the findings of Ofsted (2016a), who reported that the numbers of children identified with SEND has fallen by 3.5% since 2014.

Prevalence note: In the current academic year, the highest rates of MLD prevalence, as a percentage of all children and young people in Sunderland, are in: Year 4 (4.82%), Year 5 (5.33%), Year 6 (5.55%), and Year 7 (5.24%).

- **Speech Language Communication Needs:** The number of children identified with SLCN in Sunderland peaks in year 1 at 6.14%. There is a dramatic reduction in rate of identification between Year 1 and Year 6, by Year 7 only 1.69% of all children in Sunderland are identified with SLCN. The reduction in SLCN rate presents the most dramatic change in identification rate across all primary needs and ages in Sunderland. This indicates that the early years and early primary age phases are effectively supporting children in developing age-appropriate speech, language and communication skills. This is meeting the needs of children identified with this primary need early on in their education, thus, better enabling children to progress without additional support later in their schooling. It is likely that the formal and full-time nature of the learning environment in Key Stage 1 is accelerating children's language skills. It would also be useful to investigate the availability and quality of non-formal educational provision in the early years, across communities in Sunderland to ensure that children are being supported to develop age-appropriate language and communication skills before entering formal, full-time education.

Prevalence note: In the current academic year, the highest rates of SLCN prevalence, as a percentage of all children and young people in Sunderland, are in: Year 1 (6.14%), Year 2 (5.49%), Year 3 (4.30%) and Year 4 (4.57%).

**Recommendation 9:** For the Council to complete a geographical mapping exercise of the children on the SEN register with a primary need of SLCN, to locate their local community and identify links between the level of need and the services available in their area through the local offer. This would better inform forward planning and early intervention to reduce the high levels of prevalence on entry into formal education.

- **Autism Spectrum Disorder:** The numbers of children identified with ASD as a primary need in Sunderland remains relatively constant across year groups. However, there are notable peaks in prevalence following Key Stage transition points.

Prevalence note: In the current academic year, the highest rates of ASD prevalence, as a percentage of all children and young people in Sunderland, are in: Year 2 (2.27%), Year 3 (2.41%) and Year 7 (2.17%). As was previously discussed, there is an anomaly in the rates of prevalence between the PLASC data and the Autism Outreach Team data collected by the Council.

- **Specific Learning Difficulties:** The numbers of children identified with SpLD in Sunderland are exceptionally low, as a proportion of all children identified with SEND. This could be due to a lack of staff knowledge and confidence in identifying and assessing for SpLD across all age ranges and Key Stages. The numbers of children with an identified SpLD do steadily increase from Year 1 to Year 11, though these numbers are still exceptionally low.

Prevalence note: In the current academic year, the highest rates of SpLD prevalence, as a percentage of all children and young people in Sunderland, are notable in Key Stage 4, as the numbers of children increase as they progress through school years.

### 12.3 Theme 3: Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support in Sunderland (2017).

Theme 3 explores the proportion of SEN classifications for each identified primary need for 2017 and the data are given in Table 13 and Figure 14; the main findings and subsequent recommendations are given below.

Table 13

*Prevalence of Primary SEND classification in Sunderland: Statement of SEN, EHC plan and SEN Support (2017).*

Primary Need	SEND Classification					
	Statement of SEN		EHC plan		SEN Support	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
SpLD	-	-	4	0.83	420	9.17
MLD	23	7.14	22	4.57	1400	30.56
SLD	30	9.32	32	6.65	16	0.35
PMLD	2	0.62	2	0.42	-	-
SEMH	59	18.32	118	24.53	1051	22.94
SLCN	54	16.77	85	17.67	898	19.60
HI	9	2.80	8	1.66	86	1.88
VI	3	0.93	2	0.42	39	0.85
MSI	-	-	-	-	4	0.09
PD	45	13.98	42	8.73	105	2.29
ASD	97	30.12	165	34.30	391	8.54
OTH	-	-	1	0.21	135	2.95
NSA	-	-	-	-	36	0.79
<b>Total</b>	<b>322</b>	<b>100.00</b>	<b>481</b>	<b>100.00</b>	<b>4581</b>	<b>100.00</b>

*Note.* Data includes state-funded primary schools, secondary schools, special schools and Pupil Referral Units. '-' denotes zero values. Boxed values highlight figures of interest.

*Source: PLASC*

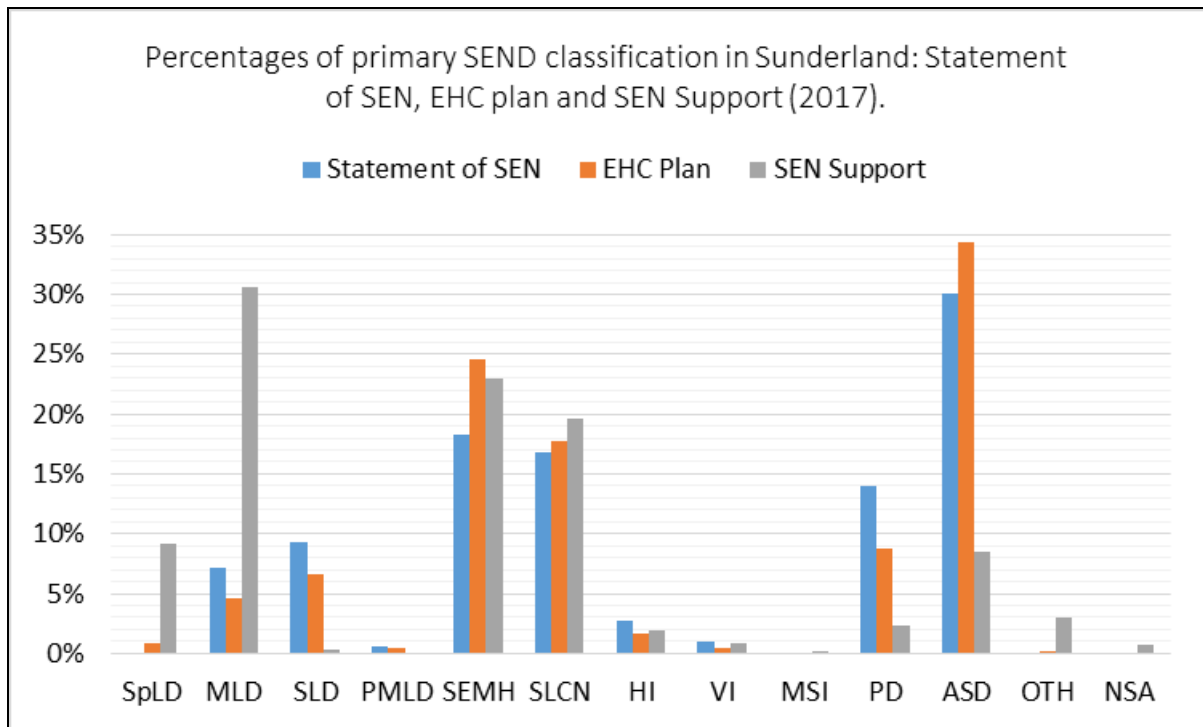


Figure 14: Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support (2017) in Sunderland.

The data shows that 322 children and young people in Sunderland currently have a Statement of SEN, with 481 children currently in receipt of an EHC plan. This represents 40% of all children who require significant additional support, provided by an EHC plan/Statement, who need to be transferred to an EHC plan by April 2018 to be compliant with national legislation (DfE, 2016b).

- Moderate Learning Difficulties:** MLD is the most prevalent primary need of all children identified with SEND in Sunderland. 30.56% of all children on SEN Support in Sunderland are identified with MLD. This means that more children on SEN Support are identified with MLD than any other primary need. However, there are few Statements/EHC plans issued for children identified MLD (45 in total), than those on SEN Support identified with MLD, at 1400 children. This is a stark difference in categorisation of support level, therefore, requires reviewing to ensure that it is representative of additional needs presented by children identified with MLD.

- **Social Emotional Mental Health:** SEMH is the second most prevalent primary need of all children identified with SEND in Sunderland, with 1228 children within this broad area of need. The significant majority of these children are on SEN Support, at 1051. However, SEMH is the second most prevalent need in all children awarded a Statement/EHC plan in Sunderland.
- **Speech Language Communication Needs:** SLCN is the third most prevalent primary need in Sunderland, with the majority of children (898/4581) on SEN Support. A total of 139 children with SLCN have been awarded a Statement/EHC plan in Sunderland.
- **Autism Spectrum Disorder:** Approximately a third of all Statements/EHC plan issued by Sunderland City Council are to support children identified with ASD. However, a relatively low percentage of Sunderland's SEN Support children are identified with ASD, at 8.54%.

**Recommendation 10:** For the Council to ensure the timely transfer of all 322 children currently in receipt of a Statement of SEN to an EHC plan, by April 2018.

**Recommendation 11:** A high number of children identified with ASD have been awarded Statements/EHC plans. This indicative of a particularly high prevalence of ASD in Sunderland. It is important that the Council reviews all provision for children identified with ASD to inform future planning and CPD needs of staff over the next 5 years (see appendix 5 for an example of a training audit).

#### 12.4 Theme 4: Analysis of national data compared to Sunderland City Council data based on primary type of need identified in children and young people 5-16 years (2016).

Theme 4 compares National and Sunderland City Council data regarding the prevalence of identified primary need in children and young people aged 5-16 years. Data are presented in Table 14, with main findings and recommendations given below:

Table 14

*Analysis of national and Sunderland City Council data based on identified Primary Needs: children and young people 5-16 years (2016).*

SEND Primary Need	SEN Support %			Statement of SEN or EHC plan %		
	National	Sunderland	% Diff	National	Sunderland	% Diff
SpLD	15.6	10.32	-5.28	4.0	0.37	-3.63
MLD	26.8	32.72	+5.92	13.4	5.93	-7.47
SLD	0.4	0.45	+0.05	13.1	7.29	-5.81
PMLD	0.1	0.05	-0.05	4.5	0.62	-3.88
SEMH	17.3	20.32	+3.02	12.3	26.33	+14.03
SLCN	20.9	20.07	-0.83	14.0	15.33	+1.33
HI	1.6	1.83	+0.23	2.7	1.61	-1.09
VI	0.9	0.79	-0.11	1.5	0.87	-0.63
MSI	0.2	0.07	-0.13	0.3	0.12	-0.18
PD	2.2	2.03	-0.17	5.8	10.14	+4.34
ASD	4.7	7.25	+2.55	25.9	31.03	+5.13
OTH	5.5	3.25	-2.25	2.4	0.37	-2.03
NSA	3.9	0.86	-3.04	0.1	-	-0.10
Total	100.00	100.00		100.00	100.00	

*Note.* Percentages expressed include pupils with SEN provision only. Percentages are rounded to the nearest 0.1. '-' denotes zero values. Data includes state-funded primary, middle (where applicable), secondary and special schools. Data excludes nurseries, independent schools and pupil referral units (DfE, 2016c).

*Source: PLASC and School Census*



There is higher prevalence of children on Statements/EHC plan, compared to national data, with the following primary needs:

- **Social Emotional Mental Health:** National prevalence = 12.3%; Sunderland = 26.3%. This represents an increase in prevalence of **+14.03%** in Sunderland.
- **Autism Spectrum Disorders:** National prevalence = 25.9%; Sunderland = 31.03%. This represents an increase in prevalence of **+5.13%** in Sunderland.
- **Physical Disability:** National prevalence = 5.8%; Sunderland = 10.14%. This represents an increase in prevalence of **+4.34%** in Sunderland.

There is lower prevalence of children on Statements/EHC plan, compared to national data, with the following primary needs:

- **Moderate Learning Difficulty:** National prevalence = 13.4%; Sunderland = 5.93%. This represents a decrease in prevalence of **-7.47%** in Sunderland.
- **Severe Learning Difficulty:** National prevalence = 13.1%; Sunderland = 7.29%. This represents a decrease in prevalence of **-5.81%** in Sunderland.
- **Specific Learning Difficulty:** National prevalence = 4%; Sunderland = 0.37%. This represents a decrease in prevalence of **-3.63%** in Sunderland.

**Recommendation 12:** For the City Council to use the National Data to monitor the prevalence rates of SEMH in Sunderland to inform future service planning and CPD needs of educational contexts. There needs to be further analysis carried out as to why SEMH is 14.03% above the national average.

There is higher prevalence of children on SEN Support, compared to national data, with the following primary needs:

- **Moderate Learning Difficulty:** National prevalence = 26.8%; Sunderland = 32.72%. This represents an increase in prevalence of **+5.92%** in Sunderland.
- **Social, Emotional and Mental Health difficulties:** National prevalence = 17.3%; Sunderland = 20.32%. This represents an increase in prevalence of **+3.02%** in Sunderland.
- **Autism Spectrum Disorder:** National prevalence = 4.7%; Sunderland = 7.25%. This represents an increase in prevalence of **+2.55%** in Sunderland.

There is lower prevalence of children on SEN Support, compared to national data, with the following primary needs:

- **Specific Learning Difficulty:** National prevalence = 15.6%; Sunderland = 10.32%. This represents a decrease in prevalence of **-5.28%** in Sunderland.
- **No Statutory Assessment:** National prevalence = 3.9%; Sunderland = 0.86%. This represents a decrease in prevalence of **-3.04%** in Sunderland.
- **Other:** National prevalence = 5.5%; Sunderland = 3.25%. This represents a decrease in prevalence of **-2.25%** in Sunderland.

## 12.5 Theme 5: Analysis of Early Years data (Reception year) by primary type of need and Good Level of Development in Sunderland (2014 - 2017).

Theme 5 explores the identified primary needs and achieved Good Level of Development (GLD) rates of children in Reception for academic years 2013/14, 2014/15 and 2015/16. The data were captured each year in January as part of the school census, with children now in the following year groups: 2013/14 - Year 3, 2014/15 - Year 2 and 2015/16 - Year 1. Data are presented in Tables 15 - 17 and Figure 15 - 17, with main findings and recommendations given below.

### 12.5.1 Primary needs of Reception aged children in Sunderland

Table 15

*Prevalence of identified Primary Needs with Reception aged children in Sunderland (2014-2017).*

Primary Need	Year							
	2014		2015		2016		2017	
	N	%	N	%	N	%	N	%
SpLD	19	4.31	14	2.73	10	2.15	6	1.53
MLD	110	24.94	118	23.00	83	17.81	41	10.46
SLD	4	0.91	2	0.39	2	0.43	2	0.51
PMLD	1	0.23	1	0.19	-	-	-	-
SEMH	62	14.06	81	15.79	73	15.67	45	11.48
SLCN	129	29.25	171	33.33	195	41.85	218	55.61
HI	9	2.04	2	0.39	8	1.72	5	1.28
VI	3	0.68	4	0.78	3	0.64	1	0.26
MSI	1	0.23	-	-	1	0.21	-	-
PD	16	3.63	19	3.70	24	5.15	21	5.36
ASD	68	15.42	71	13.84	51	10.94	43	10.97
OTH	17	3.85	24	4.68	10	2.15	9	2.30
NSA	2	0.45	6	1.17	6	1.29	1	0.26
Total	441	100.00	513	100.00	466	100.00	392	100.00

Note: '-' denotes zero values. Boxed values highlight figures of interest.

Source: School Census

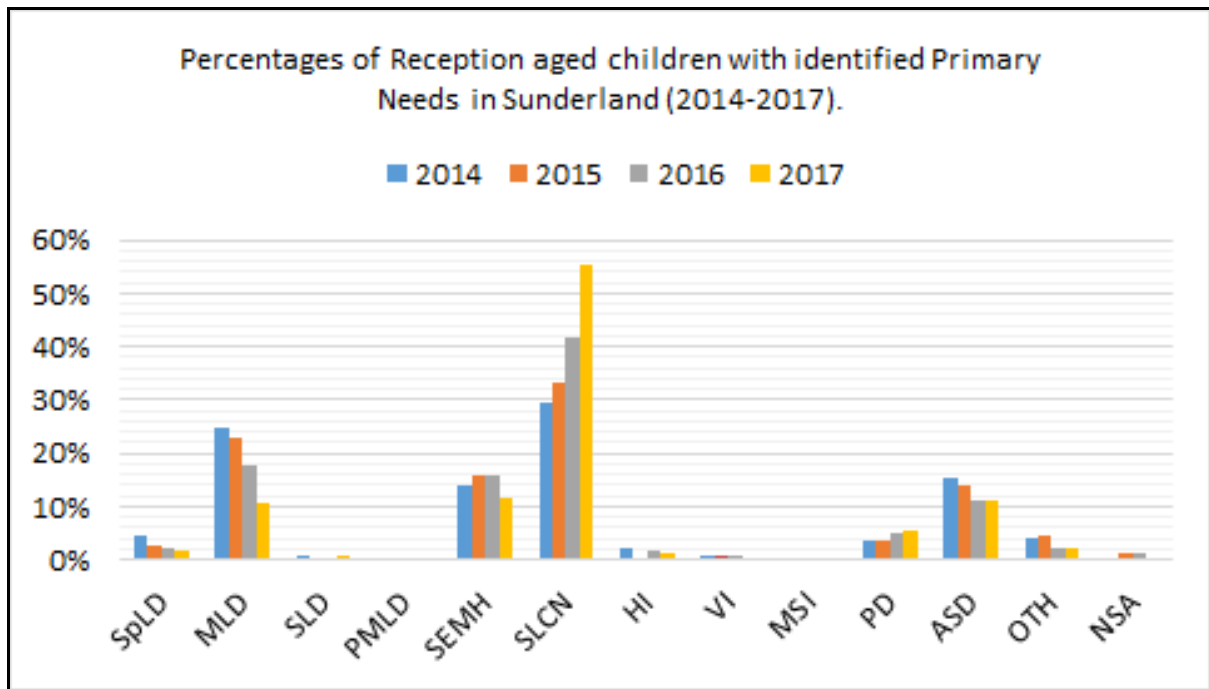


Figure 15: Percentages of Reception aged children with identified Primary Needs in Sunderland (2014-2017).

**Analysis of early years data provided by the City Council from 2014-2016 indicates the following:**

- SLCN is the most prevalent need and is rising year on year; currently this is the most prevalent primary need of children in the reception year with 41.85% of all children with SEND having this need.
- MLD is the second most prevalent need however, this is showing a year by year decrease from 24.94% in 2014 to 17.81% in 2016.
- SEMH is variable but still the third most prevalent need in 2016 within the SEND population.
- ASD remains the fourth most prevalent need but is reducing year on year as a primary need according to this data set.
- There are also early indications that the prevalence of PD is increasing with time in the early years, making it the fourth most prevalent need in both 2016 and 2017.

The analysis also includes the PLASC data for early years who are the children currently in reception 2016/2017.

**The 2017 PLASC data on early years in Sunderland indicates some changing trends from previous years:**

- The main primary need within early years in the current academic year remains SLCN with 55.61% of all children with identified need.
- The second highest primary need has become SEMH, with 11.48% of the SEND population. This raises the concern that that these children may not be school ready for the demands of Key Stage One.
- ASD is the primary need of 10.97% of the SEND population, reducing from 2016. This statistic does not include those children yet to be identified, assessed and diagnosed. These children will need to be supported with the transition to year one.
- MLD is the primary need with 10.46% of the children with SEND, reducing to the fourth most prevalent need amongst the Early Years population. There is a concern as to whether this is the correct classification for this group of 41 children, due to the possible difficulties associated with MLD identification and assessment, as has been previously discussed.

## 12.5.2 SEND classifications of Reception aged children in Sunderland

Table 16

*Prevalence of primary SEND classification with Reception aged children in Sunderland: Statement of SEN, EHC plan, and SEN Support (2017).*

Primary Need	SEND Classification					
	Statement of SEN		EHC plan		SEN Support	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
SpLD	-	-	-	-	1	0.26
MLD	-	-	-	-	41	10.85
SLD	-	-	-	-	1	0.26
PMLD	-	-	1	3.03	1	0.26
SEMH	-	-	-	-	49	12.96
SLCN	1	33.33	11	33.33	199	52.65
HI	-	-	2	6.06	3	0.79
VI	-	-	-	-	6	1.59
MSI	-	-	-	-	1	0.26
PD	1	33.33	9	27.27	10	2.65
ASD	1	33.33	10	30.30	37	9.79
OTH	-	-	-	-	18	4.76
NSA	-	-	-	-	11	2.91
Total	3	100.00	33	100.00	378	100.00

Note. '-' denotes zero values. Boxed values highlight figures of interest.

Source: PLASC

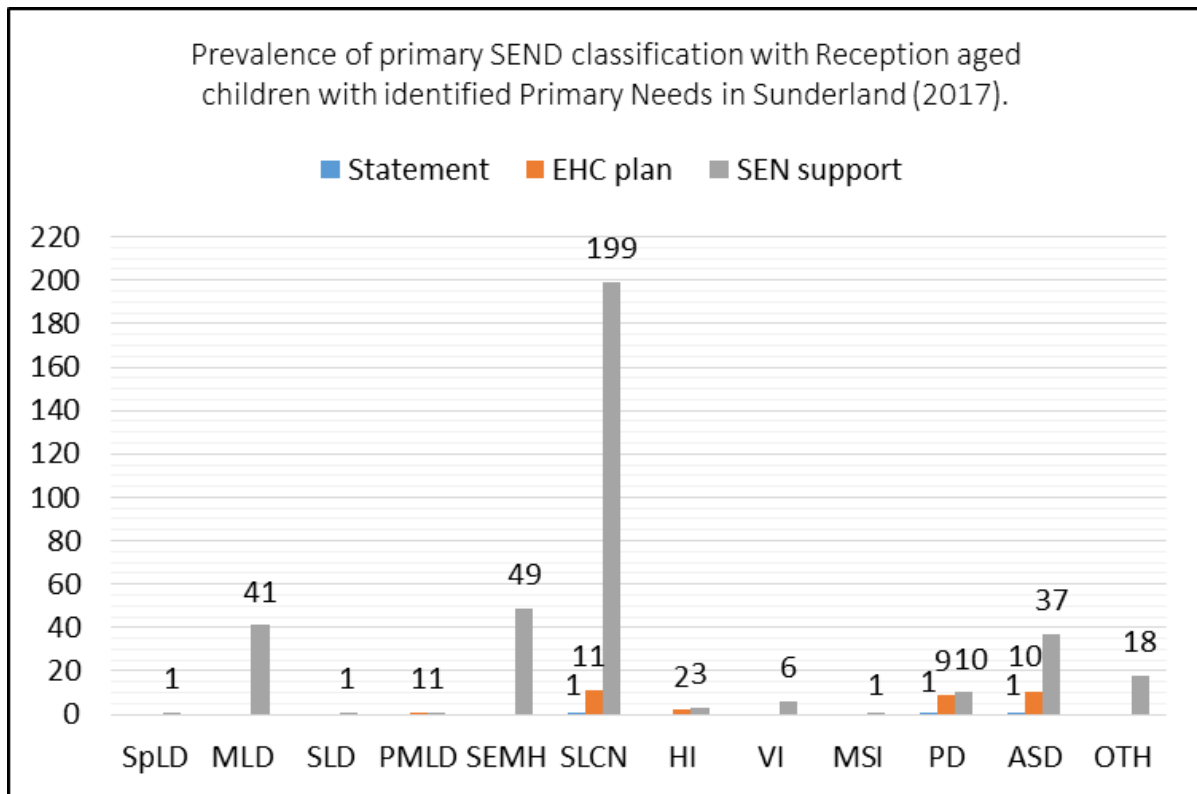


Figure 16: Prevalence of primary SEND classification with Reception aged children with identified Primary Needs in Sunderland (2017).

#### Analysis of SEND classification of Reception children in Sunderland

- The classification data indicates that there are only three children of Reception age that have Statements of SEN. These children need to be moved to EHC plans by April 2018, which will result in a total of 36 children on EHC plans in this year group but April 2018.
- There are a total of 378 children, currently in Reception, who are on SEN Support. Of these children:
  - 52.68% are identified with SLCN, which represents 199 children. Consequently, supporting early years practitioners with meeting the needs of children identified with SLCN is imperative.
  - 12.96% are identified with SEMH, which represents 49 children. These children are likely to require effective multi-agency working, in meeting their needs, to make a successful transition into primary school.

- 10.85% are identified with MLD, which represents 41 children. As discussed earlier in this report, the identification and assessment of these children requires review.
- 9.79% are identified with ASD, which represents 37 children.
- There are a total of 33 children currently with an EHC plan in Reception. Of these children:
  - 33.33% are identified with SLCN, which represents 11 children.
  - 30.30% are identified with ASD, which represents 10 children.
  - 27.27% are identified with PD, which represents 9 children. This suggests that it is particularly important for early years practitioners to have adequate training and CPD to support children with Physical Disabilities. This will likely better support the transition of these children through the phases of their education, as their needs have been identified and support early.



### 12.5.3 Good Levels of Development with Reception aged children identified with SEN in Sunderland

Table 17

*Prevalence of identified Primary Needs and achieved Good Level of Development with reception children in Sunderland (2014-2016).*

Primary Need	Year					
	2014		2015		2016	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
SpLD	3	15.79	1	7.14	2	20.00
MLD	6	5.45	12	10.17	5	6.02
SLD	-	-	-	-	-	-
PMLD	-	-	-	-	-	-
SEMH	14	22.58	19	23.46	18	24.66
SLCN	10	7.75	14	8.19	35	17.95
HI	5	55.56	2	100.00	5	62.50
VI	-	-	-	-	2	66.67
MSI	1	100.00	-	-	-	-
PD	4	25.00	4	21.05	5	20.83
ASD	10	14.71	16	22.54	4	7.84
OTH	2	11.76	8	33.33	4	40.00
NSA	-	-	-	-	1	16.67
Total	55	12.47	76	14.81	81	17.38

Note . '-' denotes zero values. Boxed values highlight figures of interest.

Source: School Census

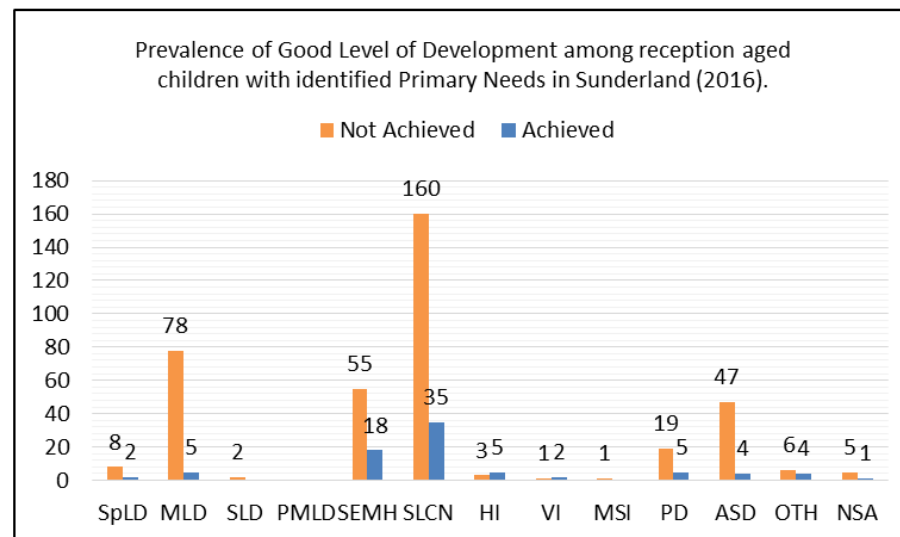
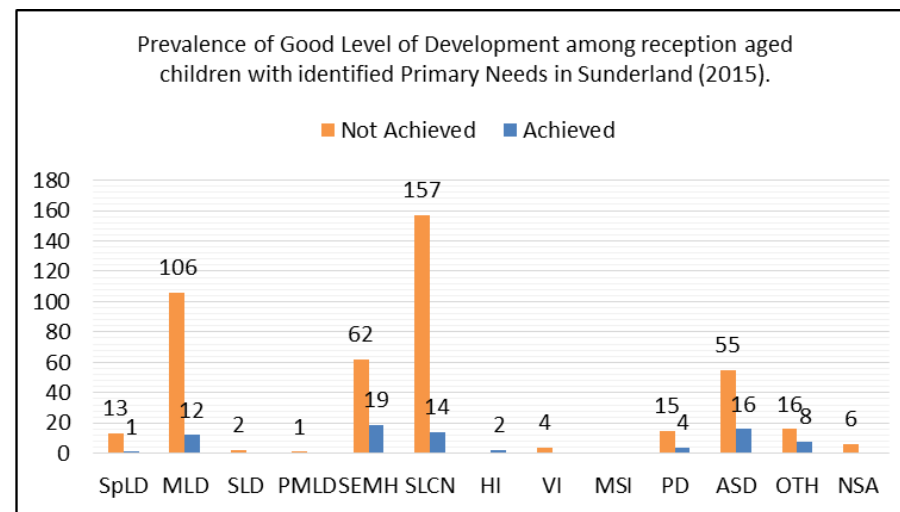
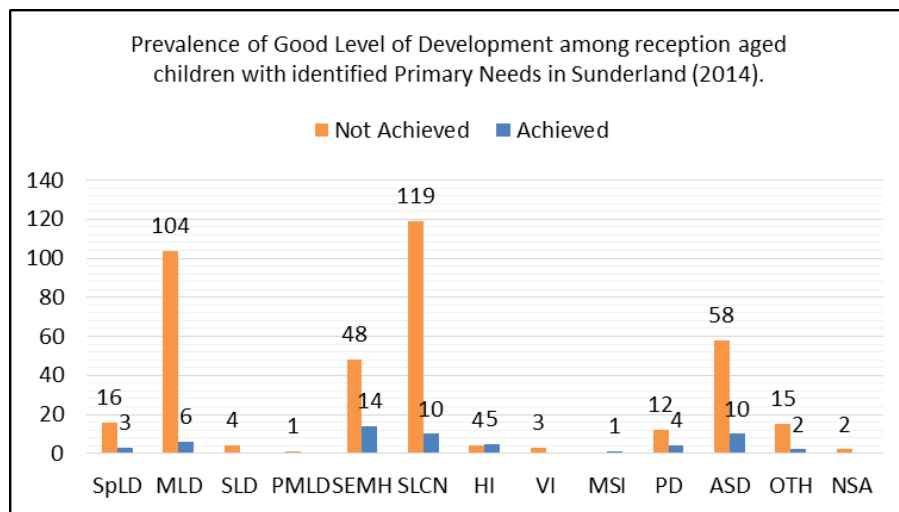


Figure 17: Prevalence of Good Level of Development among reception aged children with identified Primary Needs in Sunderland (2014 – 2016).

## **Analysis of data regarding Good Levels of Development in Reception aged children identified with SEN in Sunderland**

Analysis of data indicates that the proportion of children identified with SEN in the early years that achieve Good Levels of Development (GLD) is extremely low. Of all children identified with SEN in Reception, **only 17.38% of those children achieved a GLD in 2016**. It appears that children identified with the following primary needs are having significant difficulties in meeting Good Levels of Development in Reception:

- **MLD:** 6.02% of Reception aged children achieved a GLD in 2016 this represents 5 out of eighty-three children. The rates of GLD attainment in children identified with MLD remain consistently low over time.
- **ASD:** The rate of GLD attainment in children identified with ASD was 7.85%, or 4 out of forty-seven children, in 2016. This indicates a significant reduction in children identified with ASD meeting GLD since 2015 and should investigate via further research.
- **SLCN:** 17.95%, or thirty-five out of one hundred and ninety-five children identified with SLCN achieved a GLD in 2016. Although this figure is very low, it has increased slightly since 2014, indicating good practice in supporting these pupils to meet GLD.
- **SEMH:** 24.66% of children identified with SEMH reached a GLD in 2016. This represents eighteen out of fifty-five children. Again, the rates of children achieving a GLD do appear to be slightly increasing over time; however, they are still low.

Key recommendations pertaining to the early years are presented below:

**Recommendation 13:** For the Council to provide training to nurseries in collaboration with speech and language therapists, playgroup leaders and parents and carers on how to create language rich environments. This should be targeted to early years settings rated requires improvement or in special measures initially.

**Recommendation 14:** For the Council to further investigate and analyse the specific needs of children identified with SEMH in Sunderland and to develop in conjunction with TaMHS a good practice model for use in early years setting to address the range of SEMH needs. This would require appropriate staff training on identification for optimum implementation to occur.

**Recommendation 15:** For the Council to investigate the support provided to children identified with SEN in meeting a GLD, given the current low levels of GLD attainment amongst these children. This will inform strategies to better support professionals, families and children with improving the levels of GLD amongst the SEN population. The 2016 reduction in the achievement of a GLD for Reception aged children identified with ASD should also be investigated.

**Recommendation 16:** For the Council to use the Local Offer to make it easier for parents and carers to compare the quality of early years services, including childcare for children before the start of Reception.

## **12.6 Theme 6: Analysis of interviews with the NHS and CCG**

The key findings presented under this theme have emerged from the analysis of transcript data gathered from two participants, one a representative of the NHS in Sunderland and one a representative of the CCG in Sunderland. It should be noted that the assertions made in this section are not widely generalisable and may not be wholly representative of the bodies involved, as they are based upon data gathered from a small number of participants. However, they should be relevant to the region and themes explored within this report. It is recommended that further research be conducted to identify perspectives on the themes explored in this report involving participants from the Social Care sector, to better inform recommendations for effective multi-agency working.

Interviews with representatives from the NHS and CCG, working in Sunderland, highlight that there is a large amount of effective practice with regard to supporting children identified with SEND in Sunderland. The NHS in Sunderland appears to have particularly well defined care pathways to support children with an identified primary need (for example Diabetes, Epilepsy and ASD). The interviewed participant from the NHS stated that there are, “very clear pathways about who gets picked up and when.” These pathways often require strong multi-agency working, however, and this can be very challenging, particularly at a time of significant funding cuts to public bodies. Several specific challenges to multi-agency working were identified by the participants involved in this study. This has enabled a range of recommendations to be made, with the aim of promoting better joined up working amongst the stakeholders involved in supporting children identified with SEND.

### **12.6.1 Multi-agency working**

As was discussed earlier in this paper, the 2014 Children and Families Act replaced Statements of SEND with Education, Health and Care plans with immediate effect. This approach was thought to engender better more integrated, multi-agency working for all children identified with SEND (NASEN, 2014). Yet, the focus on bringing together education, health and social care has provided logistical challenges to the implementation of this

reform. Transcript analysis of the interviews conducted with participants suggest that multi-agency working between education and health is largely deemed to be effective. This is thought to be due to the open and honest communication between stakeholders. However, the participant from the NHS considered working closely with social care to be more challenging, than with partners in education. She explained that social care have higher thresholds, than education and health, for determining the children and families that they can support, due to demands on the service and growing financial pressures. This means that the social care system is likely to predominantly support children and young people who are at a Safeguarding risk, or those who have a Severe Learning Difficulty; whereas health and education are more likely to support those identified with a range of SEND needs.

Nevertheless, the respondent also highlighted that representatives from health and social care meet once a month on a Friday afternoon to, “problem solve together, communicate about any issues and iron out any issues.” The regularity of that meeting is likely to support more effective sharing of information, as all stakeholders involved are aware that they have a regular forum through which to air any concerns, challenges or opportunities with the relevant people. It was suggested by one respondent that both social care and CAMHS teams may have experienced re-structures over recent months, which has resulted in significant changing of appointments. Changes in staffing may have presented challenges to building effective multi-agency relationships in Sunderland, as representatives from Health and Education may not have been able to have regular conversations about children’s needs with a consistent representative from social care/CAMHS which then delays intervention. If this is an accurate representation of the facts then a recommendation is presented below:

**Recommendation 17:** For the Council, in collaboration with stakeholders to examine ways of consistently engaging social care to promote effective multi agency working. Introductory meetings for new staff members involved in assessing children’s SEND needs should be arranged across all stakeholder groups, to ensure consistent sharing of information. This should be a meeting independent of EHC plan review meetings.

### **12.6.2 Relationships with parents**

Good practice with regard to the engagement of families was expressed by one interviewed participant in this study. It was highlighted that Sunderland has a specialist health visitor, carer centre and parent carer network, all of whom are primarily concerned with building sustained engagement with parents and carers. The role of parents as decision-makers for their children was further endorsed by the 2014 Children and Families Act; therefore, it is particularly encouraging for Sunderland to have built such strong networks for engaging parents in communicating their priorities in meeting their children's needs. A specific example of early intervention in involving parents was given by one respondent, that Neonatal specialists often contact a paediatrician when a premature baby has been born who is likely to need specific and sustained SEND care; the paediatrician then visits the Neonatal unit to meet the parents, resulting in, as the respondent articulated, "smooth transition of care and continuity of care right from the outset."

It was suggested by one participant that parents may initially be averse to the involvement of a Social Worker in determining the support for their child. This suggests that an underlying stigma exists in Sunderland, regarding the involvement of social care. Yet, the participant went on to explain that open and honest communication with parents frequently always any fears that the parent may have with the involvement of social care. This further reinforces the importance of good communication in effective multi-agency working.

### **12.6.3 Changes in need prevalence**

It was suggested by interviewed participants that there has been a significant and visible increase in the number of children and young people identified with ASD, Diabetes, Child Obesity and Child Mental Health Difficulties in Sunderland over recent years. The PLASC data sets from 2017 support this finding with regard to numbers of children identified with ASD. Additionally, the complexity of needs that children present with is also deemed by the participants to have increased. The 2017 PLASC data does not support nor discredit this

assertion, as it only presents the primary need of an individual, therefore is unable to provide us with rates of co-morbidity for individuals.

Autism has seen a significant rise in diagnosis rates across Sunderland, which the NHS participant believed to be due to better diagnosis techniques, rather than an actual increase in prevalence, supporting findings the literature review. The NHS respondent highlighted that over a third of all referrals to a paediatric doctor are now for investigation into ASD, highlighting prevalence of this need in the region. However, as was highlighted in the literature review section of this paper, ASD is a complex and multi-faceted condition, often involving inter-related needs. Therefore, Horridge et al. (2016a) Identified that structuring support for a child around their primary need is not always appropriate, as it may not take into account the child's multi-faceted needs. The authors suggest that recording the number of needs that a child/young person presents with, rather than the primary need, is likely to be more effective in meeting their overall needs. It is highly likely that many children and young people identified with ASD in Sunderland present with a range of inter-connected needs, which may not be optimally accommodated through the care pathway that they assigned to.

**Recommendation 18:** In addition to recording children and young people's primary needs, the Council should explore recording the number of additional needs that a child presents with. This may then better enable them and educational contexts to review care pathways, in ensuring that they consider the multi-faceted needs of children and young people identified with SEND, particularly those identified with ASD (Horridge, 2016a., 2016b).

The increase in number of children presenting with mental health difficulties in Sunderland is particularly noticeable with younger children, according to our interviewed Health participant. The NHS in Sunderland is often accepting immediate referrals from young children presenting with Social, Emotional and Mental Health difficulties, rather than the immediate referral going to Children and Young People's Services (CYPS). In the interests of effective multi-agency working it was suggested by the participant that, as far as possible, CYPS, the NHS and CAMHS undertake assessments of children presenting Social, Emotional



and Mental Health needs concurrently, to inform provision. This may better support the child to remain in mainstream school, as early intervention would be better enabled. Notifying SENCOs of ongoing assessment was also highlighted, in ensuring that schools are made aware of joined up working.

**Recommendation 19:** Identify a key person with responsibility for promoting multi-agency working between CYPS, Paediatricians and CAMHS, to undertake initial assessments of children presenting with Social, Emotional and Mental Health difficulties concurrently, wherever possible. This will ensure that needs are clearly understood and plans swiftly drawn up to meet them.

#### **12.6.4 Training of teaching staff supporting children identified with SEND**

Ensuring that teaching staff and assistants are supported to meet the needs of all of Sunderland's children and young people identified with SEND is vital, especially in a climate of reform. The interviewed NHS respondent shared good practice examples of providing teachers with training and CPD support to meet the needs of SEND learners. She highlighted the practice of maximising the skills, knowledge and expertise of Sunderland's specialist nurses by having them provide outreach work to schools and sharing their knowledge of specific needs with teachers in schools, for example on managing Epilepsies or Diabetes in schools. Additionally, it was shared that some specialist nurses are now permanently based in Sunderland's specialist schools, to support with the health needs that a child might present with. This is an example of joined up and effective multi-agency working which, as was previously discussed, is vital to meeting the demands of creating and managing a successful EHC plan for a child/young person in Sunderland. However, it is important to acknowledge that support is needed for staff at all levels, who work with children identified with SEND.

The role of Teaching Assistants (TAs) in supporting both the academic achievement and social inclusion of children identified with SEND has been the subject of much debate over recent years and is especially pertinent in the North East, as Durham County Council is the first LA in the country to recently commit to reducing TAs' wages across the LA. Yet, TAs' high contact time with children means that they have a very strong influence on the educational experiences of many children and young people identified with SEND and there is strong evidence to show that when TAs are deployed effectively they can have strong, positive impacts on pupils' outcomes (EEF, 2015; Saddler, 2014). However, TAs require access to training and CPD to enable them to build the skills, knowledge and expertise required to support children identified with SEND effectively. The NHS respondent in this study highlighted that she felt Sunderland have improved their approach to care by taking into consideration young people's rights and pastoral management of needs; therefore, are very much engaging with the child before the disability model of SEND. It is important to acknowledge the influence of TAs on the pastoral management of children's needs, due to the strong pastoral relationships that they frequently build with pupils they support. The respondent called for additional TA training in Sunderland, stating that training TAs was 'crucial to meeting needs.'

**Recommendation 20:** Audit CPD and training opportunities for Teaching Assistants in Sunderland, to better meet the needs of children and young people identified with SEND.

Regarding Teacher CPD and 'on the job' training, one of the respondents in this study called for more training in schools that was specifically related to Autism and was inclusive in nature, stating that there was a real need to 'make sure that the workforce is disability aware and disability welcoming, have got can do attitudes and problem solve.' There was also a call for training on what the SEND definition terms as 'reasonable adjustments.' This would need to cover what the 'reasonable adjustments' look like in mainstream schools, to ensure that teachers and SENCos can consistently devise and implement an effective EHC plan for an individual. This would also support SENCos and senior management teams with decision-making regarding the place of a child's education.

Additionally, the NHS respondent indicated that there is currently no standardised exemplar EHC plan shared across Sunderland's schools. This is causing delays in assessing children's needs during SEN Panel meetings, due to excessive time required to identify children's needs from inconsistent written submissions. Therefore, it is recommended that the Council devise an exemplar EHC plan for all SENCOs to use in recording pupils' needs, which will then afford better efficiency across the authority. The NHS respondent highlighted that Sunderland has created a 'Specialist Support Team' that goes into schools and trouble shoots with teachers, undertakes risk assessments, provides support and looks at ICT solutions for children identified with a Physical Disability. This team may be well placed to provide training and CPD for teachers on what constitutes 'reasonable adjustments,' as described in the 2015 SEND Code of Practice, and may also be well placed to distribute an EHC plan exemplar to SENCOs.

**Recommendation 21:** For the Council to devise and distribute an exemplar Education, Health and Care Plan and accompanying evidence to support SENCOs. This will have the added benefit of improving the efficiency of the SEN Panel meetings.

#### **12.6.5 Supporting children in specialist provision (PRUs, special schools and young offenders' institutions)**

The interviews conducted for this study highlight that it is often more difficult to meet the needs of children/young people identified with SEND if they have been educated in multiple educational settings. This may be due to poor data sharing between the multiple settings that a child may have attended and/or the difficulties associated with establishing effective multi-agency working for a child that has moved between different educational settings over a short period of time.

The NHS respondent identified that there is difficulty in identifying a common and agreed framework for identifying children that would most benefit from education in Sunderland's specialist provisions. This may be a contributing factor to some children being educated in multiple settings across the city, as the conditions under which it is most appropriate to

educate a child in a special school/PRU/mainstream school can be argued to be somewhat unclear. It is, therefore, recommended that Sunderland City Council work towards devising guidelines that indicate the criterion for placement in its various types of educational setting, to ensure consistency in decision-making regarding placements. It is acknowledged that all decisions of educational placement must be made on a case by case basis, due to the unique nature of each child/young person's needs, however, guidelines would likely support provide a starting point for discussions and would likely engender a more structured process for decision-making.

The NHS respondent also highlighted that she has noticed an increase in the number of children and young people educated in young offenders' institutions who are presenting with undiagnosed learning difficulties. Additionally, the respondent identified that there needs to be better support pathways for children educated in a PRU. These young people are highly likely to have passed through a range of different educational settings, therefore, are more at risk of what the respondent calls 'dropping off the radar,' particularly those in a young offenders' institution. Devising an agreed framework for placement decisions should help in reducing the number of Sunderland's young people who are educated in a Young Offenders' Institution, as their additional needs are likely to be identified earlier and support to meet those needs is likely to be put in place earlier. However, further research is recommended to explore the educational pathways taken by children educated in both PRUs and young offenders' institutions to identify the additional support they have accessed and to identify good practice examples of early identification of need and support pathways for those children.

**Recommendation 22:** To assess children and young people in a PRU context on entry, to ensure that their range of needs are identified early and that EHC plan can be either created or updated to reflect their current needs. This assessment must involve multi-agencies, as it is highly likely that the child will require support from CAMHS as well as from the educational setting itself.

### **12.6.6 Role of Designated Medical Officer**

Both respondents interviewed in this study highlighted that the responsibilities associated with the DMO role require clarification. Currently, the DMO role is shared between a consultant paediatrician and the CCG. This means that clear, contractual role descriptions are imperative in facilitating joined up working. It is important for Sunderland to identify the main focus of the role to better support quality provision for children identified with SEND across education, health and care. This will then inform better delegation of responsibilities to the two parties undertaking the role.

**Recommendation 23:** For the Council to devise role descriptions, clearly delegating specific responsibilities to the two parties sharing the DMO role. These should focus on supporting joined up working across education, health and care.

### **12.6.7 Children under the age of three identification of need/Early Identification**

The NHS respondent indicated that there is a clear pathway for early identification of physical needs in Sunderland. She explained that there are a range of pre-natal screening programmes that support early identification of SEND before birth. These practices then allow for early treatment to occur, with children identified as having SEND often accessing a clear care pathway from birth. The respondent is currently reviewing drafts of forthcoming guidance from NICE. The new guidance will outline that children born prematurely will require a cognitive test at age of 4 and will split out support given for children born at levels of prematurity. The respondent's involvement in reviewing drafts of this guidance indicates that Sunderland is well placed to adapt in meeting legislative changes around early identification of needs.

The respondent also explained that Neonatalists often contact her when a child has been born prematurely and is likely to present with SEND, so that she may go into the neonatal unit and meet the families soon after the birth. The respondent explained that this initiates 'smooth transition of care and continuity of care right from the outset.' It was also made

clear that parental consent to sharing of information between relevant stakeholders is often gained early in Sunderland, so that SENCos in educational settings can be made aware of needs early and GPs can inform SENCos of when to get an Educational Psychologist involved in meeting children's needs. It is important that this practice occurs after all initial meetings between parents of children identified with SEND and GPs to better support early identification of needs.

Both interviewed respondents identified that there is currently no forum via which stakeholders who are interested in early intervention for SEND can meet. Setting up a steering group for early intervention approaches is recommended, however, this should not present a substantial additional strain on officers' time. Analysis of interview data indicated that there appear to be many regular meetings undertaken across education, health and/or care. This is encouraging in supporting multi-agency working, however, it did appear to represent a significant time commitment. It is, therefore, recommended that all multi-agency meetings are reviewed to ensure that meetings make best use of officers' time and involve all interested parties to ensure that relaying of information to other stakeholders outside of meetings is avoided. Perhaps some meetings may be combined for efficiency.

**Recommendation 24:** For the Council should review all regular, scheduled multi-agency meetings between education, health and care for efficiency. An opportunity for stakeholders interested in early identification of SEND to meet regularly should be afforded within the recommendations from this review.

#### **12.6.8 Data sharing**

Both respondents interviewed identified that there are opportunities for improvements in data sharing across the Local Authority. It was highlighted that the CCG currently do not share data from Neonatal screenings and NHS Digital with the Local Authority; it was deemed by both participants that sharing of this data would be useful for early intervention and financial forward planning. The NHS data includes information on how many children in Sunderland have a diagnosis of ASD and how many children have technological

dependent/physical needs. The CCG respondent suggested that a server should be created that would hold all relevant data regarding children's needs in Sunderland. This would require careful review of the CCG's current data protection policies, but is strongly advocated in the interests of better meeting children's needs and efficiency of resources. As was recommended in the previous section, reviewing of the contractual responsibilities associated with the DMO role should be helpful in identifying who is best placed to take this recommendation forward.

**Recommendation 25:** Review current data sharing policies to enable sharing of data, where appropriate, between CCG, NHS Digital, LA and DMO to inform better identification of needs and local decision-making around SEND. A meeting should be arranged with Horridge (2016a) to discuss the outcomes of her research into recording multifaceted needs of children and ways in which this information can be ethically shared.

## 12.7 Theme 7: Analysis of the prevalence of Autism Spectrum Disorder in the City of Sunderland (3-16 years) (2017)

Postcode data were provided by Sunderland City Council and the Autism Outreach Team, relating to this theme. The data were used to geographically plot the residences of the children and young people, from 3-16 years, identified with SEN across the City of Sunderland. This data were filtered via categorisation, as to whether children were in receipt of a Statement of SEN, an EHC plan or were receiving SEN Support by each Key Stage. It was reported by the City Council that the number of children with a diagnosis of Autism Spectrum Disorder in 2017 was 1548 this is an increase of 353% since 2005 when there were 342 children diagnosed.

Table 18

*The number of children with a diagnosis of ASD in Sunderland as recorded by the Autism Outreach Team.*

	Year						
	2005	2007	2009	2011	2013	2015	2017
<i>Number of pupils with a diagnosis of ASD under 19 on the AOT database.</i>	342	390	532	705	880	1193	1548
<i>Percentage increase.</i>		2005 2007	2007 2009	2009 2011	2011 2013	2013 2015	2015 2017
		14%	36%	33%	25%	36%	30%
<i>Overall percentage increase.</i>		2005 - 2017					
		353%					

*Note.* The percentage increase between years 2011 and 2013 has been corrected from 24% to 25%.

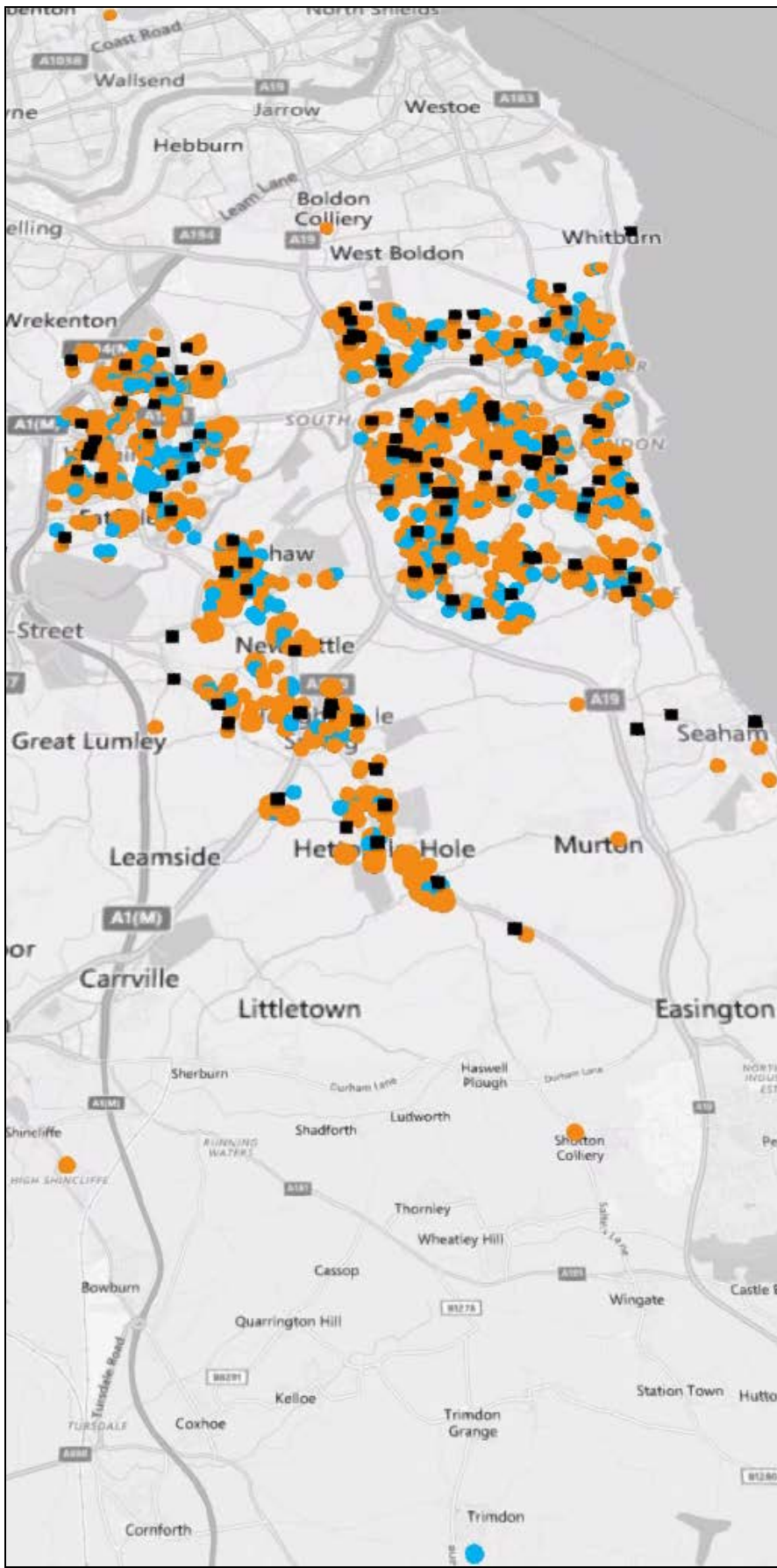
*Source: Autism Outreach*

The figures in red are as of February 2017, all the other figures were taken in July of the previous year.



Bakian et al. (2015) recommended the use of mapping tools to identify any localised regions of heightened risk of ASD. Exploratory geographical analysis was chosen to identify trends related to areas of Sunderland where there are hotspots in ASD prevalence.

The original sample that we were able to obtain consisted of 1477 children and young people with ASD living and attending schools in Sunderland. The data included the postcodes, year groups and schools relating to most of these children. The dataset was cleaned using 'listwise deletion', removing missing data, pupils living and attending school outside Sunderland, post sixteen pupils, erroneous postcodes, and school entries. The final sample consisted of 1187 pupils. Microsoft Excel 2016 and a 3D mapping add-on were used to create a series of maps.

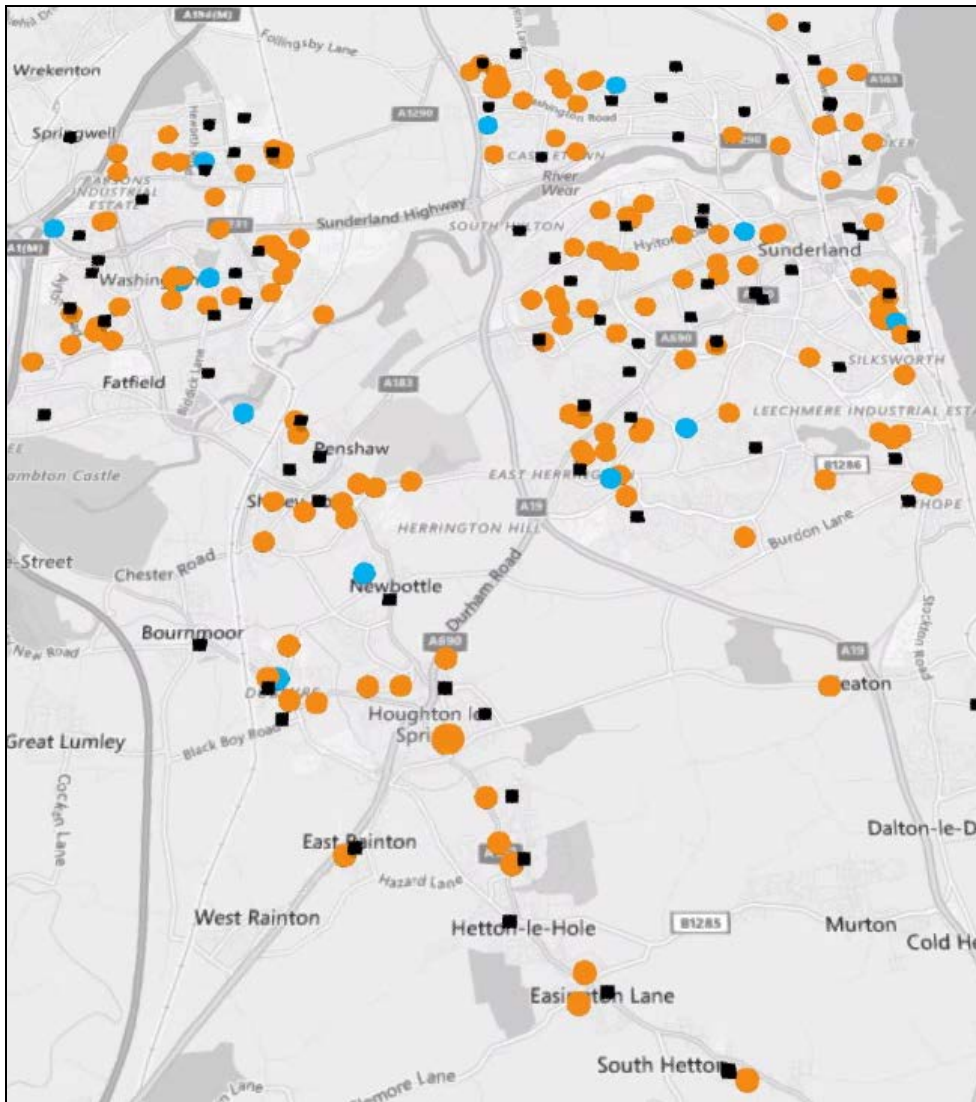


**All Pupils**

Key	
■	School/Nursery
●	SEN Support
●	EHCP/Statement

Ward	All Pupils		Total
	SEN	EHCP/St	
Barnes	37	5	42
Castletown	45	9	54
Copt Hill	39	12	51
Doxford	21	14	35
Fulwell	24	11	35
Hendon	34	8	42
Hetton	45	9	54
Houghton	37	10	47
Millfield	24	8	32
Pallion	34	5	39
Redhill	36	11	47
Ryhope	26	7	33
Sandhill	38	19	57
Shiney Row	52	19	71
Silksworth	41	11	52
Southwick	25	13	38
St Anne's	43	7	50
St Chad's	33	12	45
St Michael's	21	13	34
St Peter's	26	9	35
Washington Central	30	27	57
Washington East	44	13	57
Washington North	57	18	75
Washington South	32	9	41
Washington West	38	10	48
<b>Subtotal</b>	<b>882</b>	<b>289</b>	<b>1171</b>
Dawdon	3	-	3
Durham South	1	-	1
Lumley	1	-	1
Murton	1	-	1
Seaham	1	-	1
Shotton	2	-	2
Trimdon	-	1	1
Birtley	-	1	1
Battle Hill	1	-	1
Northumberland	2	-	2
Biddick and All Saints	1	-	1
Boldon Colliery	1	-	1
<b>Subtotal</b>	<b>14</b>	<b>2</b>	<b>16</b>
<b>Total</b>	<b>896</b>	<b>291</b>	<b>1187</b>

Map 1: Geographical representation of children with a diagnosis of ASD aged 3-16 years based on home postcode in Sunderland. The schools and nurseries shown above are attended by foundation, KS1, KS2, KS3 and KS4 pupils.

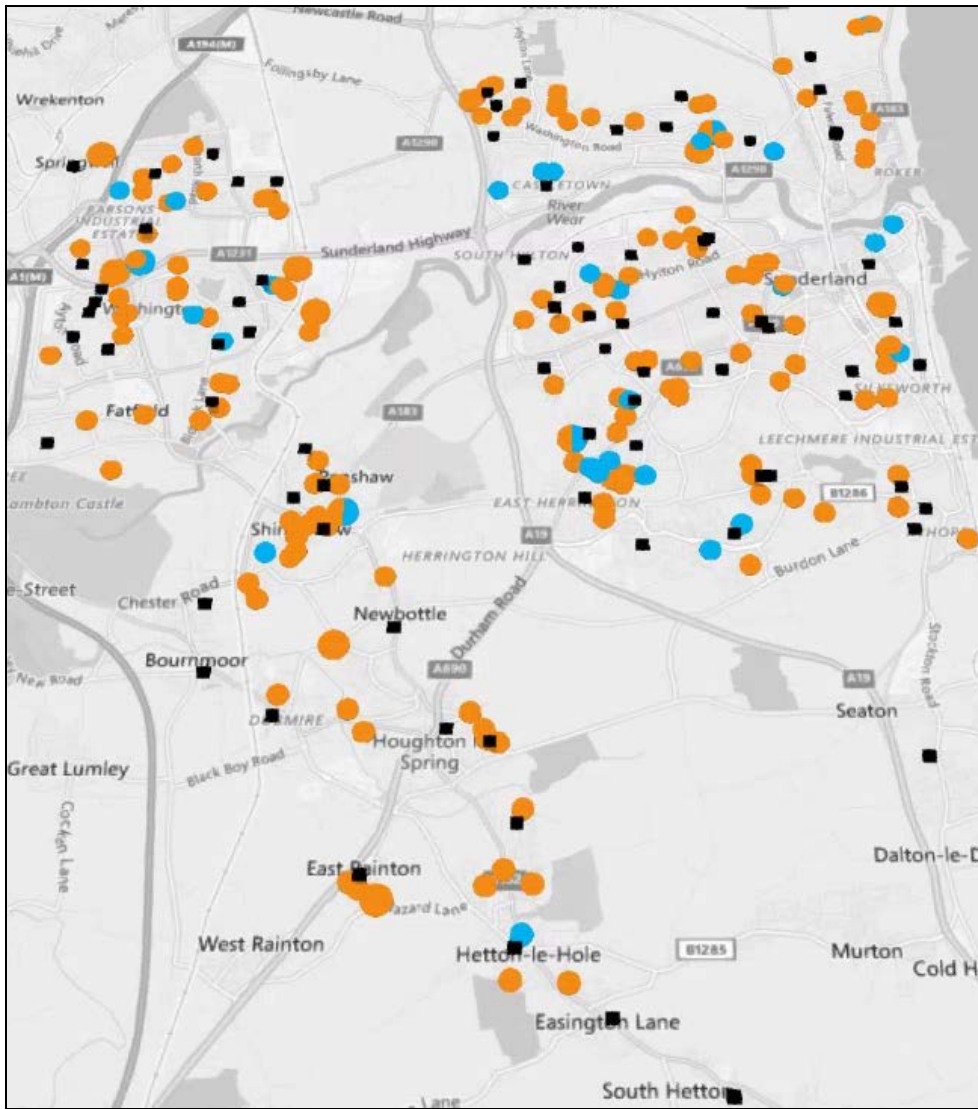


### Nursery/Reception

Key	
■	School/Nursery
●	SEN Support
●	EHCP/Statement

Ward	SEN	EHCP/St
Barnes	6	-
Castletown	9	1
Copt Hill	6	-
Doxford	3	-
Fulwell	3	-
Hendon	10	1
Hetton	4	-
Houghton	6	2
Millfield	3	1
Pallion	7	-
Redhill	6	1
Ryhope	6	-
Sandhill	5	-
Shiney Row	9	-
Silksworth	2	1
Southwick	2	-
St Anne's	8	-
St Chad's	7	1
St Michael's	1	-
St Peter's	5	-
Washington Central	8	2
Washington East	8	1
Washington North	9	1
Washington South	5	-
Washington West	4	1
Non-Sunderland Wards	3	-
<b>Total</b>	<b>145</b>	<b>13</b>

Map 2: Geographical representation of children with a diagnosis of ASD aged 3-5 years based on home postcode in Sunderland. The schools and nurseries shown above are attended by EYFS pupils.

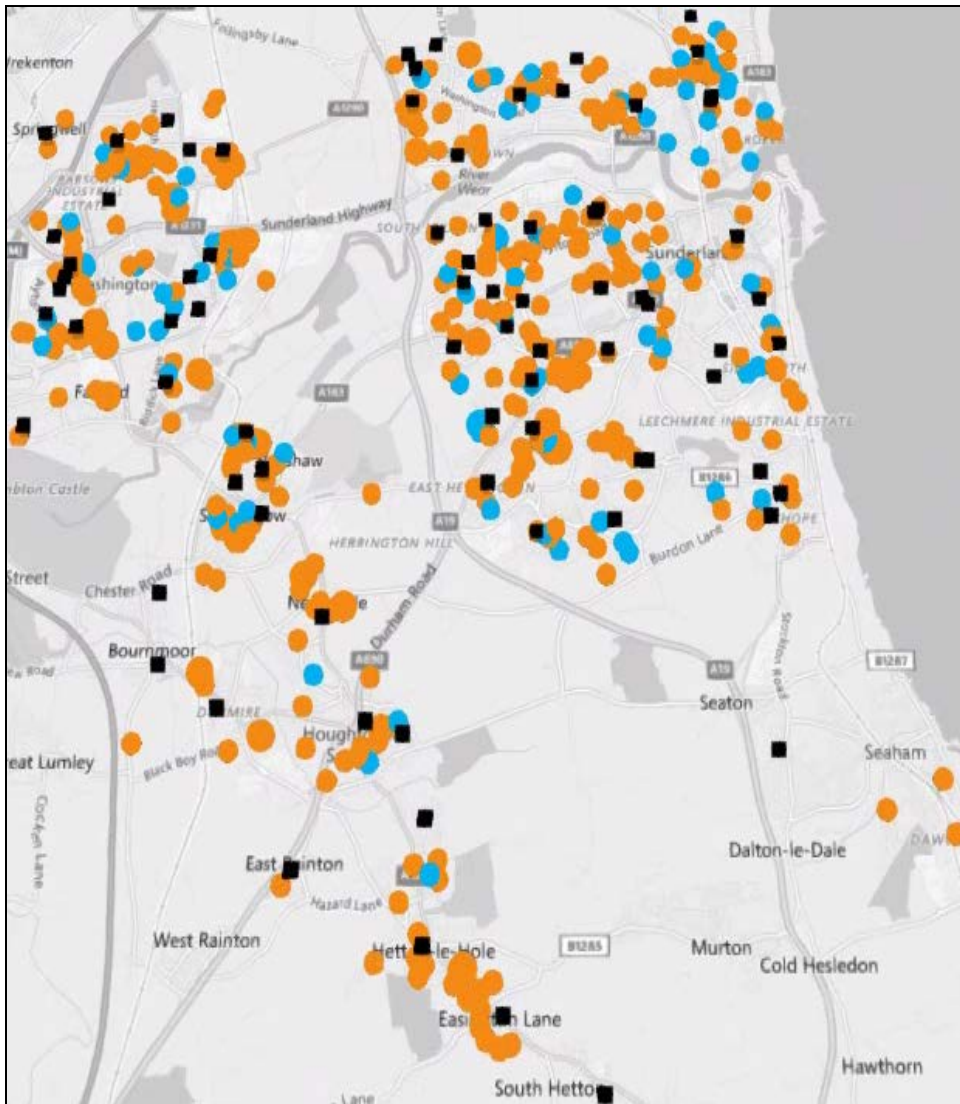


### Key Stage 1

Key	
■	School/Nursery
●	SEN Support
●	EHCP/Statement

Ward	SEN	EHCP/St
Barnes	4	-
Castletown	8	3
Copt Hill	7	-
Doxford	3	2
Fulwell	6	1
Hendon	5	3
Hetton	8	1
Houghton	7	-
Millfield	6	1
Pallion	5	1
Redhill	8	-
Ryhope	3	-
Sandhill	6	2
Shiny Row	11	2
Silksworth	7	-
Southwick	5	3
St Anne's	6	1
St Chad's	7	4
St Michael's	4	-
St Peter's	3	-
Washington Central	5	2
Washington East	12	1
Washington North	7	1
Washington South	6	-
Washington West	10	3
Non-Sunderland Wards	1	-
<b>Total</b>	<b>160</b>	<b>31</b>

Map 3: Geographical representation of children with a diagnosis of ASD aged 5-7 years based on home postcode in Sunderland. The schools shown above are attended by KS1 pupils.

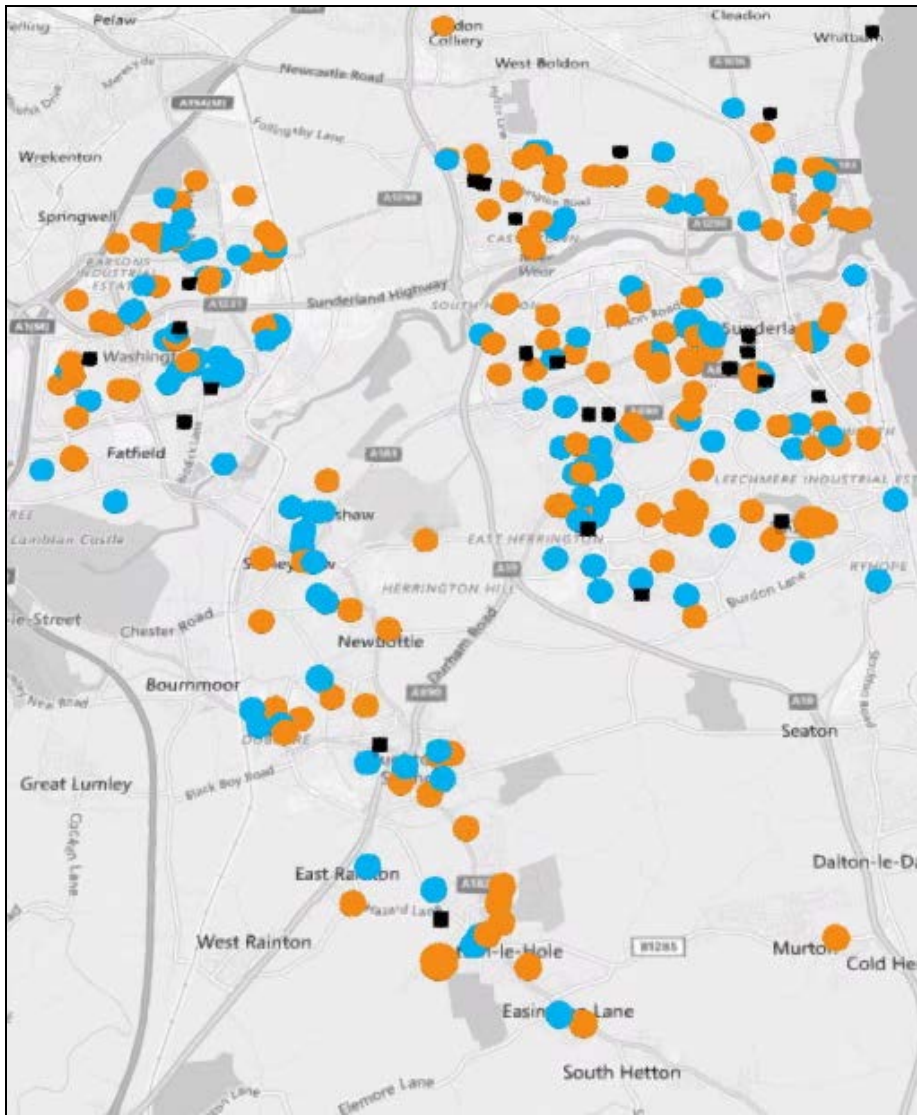


### Key Stage 2

Key	
■	School/Nursery
●	SEN Support
●	EHCP/Statement

Ward	SEN	EHCP/St
Barnes	10	-
Castletown	18	1
Copt Hill	17	3
Doxford	8	6
Fulwell	9	6
Hendon	11	2
Hetton	19	-
Houghton	15	1
Millfield	10	2
Pallion	15	3
Redhill	11	6
Ryhope	9	1
Sandhill	18	7
Shiney Row	24	6
Silksworth	15	1
Southwick	12	4
St Anne's	17	3
St Chad's	15	2
St Michael's	5	5
St Peter's	8	4
Washington Central	8	6
Washington East	19	4
Washington North	27	5
Washington South	13	3
Washington West	10	2
Non-Sunderland Wards	6	-
<b>Total</b>	<b>349</b>	<b>83</b>

Map 4: Geographical representation of children with a diagnosis of ASD aged 7-11 years based on home postcode in Sunderland. The schools shown above are attended by KS2 pupils.

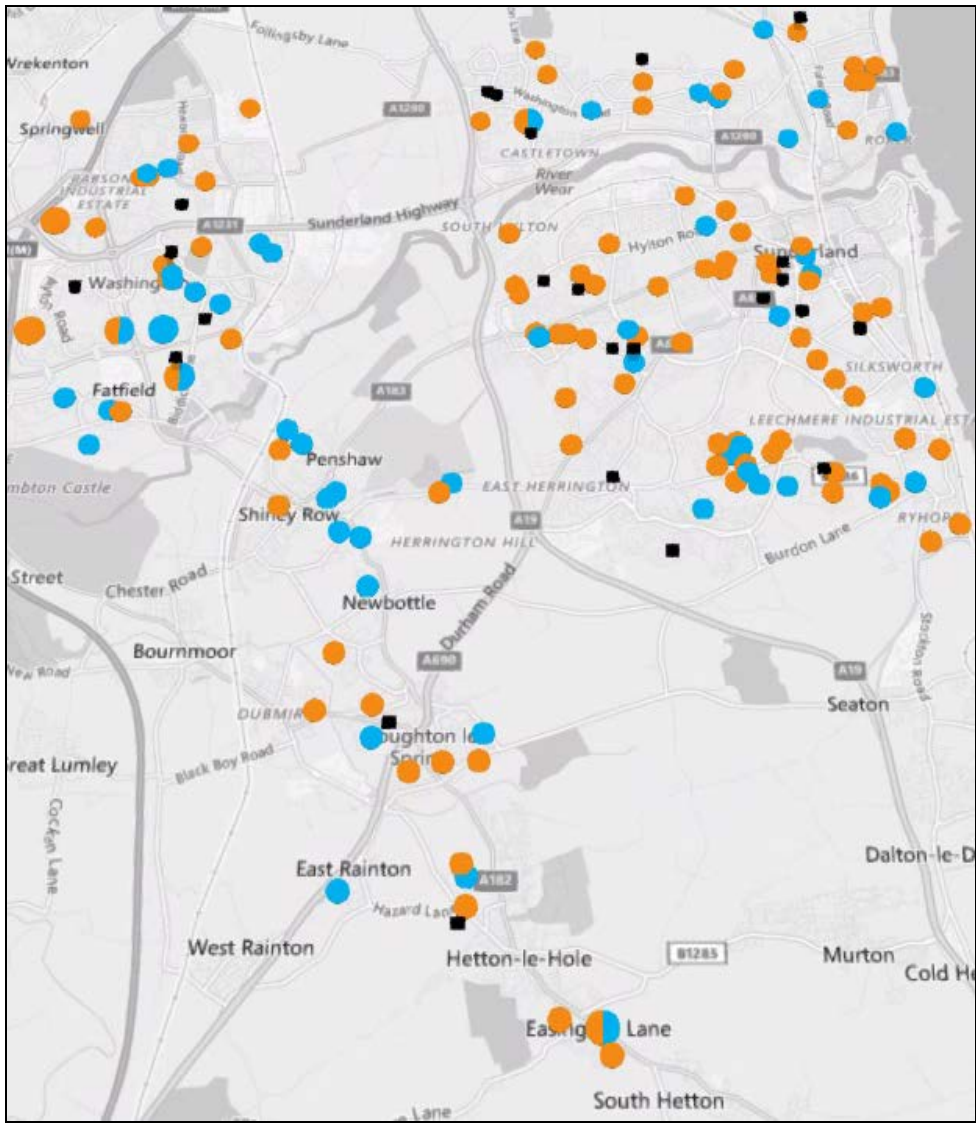


### Key Stage 3

Key	
■	School
●	SEN Support
●	EHCP/Statement

Ward	SEN	EHCP/St
Barnes	11	5
Castletown	8	3
Copt Hill	6	5
Doxford	5	4
Fulwell	3	2
Hendon	6	2
Hetton	9	5
Houghton	6	6
Millfield	1	3
Pallion	5	1
Redhill	7	3
Ryhope	2	3
Sandhill	3	7
Shiney Row	5	6
Silksworth	9	4
Southwick	4	3
St Anne's	7	3
St Chad's	3	5
St Michael's	5	5
St Peter's	7	3
Washington Central	5	10
Washington East	2	3
Washington North	11	9
Washington South	6	4
Washington West	8	4
Non-Sunderland Wards	3	2
<b>Total</b>	<b>147</b>	<b>110</b>

Map 5: Geographical representation of children with a diagnosis of ASD aged 11-14 years based on home postcode in Sunderland. The schools shown above are attended by KS3 pupils.



### Key Stage 4

Key	
■	School
●	SEN Support
●	EHCP/Statement

Ward	SEN	EHCP/St
Barnes	6	-
Castletown	2	1
Copt Hill	3	4
Doxford	2	2
Fulwell	3	2
Hendon	2	-
Hetton	5	3
Houghton	3	1
Millfield	4	1
Pallion	2	-
Redhill	4	1
Ryhope	6	3
Sandhill	6	3
Shiney Row	3	5
Silksworth	8	5
Southwick	2	3
St Anne's	5	-
St Chad's	1	-
St Michael's	6	3
St Peter's	3	2
Washington Central	4	7
Washington East	3	4
Washington North	3	2
Washington South	2	2
Washington West	6	-
Non-Sunderland Wards	1	-
<b>Total</b>	<b>95</b>	<b>54</b>

Map 6: Geographical representation of children with a diagnosis of ASD aged 14-16 years based on home postcode in Sunderland. The schools shown above are attended by KS4 pupils.

In addition to the data mapping exercise, we received data from the Council (February 2017) that indicated the following:

- The Autism Outreach Team (AOT) receives approximately 6 new ASD diagnosis confirmations per week from medics.
- The AOT receives approximately 15 new referrals per week requesting support from educational provisions.
- The AOT has 396 active pupils on the caseload.

As was discussed under previous themes presented in this report, Sunderland has a particularly high rate ASD diagnosis, when compared to national statistics. The mapping exercise has enabled us to break down the diagnoses rates further, by indicating the age phases at which diagnosis is occurring more frequently.

Upon analysis of the postcode data, we were able to identify specific streets in which multiple children with a diagnosis live, with this accounting for more than 16% of the postcodes represented within the study sample. We were unable to identify whether these children are siblings or related in any way.

### **Main Findings: Early Years**

- Currently, in the EYFS, there are 155 children with a diagnosis of ASD. Of these 155, 13 have an EHC plan and 142 are on SEN Support.
- When examining where these children live, it is evident that the ward with the greatest number of resident children with a diagnosis is Hendon. Conversely, there is only 1 child in St Michael's and 2 children in Southwick.



### **Main Findings: Key Stages 1-4**

- The maps indicated that there is a particularly high prevalence of diagnosis within KS2 in Sunderland, there are 426 children out of 1187 in this age phase.
- The data indicates that higher numbers of children are in the lower key stages and the Early Years Foundation Stage which will have implications for future planning provision and training.
- The lowest number of children with ASD are currently in Key Stage 4; this could suggest there are some undiagnosed young people in this age phase. However, given that Sunderland has a higher diagnosis rate compared to national statistics the rates in KS4 may be accurate.
- In Washington district there appear to be a large number of children and young people with a diagnosis of Autism. This is particularly apparent in Washington North which has 75 children. This is closely followed by Shiney Row with 71.
- The lowest prevalence rate is in Millfield with 32 children, 33 in Ryhope and 34 children in St Michael's Ward.
- It is not possible to determine from the data if there is a link between social deprivation or elevated economic status and prevalence rates by postcode (Larsson et al., 2005; Rai et al., 2012).

**Recommendation 26:** For the Council to take note of the high prevalence rate of ASD diagnoses in children currently in KS2, to provision plan as they progress through education into KS3. This will require an audit of teachers' knowledge and understanding of the indicators and evidence based practice related to approaches to learning in meeting the needs of children identified with ASD.

**Recommendation 27:** For the Council to conduct additional analysis into where there needs to be additional provision particularly in terms of nursery and school placements and where the children and young people reside, this should inform capacity building within the Autism Outreach Team. The local offer needs to be reviewed to ensure it effectively signposts families to support and services.

## 12.8 Theme 8: Analysis of high needs funding

It is evident from discussions with the stakeholders that Sunderland City Council has a robust banding system in place that is transparent and related to costed provision planning. Within Sunderland City Council there are systems in place to target provision for pupils with SEND and the following recommendations will support further strategic review and planning. At this point in time the Council are aware of their high needs allocation; however it is unclear what future funding allocations will be, as a result of insufficient clarification from Government.

Discussions with the commissioner of this report have suggested that a proactive approach to supporting children with their mental health may be worth close consideration, especially in light of the rising prevalence of SEMH in Sunderland. The City Council currently commission £500,000 of additional CAMHS services to support children and young people with Social, Emotional and Mental Health difficulties.

**Recommendation 28:** For the Council to develop a strategic SEND Provision map for the next five years in line with guidance (DfE, 2016a). This map will support optimal allocation of funding, resources and provision for SEND across Sunderland. The data contained in this report will support this process.

**Recommendation 29:** For the Council to analyse whether some children taught in specialist/alternative provision could have their needs met in an inclusive mainstream environment through effective early identification and assessment of need and staff training.

**Recommendation 30:** For the Council to support educational settings in gaining 'The Inclusion Quality Mark: a framework for evaluation of evidence based inclusive practice.'

## **12.9 Theme 9: Analysis of the primary need of children missing from education in Sunderland**

Unfortunately, the City Council was not able to provide any data for this theme. In light of this the recommendations are based on national data and research.

**Recommendation 31:** Ofsted (2013) encourage effective multi-agency working to avoid any unlawful forms of exclusion. Refresh school leaders understanding of statutory duties relating to children missing from education to ensure that they are fulfilling their role.

**Recommendation 32:** For the Council to appoint a senior officer responsible for obtaining and collating data on children missing from education to ensure they are meeting their statutory obligations (Ofsted, 2013).

## **12.10 Theme 10: Analysis of the primary need of children and young people in a Pupil Referral Unit (PRU)**

Table 19 (overleaf) was provided by City of Sunderland Council and shows that in the Pupil Referral Units they have identified:

- 86% of children and young people are identified as SEMH as their primary need with 101 children on SEN Support and 1 with an EHC plan (also for SEMH).
- 7% of the children and young people are identified as SEN Support for cognition and learning as their primary need.
- 5% of the children and young people have communication and interaction as their primary need.
- 2% (1 pupil) are classified as having other difficulty/disability.

Table 19

*The number of children and young adults attending PRUs in Sunderland (5 -16 years) (2017).*

Broad Areas of Need	EHC plan / Statements	SEN Support
<b>Beacon of Light School</b>	-	<b>3</b>
Cognition and Learning	-	1
Communication and Interaction	-	1
Other Difficulty/Disability	-	-
Social Emotional Mental Health	-	1
<b>KS1 Pupil Referral Unit</b>	-	<b>21</b>
Cognition and Learning	-	2
Communication and Interaction	-	2
Other Difficulty/Disability	-	1
Social Emotional Mental Health	-	16
<b>School Returners - Young Mum's Provision</b>	-	<b>12</b>
Cognition and Learning	-	-
Communication and Interaction	-	1
Other Difficulty/Disability	-	-
Social Emotional Mental Health	-	11
<b>The Link School - Pallion</b>	<b>1</b>	<b>32</b>
Cognition and Learning	-	3
Communication and Interaction	-	1
Other Difficulty/Disability	-	-
Social Emotional Mental Health	1	28
<b>The Link School - Tudor Grove</b>	-	<b>33</b>
Cognition and Learning	-	1
Communication and Interaction	-	1
Other Difficulty/Disability	-	-
Social Emotional Mental Health	-	31
<b>Total</b>	<b>1</b>	<b>101</b>

*Source: School Census*

**Recommendation 33:** For the Council to expand their data set from broad area of need to primary and additional needs for the children and young people in a PRU. This should also include a chronology of each child and young person in terms of their particular difficulties and strategies used to support their SEMH needs and a reintegration to mainstream package(s). The City Council should consider the viability of the educational psychology service providing a psychological service across all PRU provision to facilitate effective integration into mainstream through person centred approaches (Lawrence, 2011).

**Recommendation 34:** For the Council to commission further research into effective alternative provision models that support children and young people in achieving good outcomes in terms of education and to examine good practice approaches in meeting social, emotional and mental health needs. A similar review was carried out by Newcastle City Council in September 2016.

**Recommendation 35:** For the Council to collate data on which educational contexts are excluding children and young people on fixed or permanent basis to carry out a debrief with these schools to analyse the factors leading to the exclusions. This would allow the Council to target training to support schools in addressing early signs of behavioural difficulties which lead to SEMH difficulties.

### 13 Concluding remarks

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It is evident that there is a deep level of commitment from health and education services that have been involved in this research to improve outcomes for children identified with SEND. The process of referrals from Health Visitors and GPs to Consultant Paediatricians often results in early identification, intervention and clear support pathways for many children and young people. Constant comparative analysis of interviews with both the National Health Service (NHS) and Clinical Commissioning Group (CCG) highlighted areas of good practice in collaboration, particularly across health and education. However, a key recommendation to emerge from this research is for stakeholders to examine ways of collaborating to ensure that the care sector becomes an effective agency in contributing to and sharing the particular needs of children and young people with special educational needs and disabilities in Sunderland.

To further promote effective multi-agency working, the role of the Designated Medical Officer in Sunderland requires review. This will support the CCG in meeting its statutory responsibilities for children identified with SEND. If the role is to remain shared, clear role descriptors and responsibility allocation needs to be made explicit.

Following classification analysis of children and young people with SEND, it appears that there remain a significant number of children and young people whose needs require converting from a Statement of SEN to an Education, Health and Care plan by April 2018. This should be prioritised so that these children and families can have the advantages of the person-centred approach advocated by the new system (DfE, 2015a).

It is advised that the City Council use the recommendations of this study to plan future provision, practice and Continuing Professional Development (CPD) in light of prevalence findings in relation to specific primary needs of children with SEND. There has been a particular development need identified at SENCo level, due to the suspected over/under identification of a number of primary needs. SENCos within the Local Authority need to be supported to attend high quality training, which they then cascade and monitor the impact of with all staff members in their educational contexts. It is vital that Teachers and Teaching Assistants also need to be supported to meet the needs of children identified with SEND. It is imperative that all services know a child's holistic needs, not simply their primary need.

The key priority areas for CPD, as identified in the main report are associated with identification and assessment of the following primary needs:

- Autism Spectrum Disorders
- Social, Emotional and Mental Health
- Specific Learning Difficulties
- Moderate Learning Difficulties
- Speech, Language and Communication Needs (EYFS and Primary phase)

There is currently an under identification of Specific Learning Difficulties in schools, when compared to national averages. Across all age phases there needs to be further investigation into the classification of Moderate Learning Difficulties (MLD), as this is the most prevalent need in school-age children and is high in children in Reception. Social, Emotional and Mental Health Difficulties (SEMH) are also rising and are particularly prevalent from Year 5 onwards, peaking in Year 11. The factors contributing to this need to be further explored to ensure that early support is provided and sustained. Within the early years, and into Year 2, Speech, Language and Communication Needs (SLCN) is also a primary need with high prevalence.

It is considered by the research team and those interviewed that the SEN panel needs to become more efficient. This could be supported by the development of training materials and exemplars to promote consistency and compliance through a locally agreed EHC plan format, which reflects the principles, set out in Chapter 1 of the SEND Code of Practice (DfE, 2015a).



### 13.1 Further research opportunities

- To examine effective alternative provision models that support children and young people in other Local Authorities in achieving good educational and social outcomes
- To examine knowledge and understanding of school leaders and staff of the meaning and indicators of Moderate Learning Difficulties and Specific Learning Difficulties.
- To examine why there is a steady increase in SEMH diagnoses as children move through school. It is recommended that a mapping exercise is carried out to explore service provision and the effectiveness in meeting the range of needs associated with SEMH. This should explore the value for money in the commissioning of mental health services to children and young people.
- To analyse the range and effectiveness of educational pathways, including dual placements, taken by children and young people educated in both PRUs, young offenders' institutions and those missing from education. This will identify the additional support that children need to access or have accessed and will highlight good practice examples of early identification in need and support. As reported by DfE (2016h) Sunderland had the highest number of permanent exclusions in primary schools in 2016, at 10.
- To pilot an ethical approach to data sharing through NHS digital, CCG, City Council and educational providers, with the aim of engendering effective multi-agency working through accurate and timely information sharing of the health needs of children and young people.
- A strategic SEND Provision map for the next five years should be developed, in line with guidance (DfE, 2016a). This map will support optimal allocation of funding, resources and provision for SEND across Sunderland. The data contained in this report will support this process.

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## **15 Appendices**

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### **15.1 Appendix 1: Interview questions for CCG**

#### **The commissioning of Services**

1. How do you ensure there is sufficient capacity to meet the range of need? How do you monitor/record this and is this shared with the LA?
2. How far in advance do you plan for the commissioning of services for children and young people with SEND?
3. Have you seen an increase in any disabilities over the last few years, why do you think this is?
4. Do you have any suggestions/concerns regarding any trends in types of needs being identified?

#### **Effectiveness of multi-agency involvement**

4. Which of these agencies is it easiest to access and collaborate with, why do you think this is?
5. Where multi agency working is less effective, why is this? What are the barriers?



### **Joint commissioning – provision**

6. How do you strategically plan for the commission of services or placements for children with high level needs? What information is used? Where does the come from? What is the process of gathering this information and sharing? Whose role is this?

7. How is the Local Authority involved in the decision making processes for the placement of children with education as well as health needs?

8. How much control does the LA have for commissioning services, is there a particular type of need where this is more difficult to achieve?

### **Data sharing protocols to inform strategic decision across the local area**

9. What is the process for communicating confidential information from the CCG to outside agencies? Is it effective? How could it be improved?

### **Possibility of joint data base to inform decision making**

10. How could you see data being shared more effectively on the needs of children given the NHS protocols and current systems used by the different agencies?

11. Are you aware of any areas of best practice?

12. Is there anything else you would like to add which we have not discussed?

## **15.2 Appendix 2: Interview questions for NHS**

### **Theme (a) Criteria and pathways – diagnosis**

1. How do you provide early identification of physical disabilities in neonatal screening programmes? How is this information used/shared?
2. Who is usually the first person to notify the other professionals/LA once an SEN/D is identified? How effective is this process?
3. How well does the current system allow for effective planning for all provision (Health, education and social care?) based on the identified need?
4. What increases in prevalence of any particular primary need in children 0-16 years? For example ASD, PMLD have you identified? What trends (if any) have you noticed?

### **Theme (b) Effectiveness of multi-agency involvement**

5. Which agencies across education, health and care is it easiest to access and collaborate with about the needs of children, why do you think this is?
6. Where multi agency working is less effective, why is this? What are the barriers?
7. How able do you and your team feel in advising and train education staff in schools for meeting the needs of children with SEND (for example managing epilepsies and diabetes?)
8. What are the barriers to this or aspects of good practice you can identify? What is the current capacity for liaising with education?

### **Theme (c) Joint commissioning – provision**

9. What is the process by which local health services (including primary and secondary care) are able to inform them of children, including those under compulsory school age who are identified as having an SEN and/or disability. How effective is this and how could it be improved?

### **Theme (d) Data sharing protocols to inform strategic decision across the local area**

10. What is the process for communicating confidential information from the NHS to outside agencies?

11. How are under 3s flagged up from health visitors to consultants and how is this shared with the Local Authority for planning purposes and early years providers?

12. What increases in prevalence of SEMH issues have you identified? Are mental health services able to manage the level of need? How can these be improved? What additional funding is available based on recent Government pledges? Who targets funding? How are decisions made? What funding is still available for TAMHS (Targeted Adolescent Mental Health)?

### **Theme (e) Possibility of joint data base to inform decision making**

13. How could you see data being shared more effectively given the NHS protocols? Would co-location of services make this more effective?

14. To what extent is there is a shared understanding across the agencies of 'disability?' How does this impact on decision making and provision planning?

### 15.3 Appendix 3: Codes to emerge from interview transcripts

#### NHS Interview

Early identification of physical disabilities:

- Clear pathways for each identified condition (structured approach to treatment from newborn)
- Early identification is effective for pre-term/high risk children.
- Universal screening at set times such as the Newborn Hearing Screening programme which has been effective.
- Respondent reviewing drafts of guidance from NICE (shows that the Council is involved in shaping policy changes/new guidance)
- New guidance insists that children born prematurely will have to have a cognitive formal test at age of 4, and the guidance will split out support given for children born at levels of prematurity (more evidence of early intervention)
- Advocating standardised testing of children's health.
- Evidence of strong multi-agency working. Neonatalists contact respondent to go into the neonatal unit and meet the families- 'smooth transition of care and continuity of care right from the outset.' Also parental consent to share information is gained early so that SENCos in educational settings can be made aware of needs early and GPs can inform SENCos of when to get Ed Psych involved
- Open and honest communication is important- acknowledges that schools and GPs can have different agendas and this can mean conflicting priorities, but open and honest communication can get around those
- 'very clear pathway about who gets picked up and when'
- Paediatrician/Health Visitor usually the first to identify SEND

### Relationships between Education, Health and Care:

- Health and Education work very well together
- Social Care different- they have a much higher threshold for which children and families they will support- usually safeguarding/severe learning disability. Difficult for joined up working across the piece.
- Families defensive about having a Social Worker involved (stigma towards involvement of social care)
- Sunderland has a Specialist Health Visitor, Carer Centre and Parent Carer Network. These help with signposting and joined up working with families
- Operational meetings once a month that involve representatives from Health and Social Care. 'everybody knows on a Friday afternoon once a month where to find everybody so we can problem solve together, communicate about any issues and iron out any issues.'

### Changes in need prevalence:

- Complexity of need is increasing
- Increase in Autism diagnoses in ages up to teenage years. These are due to failures previously. A third and a half of the referrals are for Autism.
- Complexity of need is hidden by the primary need heading, ASD often overlaps with other needs.
- Increase in technology dependent young people

### Approach to meeting needs

- Sunderland have improved their approach to care by taking into consideration young people's rights and pastoral management of needs.
- A move to 'proactive management' rather than 'passive monitoring'
- Nurses are now based in Sunderland's special schools to make sure that their complex medical needs are met, enabling their education

- Examples of using specialist nurses to provide training and teaching to schools about specific conditions e.g. epilepsy, diabetes
- Respondent calls for more Autism training in schools and a real need to 'make sure that the workforce is disability aware and disability welcoming, have got can do attitudes and problem solve.' Also call for training on what 'reasonable adjustments' are in mainstream, could use Disability Matters for this.
- Training Teaching Assistants crucial to meeting needs
- 'Specialist Support Team' go into schools and trouble shoot, do risk assessments, provide support, look at ICT solutions for children with physical disabilities- innovative ways of problem solving
- Not a huge amount of migration in Sunderland- means there aren't often barriers to notifying people or communication with relevant teams once initial assessment has been done. Paediatricians automatically notify the LA.

#### Under 3 identification of need:

- Under 3 children with SEN identified through the Healthy Child Programme
- Specialist Health Visitor flag children not yet in education but with a need.
- Good communication to meet the needs of the under 3s- there is a two year pathway- pro-active in Sunderland to get commissioned early Nursery places for children with extra needs.

#### Barriers to effective multi-agency working:

- Potential difficulties with appointments in Social Work teams- meaning difficult to build familiarity with health and education
- Safeguarding seems better connected- 'robust inter-agency meetings and networking going across agencies.'
- 25% cut in paediatric team- staff aren't being replaced when colleagues move on
- Health isn't represented at every Education and Health Care Planning meeting- not the staffing - Health are able to SEND reports due to effective inter-agency working.

- CAMHS pressure is increasing- lots of reorganisation and shifts in personnel- problems with waiting times
- Respondent has 'special reserve new patient slots'- can get advice and make sure the child is seen early, even if big waiting lists for treatment. CYPS doesn't have this
- Finding a significant number of children under the Youth Offending Team who have undiagnosed learning disabilities. These children are often educated in a number of different schools/educational institutions and passed between them. Data systems are not robust enough to know where children are and how their needs are being met so can easily drop off the radar
- Children are referred at the end of the 12 week period whilst in a PRU – why aren't they seen at the start?
- Difficulty in meeting the needs of very young children (under 6), who present with behavioural needs- often a pressure for SENCOs to exclude. CYPS don't take the children, CAMHS not assessing because of social work involvement etc.
- SEN Panel isn't running as efficiently as it should be- no set templates for SENCOs to fill in which is resulting in disparate levels of information given, particularly about what they're spending on meeting the needs of a child and the impact it's having
- General recommendation that all processes should be person-focused rather than process-focused
- Problem with using common and agreed criterion for identifying children that would benefit from specialist provision

#### Social, Emotional and Mental Health Needs

- Not enough capacity in the system to assess the young children presenting with mental health difficulties effectively- there needs to be a timely assessment
- Paediatricians getting a lot of younger children coming directly to them, rather than CYPS. Respondent asks for CYPS to be a bit more responsive and pick them up quicker, so that assessments can be done concurrently with health assessments and needs better identified.
- Respondent has no additional funding for SEMH- all goes to CYPS and respondent has no say over what the funding is spent on

- DMO role shared between respondent and CCG- not clear who is doing what.

#### Sharing of data:

- LA need to work out the governance around sharing data. CCG currently do not share data from Neonatal screening with the LA – (it would be useful if they did so)
- Respondent suggests that data from NHS Digital be SEND to the CCG- CCG decide how data can be safely triangulated with LA data from school census etc.

#### Understandings of disability:

- All organisations use WHO's International Classification and Functioning Disability of Health' model of disability.
- There seem to be a vast number of different groups/meetings between individuals that are designed to meet the needs of children identified with SEND. It seems convoluted and superfluous- maybe a recommendation to review all groups that meet regularly and identify cross-overs to maximise efficiency?

#### **CCG Interview**

#### Codes to emerge from data:

- Undertake assessments every year for every acute service- analyse data to monitor staffing, resourcing and working with providers
- Run 3 acute services in Sunderland- SALT, physiotherapy and hearing service.
- Services that are additional to the 3 acute services are commissioned via a 'special requests.' These could be additional hours or short breaks.
- Increases in ASD and Diabetes prevalence- predominantly in primary for Diabetes. Increased numbers of child obesity and child mental health figures have continued to rise.



- CCG supports third sector organisations working to support children with ASD
- CCG respondent identified good working relationships with the LA (through regular meetings to discuss EHC plans and LAC) and City Hospital Sunderland (because CCG are a direct commissioner of them).
- CCG respondent identified poorer working relationships with the care industry because 'we're a bit more arm's length to the actual care home or foster care provision.'
- No current opportunity for all stakeholders interested in early intervention to meet.
- Difficulties in multi-agency working where a child has health needs because health is always the lead partner, so have to make sure that you complement the existing health services in place.
- Respondent acknowledges that there should be a server that hold shared data about children's needs, but that the complexities of having the permissions make it a difficult task.
- Respondent identifies lack of clarity with DMO role- feels that part of the role should be about helping to co-ordinate some of the issues that have been discussed.

#### 15.4 Appendix 4: Ward Map of Sunderland (2015)



## 15.5 Appendix 5: SEND Staff Training Audit

### SEND Staff Training Audit

(Adapted from Cheminais, 2015, p. 84)

Name

Date

From the list of topics below, choose three and number in order of priority (1-3).

- Identifying SEN
- Meeting pupils' SEMH needs
- Meeting pupils' communication and interaction needs
- Meeting pupils' cognition and learning needs
- Making reasonable adjustments to meet the needs of pupils with physical/sensory impairments
- Differentiating the curriculum
- Assessment for learning
- Target setting for pupils with SEND
- Working productively with parents and carers or pupils with SEND
- Making the best use of technology to enhance access to learning
- Effective deployment of support staff
- Meeting Ofsted inspection requirements for SEN
- Person Centred Planning and Supporting SEND pupils in reviewing their own progress and provision
- Any other SEND topic

Please indicate your preferred method for accessing the training identified:

External Course

Online Resources

SENCo drop in

Workshops in-house

Printed information

Teaching School CPD

School INSET

1:1 Coaching/mentoring