Joint Strategic Needs Assessment

Special Educational Needs and Disabilities (SEND) 0-25 Years In Northumberland

Northumberland County Council

NHS Northumberland Clinical Commissioning Group

Northumbria Healthcare NHS Foundation Trust

Version 2 *December 2017*

INDEX

Please note

All data relating to EHCP/Statemented students and those receiving SEN Support is based on information received during the January 2017 School Census and data extracted from the NCC EMS Information System at the end of the 2016/17 academic year. All data will be updated following the January 2018 School Census and at the end of the 2017/18 academic year.

1. Purpose

1. The Joint Strategic Needs Assessment (JSNA) is the means by which the Health and Wellbeing Board, SEND Strategic Group and other decision makers understand and agrees the needs of all local people.

2. The JSNA considers the needs of the local community as a whole, including specific analysis of the needs of vulnerable groups including disabled children and young people and those with SEN, those with life limiting conditions and looked after children. Local partners across education, health and social care work together to establish what targeted commissioning is needed to address the needs identified.

3. The JSNA helps to inform the joint commissioning decisions made for children and young people with SEN and disabilities, which will in turn be reflected in the services set out in the Local Offer. Emerging themes from recent consultation in localities across the County illustrate that the following are areas that parents and/or professionals have identified as areas for consideration:

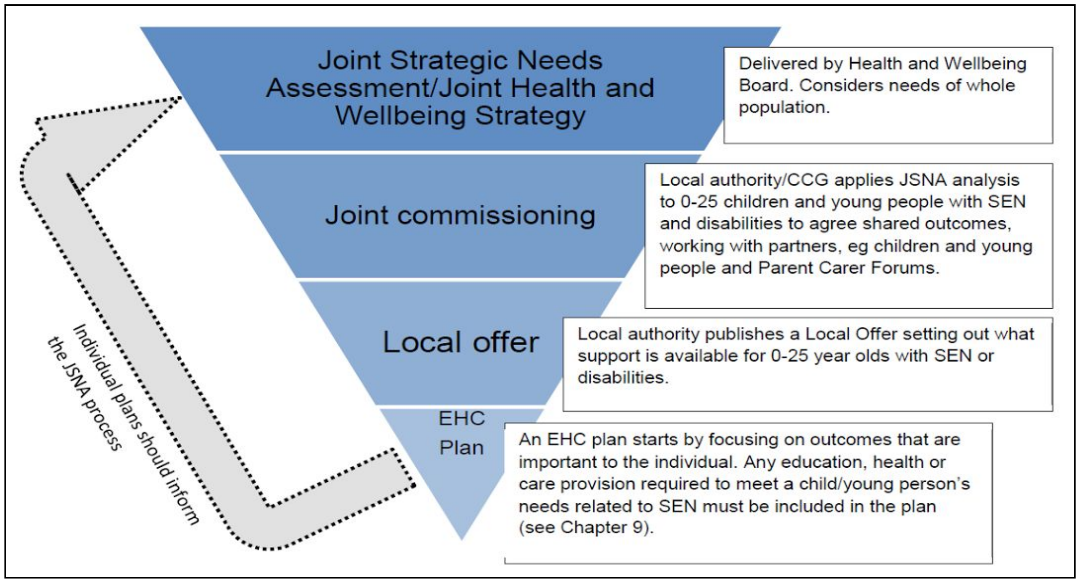
    - Improving communication between education, health and care services and with schools
    - Front line capacity and resourcing
    - Training and staff development
    - Listening to parents
    - Role of the SEN(D) support services and the service level agreement

4. Each local authority has a Health and Wellbeing Board. The Health and Wellbeing Board is a strategic forum which provides leadership across the health, public health and social care systems. The board's job is to improve the health and wellbeing of the local population and reduce health inequalities. Health and Wellbeing Boards have a duty to promote greater integration and partnership working, including through joint commissioning, integrated provision and pooled budgets.

5. Northumberland also has a SEND Strategic Group where family representatives, school representatives and lead officers for education, social care and health monitor SEND outcomes for Northumberland learners and set strategic priorities.

    The diagram below is taken from the national SEND Code of Practice 2015. It explains how the JSNA connects knowledge about the needs of individuals to the work of the Health and Wellbeing Board.

6. Please note, in some tables, data is suppressed (..) to avoid identification of individuals.



(SEND Code of Practice 2015, para 3.20)

Chart 1

6. The Northumberland JSNA report is designed to update colleagues as to the size and nature of our population of young people who have SEND and may require support from partners within the Health and Wellbeing Board, SEND Strategic Group, Strategic Transitions Group or other partners. Although the national guidance and diagram above focuses mainly upon young people with Education Health Care (EHC) Plans, we in Northumberland also focus upon learners with lower level or moderate needs (sometimes called 'SEN Support'), as you will see below.

2. The Northumberland Context in 2016, birth to 25 years – Population and Demographic Data

7. The national SEND reforms of 2014 created new legal requirements for local authorities, the NHS and others to consider SEND across the age range birth to 25 years. There are a number of specific age-phases to consider, starting with very young children who need help before they begin nursery or school and ending with young adults who have left the education system to start their increasingly independent adulthood (typically at 18-20 years of age).

The population of Northumberland in 2016 is as follows:

	Pre-school	**School-age**		**Post-16**	**Adults**	
	0-4 years	Primary 5-11 years	Secondary 12-16 years	17-18 years	19-25 years	Total
All children and young people (SEND and non-SEND)	15,109	23,605	16,664	7,035	21,237	83,650

(Source: 2016 ONS Mid-Year Statistics)

Table 1

Prevalence data for different kinds of SEN and disability

	Pre-school	**School-age**		**Post-16**	**Adults**	
	0-4 years	Primary 5-11 years	Secondary 12-16 years	16-18 years	19-25 years	Total
Number with low-moderate SEND (including 'SEN Support')	195	3396	2034	545	N/A	6170
Number with High Needs SEND (EHC Plans or equivalent and those with High Needs SEND funding)	40	579	578	151	18	1366

Table 2

8. The numbers of learners with specific kinds of needs and complex needs are described in more detail by age-phase below.

The Northumberland Context in 2016 – Pre-School

9. The main sources of information about very young children with SEND are from NHS health visitors and the local authority pre-school services for children with disabilities. These services work together to support families, childcare providers, schools and others as children's needs are formally diagnosed or emerge gradually over time.

10. There has been a net increase in the number of preschool children with complex needs of around 50% since 2013. The growth is mainly in these areas:

- Autistic spectrum disorders (ASD);
- Speech Language Communication Needs (SLCN);
- Severe learning difficulty (SLD) / Profound & Multiple Learning Difficulty (PMLD).

These patterns of growth can also be seen in the changing specialist school population 4-16 years.

11. There has also been a significant increase in the number of children with specific medical diagnoses, such as Down Syndrome, and those who rely on medical technologies to live. The causes of these increases are not known. Contributory factors may include a larger number of children increasingly surviving premature birth.

12. Other areas of need are relatively stable.

The table below gives a picture of how many children with higher levels of need become known to the local authority over a year. It is not usually possible at this age to identify the majority of children who will experience low or moderate levels of SEND: this will become apparent once they are in school from reception onwards.

	Birth to 1 year of age	**1-2 years**	**2-3 years**	**3-4 years (Nursery age)**
TOTAL NUMBER OF HIGH NEEDS CHILDREN KNOWN TO SERVICES	7	23	85	93
Autistic Spectrum Disorders (ASD)	..	..	33	51
Hearing Impairment (HI)	..	..	3	4
Visual Impairment (VI)	..	..	3	6
Speech Language Communication Needs (SLCN)	..	..	41	72
Physical Disability (PD)	..	7	14	10
Moderate Learning Difficulty (MLD)	..	5	25	37
Severe Learning Difficulty (SLD)	..	..	15	18
Profound and Multiple Learning Difficulty (PMLD)	..	..	..	..
Specific Learning Difficulty (SLD)	..	..	..	..
Social, Emotional or Mental Health Difficulty (SEMH)	..	..	..	..
Children reliant on medical technologies for eating, toileting, drinking, breathing etc.	..	..	5	5

Table 3 (Source: Portage 2016-2017 end of year record of children referred to pre-school SEND services)

The categories in the left-hand column are taken from the SEND Code of Practice and have been used to help us describe similar needs across the age ranges 0-25 years. The shaded row ‘medical technologies’ is an additional category added to highlight the number of children with those health needs.

Please note many of the children have multiple and complex needs where a single dominant category cannot yet be confirmed. For this reason, some children are ‘double-counted’ in this table. Confirmation of a dominant category takes place when they enter Reception year at school. At that point they are ‘single-counted’ with the school census.

13. The main source of SEND population and needs data is the national schools census. Each Spring since 2008 the census has collected data on SEND learners in mainstream schools and academies, local authority specialist schools and Pupil Referral Units within the boundaries of each local authority.

14. The national census data focuses upon the single dominant category of SEND identified by the school. This is called the 'primary need.' However, at a local level, schools can also identify a second additional need, called the 'secondary need.'

The table below gives details of our local population by primary need since 2015.

Primary Needs - Information from January Census									
Primary Need (SS, SAP and SA)		Jan-15		Jan-16		Jan-17		National	
ASD	Autistic Spectrum Disorder	471	6.6%	648	9.1%	451	6.5%	6.5%	
HI	Hearing Impairment	117	1.6%	160	2.2%	138	2.0%	1.6%	
MLD	Moderate Learning Difficulty	1457	20.4%	1966	27.6%	1923	27.7%	24.6%	
MSI	Multi-Sensory Impairment	5	0.1%	5	0.1%	5	0.1%	0.2%	
NSA	No Specialist Assessment of Type of Need	96	1.3%	116	1.6%	44	0.6%	3.6%	
OTH	Other Difficulty / Disability	201	2.8%	233	3.3%	241	3.5%	4.4%	
PD	Physical Disability	172	2.4%	195	2.7%	162	2.3%	3.0%	
PMLD	Profound & Multiple Learning Difficulties	57	0.8%	64	0.9%	50	0.7%	0.3%	
SEMH	Social, Emotional & Mental Health	1292	18.1%	1546	21.7%	1578	22.7%	15.6%	
SLCN	Speech, Language & Communication Needs	1267	17.8%	1243	17.4%	1563	22.5%	27.7%	
SLD	Severe Learning Difficulty	224	3.1%	358	5.0%	193	2.8%	0.9%	
SPLD	SPL Learning Difficulty (Dyslexia)	383	5.4%	524	7.4%	521	7.5%	10.5%	
VI	Visual Impairment	55	0.8%	69	1.0%	72	1.0%	1.0%	

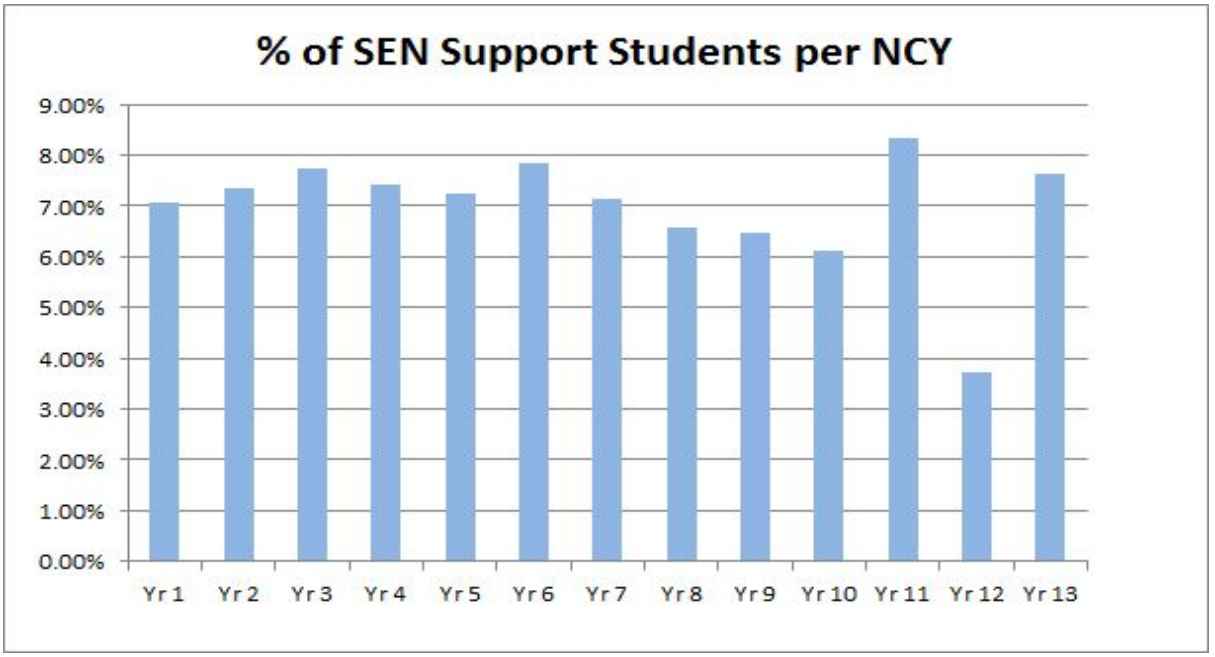
(Source: Schools census January 2015, 2016 and 2017. Please note 2016 & 2017 data includes Northumberland high needs learners out of county)

Table 4

15. This data brings together all learners with similar needs, whatever the degree of need may be. For example, ASD learners with very low levels of need are counted together with those who have very severe disabilities caused by their condition.

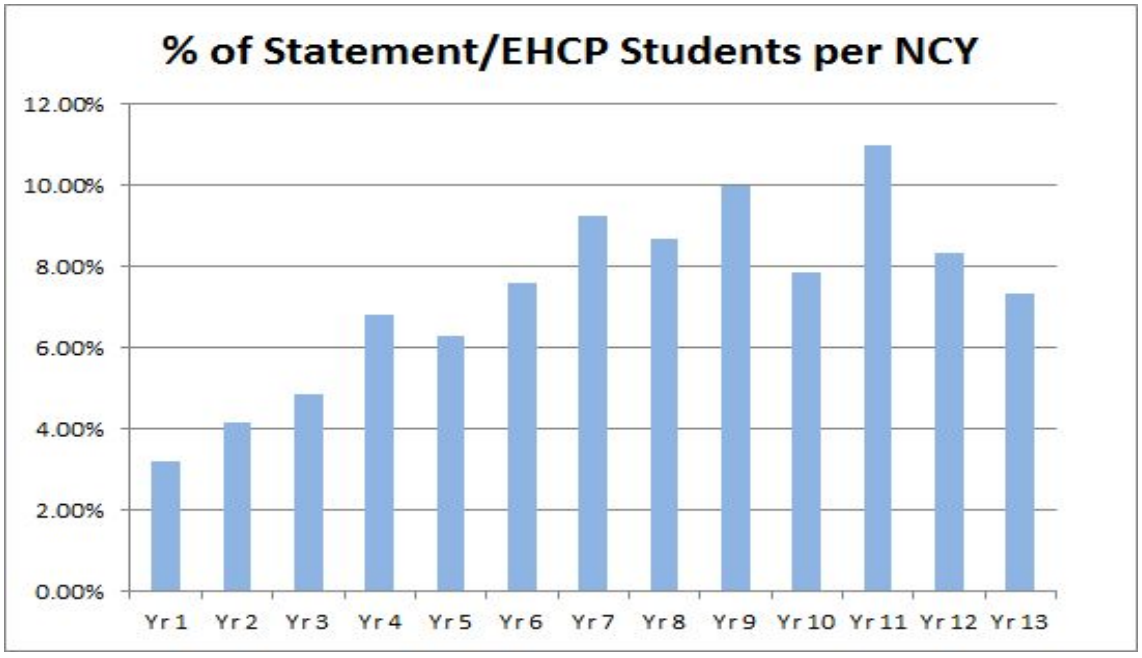
Those with low to moderate levels of need are usually categorised as 'SEN Support' and usually attend mainstream schools. Those with long term high levels of need usually have a formal statutory plan (EHC Plan or SEN Statement). Two thirds of learners with statutory plans attend specialist schools and one third attends mainstream schools.

16. There are a higher proportion of students identified with Special Educational Needs SEN Support in the lower national curriculum (NCY) groups, the high percentages in Northumberland are within the NCY 6 (10 and 11 age group), consistent with the national figures. and whilst the numbers do fall, there is a rise in NCY 11 and NCY 13. Interestingly, these year groups are all at the end of a Key Stage.



Graph 1 (Data available via NCC EMS June 2017)

17. The highest percentages of students with a statement or education, health and care plan are in the higher national curriculum groups, rising in NCY 7, 9 and 11. The highest percentage of students are within NCY 11 (age 15 and 16), this follows the national trend.



Graph 2 (Data available via NCC EMS June 2017)

18. The largest areas of general growth in Northumberland are:

- MLD
- SLCN
- SEMH
- SPLD
- ASD

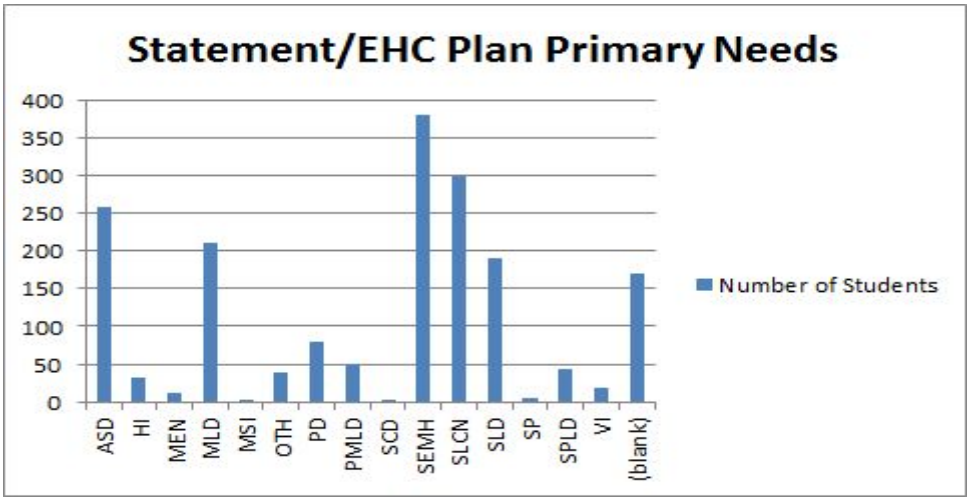
Children and young people's mental health and wellbeing

The data below shows the prevalence of mental health conditions within Northumberland. Information provided later in the document demonstrates that the prevalence of mental health in children and young people is a real issue in the county as some are waiting too long for treatment.

Prevalence of Mental Health in Young People (2015/16)

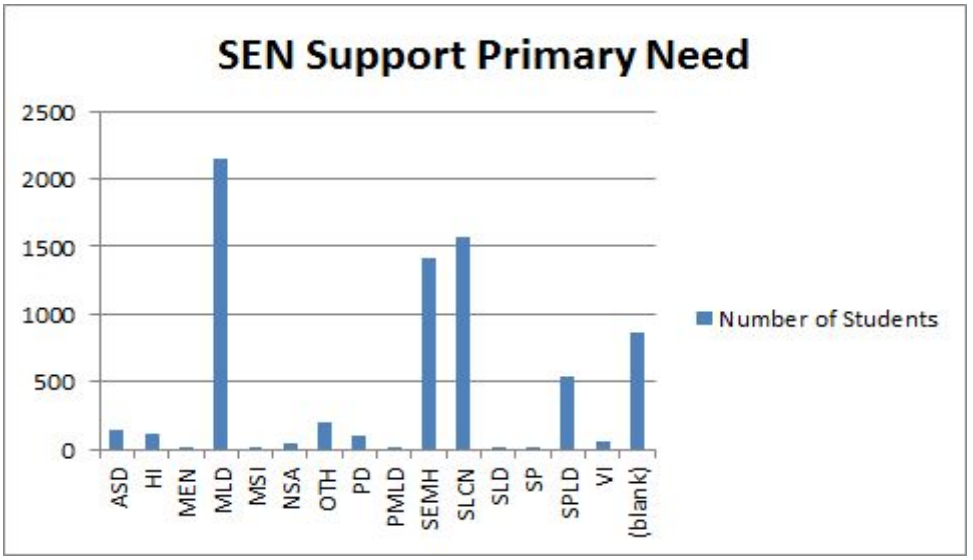
Indicator	Period	Northum'land			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	2015	-	3,809	9.4%*	10.0%*	9.2%*	7.0%		11.0%
Estimated prevalence of emotional disorders: % population aged 5-16	2015	-	1,478	3.7%*	3.9%*	3.6%*	2.8%		4.2%
Estimated prevalence of conduct disorders: % population aged 5-16	2015	-	2,304	5.7%*	6.1%*	5.6%*	4.0%		6.9%
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2015	-	617	1.5%*	1.6%*	1.5%*	1.1%		1.9%
Prevalence of potential eating disorders among young people: estimated number aged 16 - 24	2013	-	3,881	3,881*	-	*	-	-	-
Prevalence of ADHD among young people: estimated number aged 16 - 24	2013	-	4,156	4,156*	-	*	-	-	-
Cause for concern - Looked after children where there is cause for concern: % of looked after children	2015/16	-	65	46.1	40.3	37.6	55.6		20.5
Hospital admissions as a result of self-harm: DSR per 100,000 population aged 10-24	2015/16	-	240	494.8	442.9	430.5	102.5		1,444.7
Hospital admissions as a result of self harm: Crude rates per 100,000 (10-14 yrs)	2015/16	→	32	193.6	258.2*	225.1	38.9		839.3
Hospital admissions as a result of self harm: Crude rates per 100,000 (15-19 yrs)	2015/16	→	114	667.6	654.8*	649.8	157.3		1,899.9
Hospital admissions as a result of self harm: Crude rates per 100,000 (20-24 yrs)	2015/16	→	94	612.5	418.1*	410.3	53.2		1,582.3
Pupils with social, emotional and mental health needs (Primary school age)	2016	-	586	2.93%	2.28%	2.08%	0.97%		4.01%
Pupils with social, emotional and mental health needs (Secondary school age)	2016	-	726	2.85%	2.39%	2.36%	0.92%		5.51%
Pupils with social, emotional and mental health needs (School age)	2016	-	1,457	3.16%	2.65%	2.34%	0.97%		4.63%

19. When we focus specifically on those learners with high levels of need we see the most rapid patterns of growth are in ASD, SEMH and complex needs from birth. This is evidenced particularly in the changing population and increasing demand for places in our specialist schools. Nationally Autistic Spectrum Disorder (ASD) remains the most common primary need for pupils with a statement or EHC plan, (*SEN Data Bulletin, Council for Disabled Children),* however in Northumberland Social, Emotional and Mental Health (SEMH) is the most prevalent - see graphs below.



(Source: Schools Census January 2017)

Graph 3

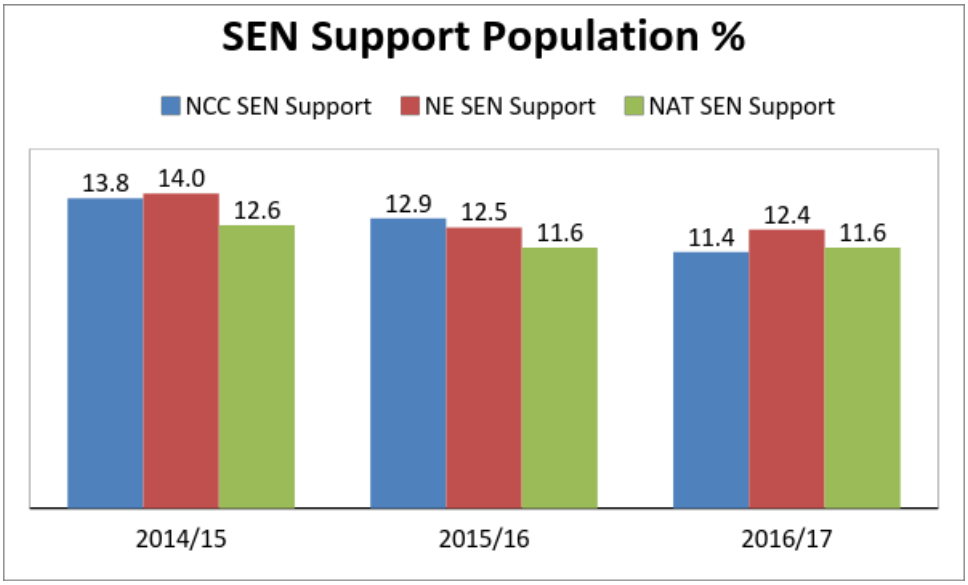


(Source: Schools Census January 2017)

Graph 4

20. The SEN Support population in Northumberland is in line with both the National and North East averages and is steadily reducing by approx. 1% per academic year. *(SEN Data Bulletin, Council for Disabled Children)* This could be attributed to the changes in 2015, when the School Action (SA) and School Action Plus (SA+) categories were combined to form the SEN Support (K) category. This led to schools reviewing the needs of pupils under the School Action and School Action Plus categories. See graphs overleaf.

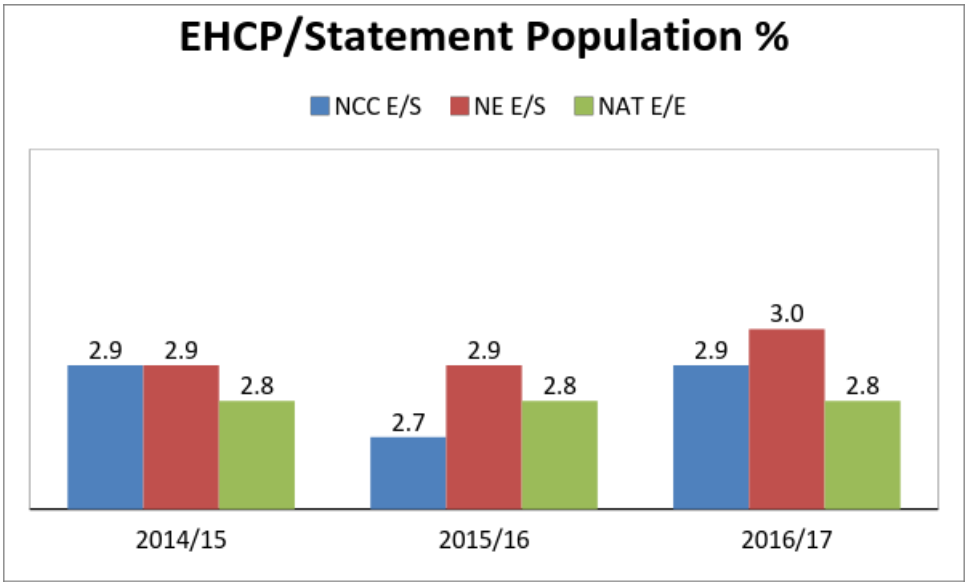
Northumberland SEND Population vs. North East and National



(Source; www.gov.uk/government/statistics/special-educational-needs-in-england-january-2017, SFR37/2017)

Graph 5

21. The percentage of students requiring an Education, Health and Care Plan is increasing, figures in Northumberland, nationally and regionally. Northumberland shows an increase of almost 0.2%.



(Source; www.gov.uk/government/statistics/special-educational-needs-in-england-january-2017, SFR37/2017)

Graph 6

22. What is evident from Northumberland's figures is that over recent years while the number of plans has remained relatively stable, the number of top ups paid to Schools has increased by 22.9% between 2015 and 2017. See tables overleaf:

Northumberland School Age Population – Top-up Funding

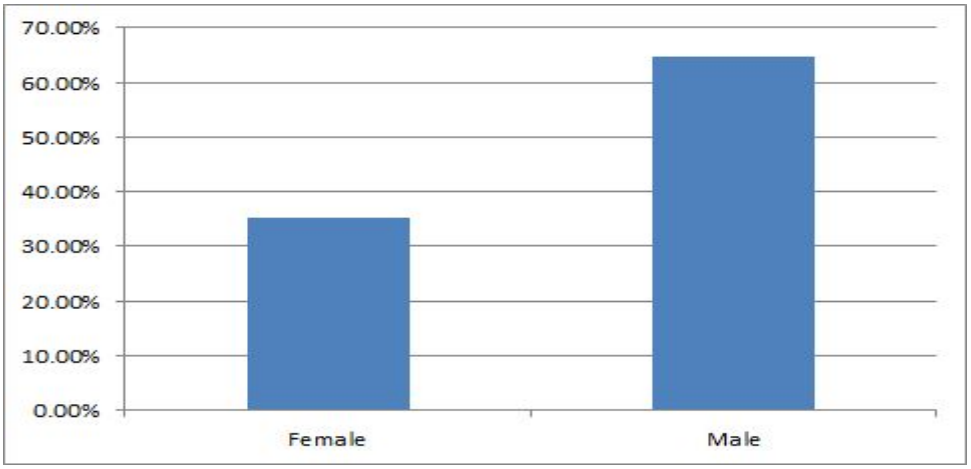
	Jan-14	Jan-15	Jan-16	Jan-17	May-17

No of Plans / Statements	1363	1324	1251	1298	1352
No of Top Ups	1367	1367	1457	1615	1680

Table 5

23. Special Educational Needs in Northumberland as they do nationally, remain more common in boys than girls, with it being identified in almost twice as many boys as girls. Nationally there is a wider gap with 73% of boys and 27% of girls having Special Educational Needs. The gender gap widens considerably for those Special Educational Needs students with a statement or education, health and care plans - see graphs below

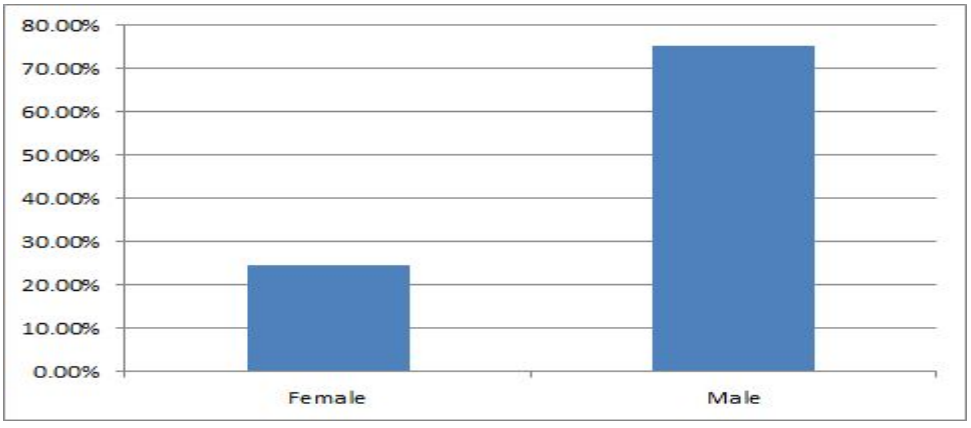
Special Educational Needs – SEND Support Gender



(Data available via NCC EMS June 2017)

Graph 7

Special Educational Needs - Statement/EHCP Gender



(Data available via NCC EMS June 2017)

Graph 8

24. Northumberland's maintained Special Schools pupil numbers show 32 % growth over the last five years. The table below shows the distribution of primary need.

Where Children and young people with SEN or disabilities are educated

The local authority holds detailed infdormaiton on which special schools, or those with specific SEN provision, children are educated, broken down into the primary need categories. The data is not provided in detail here to avoid identification of individuals, but an overview of what it tells us is that there are over 160 with either ASD, SEMH or SLD, with concentrations of ASD in Cleaswell Hill and Collingwod schools, SEMH in Atkinson House, and SLD in Hexham Priory.

3. Use of commissioned placements

The role of a Local Authority Education team is primarily to oversee school performance within the maintained sector and academies. There are however occasions when it is appropriate to commission services from external providers in order to support education delivery. These placements can be located within the County or outside and may be a day placement or a residential placement depending upon the individual needs of the child and the provider offer. Places are commissioned to meet identified need within the child or young person's EHCP. In addition to the operational systems that are in place to monitor individual outcomes a robust contract monitoring process exists to support quality monitoring, evaluation and challenge.

Please note that these figures also include those instances where the organisation is providing both care and education to a looked after child and that child also has an EHCP. The data is not provided in detail here to avoid identification of individuals, but suffice to say that we know which specific provisions are used, the type of support, and by how many children and young people they are used.

4. Numbers of local children and young people with EHC plans and their main needs

25. Number of New Plans and Assessments

Number of Assessments	1103
Number of Refusals	330
Number of Active New Plans	770

Table 6 (Data available via EMS December 2017)

26. The number of young people requiring SEN Support who have another Primary Need and a SEMH Secondary Need has increased by two thirds from 2015 to 2016 before reducing in 2017. The number with those needs who require a statement or an EHCP decreased slightly in 2017.

No of Young People with another Primary Need and SEMH Secondary Need			
	2015	**2016**	**2017**
SEN Support	399	510	359
Statement/EHC Plan	209	209	184

(Data available via NCC EMS June 2017)

Table 7

26. However, the number of those requiring SEN Support with an SEMH Primary Need and another learning difficulty Secondary Need has remained stable.

The number with SEMH needs and another learning difficulty who require a statement or an EHCP has fluctuated over the last 3 years. This variance, particularly in 2015, is subject to further investigation as it may indicate an inconsistent use of the census categories for those learners.

No of Young People with SEMH Primary Need and another learning difficulty Secondary Need			
	2015	**2016**	**2017**
SEN Support	370	382	447
Statement/EHC Plan	238	102	229

(Data available via NCC EMS June 2017)

Table 8

The Northumberland Context in 2016 – Post 16 Learners

27. Post-16 learners are those who are aged 16-18 years and are in 6th form or college years 12 and 13. Many 6th forms and colleges, including 6th forms at SEND specialist schools, offer year 14 too to SEND learners.

28. The LA has details on how many SEND learners with high levels of need were attending schools and post-16 provision in 2015-2016. We include those with an SEN

Statement / EHC plan and those receiving additional High Needs funding with or without a statutory plan. Learners from Year 9 to Year 11 are also been included, to show the significant increase in SEND learners requiring post-16 provision in the next 3 years. The data is not provided in detail here to avoid identification of individuals.

Of the 419 students who receive Top Up funding, the majority were primary age (aged 10 or younger) with 319 (76%) falling into this category. These pupils were generally all supported in mainstream education, though some joint placements between mainstream and special schools are in place. The most prevalent banding is Band 3 (£4,000 per annum), but it should be noted that there were a greater proportion of pupils assessed at Band 4 in this group (50 or (12%) than in the larger cohort with plans (94 or 7%).

The majority of pupils with an EHCP are of secondary age; 837 (66%) of the 1262 students were aged 11 or older at the end of August 2017. While the national picture also reflects the case that there are a higher proportion of secondary (1.6%) than primary (1.3%)age pupils with Plans, the difference between the phases is not as significant as in Northumberland.

The most prevalent banding for those pupils supported in mainstream education is Band 3 (a value of £4,000 top up per annum). In specialist provision the majority of pupils were identified as either Band C or D (£6,750 or £8,250 respectively.

Table 9: Transition to Adulthood **Current Year**	Y9, 13-14 years old	Y10, 14-15 years	Y11, 15 - 16 years	Y12, 16-17 years	Y13, 17 - 18 years	Y14, 18-19 years
No. with Statements / EHC Plans	154	175	156	151	136	90
Of the above, number of learners currently in specialist provision	66	60	73	52	37	9
Number of High Needs funded in mainstream without EHC plan	12	12	14	..	..	..
Total with High Needs funding in mainstream or specialist schools	127	128	112	73	55	20
High Needs and primary need autism (ASD)	23	27	22	14	12	6
High Needs and primary need social / emotional/mental health (SEMH)	33	38	35	13	9	..
High Needs and primary need severe / profound learning difficulty (SLD, PMLD)	21	9	14	17	25	13

High Needs and primary need sensory (visual, hearing, multi sensory) (VI, HI, MSI)	..	..	5	..	..	..
High Needs and primary need speech & language (SLCN)	8	21	7	..	..	..
High Needs and primary need physical (PD)	..	..	..	..	..	..
High Needs and other primary need (specific learning difficulties, moderate learning difficulties) (SPLD, MLD, Other)	32	27	25	20	..	..
	School-age.			Post-16.		Adults in education

(Data available via NCC October 2017 Census)

Special Educational Needs Population by Ward and Category

Given the Geography of Northumberland, the local authority holds maps showing prevalence on a more localised level. The data is not provided in detail here to avoid identification of individuals, but an overview of what it tells us is that the east of the county, particularly the south east has a higher incidence of SEND in line with the population distribution. The incidence decreases towards the west of the county. There are individual pockets of high incidence in Berwick, Alnwick, Morpeth and Hexham. The geography of Northumberland, being a combination of rural and urban areas makes it difficult to ensure specialist provision is available to all those who require it while keeping travel time down to a minimum.

5. Employment rates for young people leaving education

29. The data below shows how many Northumberland post-16 young people with SEND were in Education, Employment or Training (EET) in November 2017. Year groups 12, 13 and 14 are shown.

Table 10: November 2017

	Year Group, Gender						
	12		12 Total	13		13 Total	Grand Total
Activity Type	F	M		F	M		
Total EET	**34**	**106**	**140**	**33**	**107**	**140**	**280**
NEET Available	0	7	7	0	11	11	18
NEET Not Available	0	1	1	1	0	1	2
Total NEET	**0**	**8**	**8**	**1**	**11**	**12**	**20**
Total Unknown	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**34**	**114**	**148**	**34**	**118**	**152**	**300**

30. The number of Northumberland young people whose destination is ‘Not Known’ is very low in comparison with other local authorities. The careers guidance team and other services aim to ensure all SEND learners continue to be known to services and have regular offers of support. However, as a result of reducing the ‘Not Known’ group the number of additional young people who are not in EET (i.e. NEET) has increased.

Gap measurements have changed - where once differences were measured against similar students, the measurement is now between SEN students and all other nationally (i.e. students without SEN). This has resulted in the gap for SEN students rising significantly.

31. Looking at the achievements of all pupils in the Early Years Stage in 2016, 34.6% of children requiring SEN support achieved a good level of development in Northumberland, this declined slightly in 2017 to 33.1% compared to the national average of 81% however, similar students achieved (to be added when available). See table below:

	EYFSP		
	% Acheving a Good Level of		
	2014/15	2015/16	2016/17
All Pupils	64.9	73.4	74.9
No SEN	72.0	80.0	81.3
SEN Support	23.0	35.0	33.1
Statement/EHCP	x	x	0.0
SEN Support Gap			-41.8
Statement/EHCP Gap			-74.9

(x indicates suppressed data. Data for 2016/17 Unvalidated)

Table 11

32. The proportion of pupils accessing SEN support reaching the expected level in the Year 1 phonics check has significantly increased in 2016 (56%). From 49% in 2015, however this fell slightly to 55.5% in 2017. 13.6% of pupils with Education, Health and Care plans/Statements reached the expected standard in the Year 1 phonics check an increase of 10.6% on the previous year. See table below:

	Phonics		
	% Meeting the Expected		
	2014/15	2015/16	2016/17
All Pupils	80.0	84.0	85.0
No SEN	87.0	90.0	91.4
SEN Support	49.0	56.0	53.3
Statement/EHCP	19.0	3.0	13.6
SEN Support Gap	**-31.0**	**-28.0**	**-31.7**
Statement/EHCP Gap	**-61.0**	**-81.0**	**-71.4**

(Data for 2016/17 Unvalidated)

Table 12

33. Key Stage 1 pupils accessing SEN Support who achieved the expected standard in Reading, Writing and Maths remained the same between 2015/16 and 2016/17, however the percentage of pupils with an Education, Health and Care Plan achieving the expected standard fell significantly. As with achieving expected, the percentage of SEN support students achieving greater depth remained similar, those with an Education, Health and Care Plan fell, with the exception of writing which remained the same. See table below:

	KS1											
	% Expected + in Reading TA		% Expected + in Writing TA		% Expected + in Maths TA		% Greater Depth in Reading TA		% Greater Depth in Writing TA		% Greater Depth in Maths TA	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
All Pupils	78	80.5	70.0	73.6	76.0	78.7	29.0	30.6	17.0	20.1	23.0	24.1
No SEN	87	89.0	79.0	82.7	84.0	86.6	34.0	35.2	21.0	23.6	26.0	28.0
SEN Support	40	40.0	29.0	29.0	41.0	41.4	8.0	7.4	3.0	2.6	7.0	4.6
Statement/EHCP	12	0.0	12.0	0.0	14.0	0.0	5.0	0.0	0.0	0.0	5.0	0.0
SEN Support Gap	**-38**	**-40.5**	**-41.0**	**-44.6**	**-35.0**	**-37.3**	**-21.0**	**-23.2**	**-14.0**	**-17.5**	**-16.0**	**-19.5**
Statement/EHCP Gap	**-66**	**-80.5**	**-58.0**	**-73.6**	**-62.0**	**-78.7**	**-24.0**	**-30.6**	**-17.0**	**-20.1**	**-18.0**	**-24.1**

(Data for 2016/17 Unvalidated)

Table 13

34. The proportion of pupils accessing SEN support reaching the expected standard fell for reading, however in reading and combined reading, writing and maths the % improved in 2016/17. However the percentage students with an Education, Health and Care Plan achieving the expected standard fell significantly from 2015/16. See table below:

	KS2							
	% Expected in Reading Test		% Expected + in Writing TA		% Expected in Maths Test		% Expected + in RWM	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
All Pupils	67.0	72.0	80.0	76.9	69.0	72.3	56.0	60.5
No SEN	75.0	79.1	90.0	86.0	76.0	80.4	64.0	68.7
SEN Support	33.0	40.8	37.0	35.4	38.0	36.0	17.0	20.8
Statement/EHCP	22.0	12.0	21.0	7.6	18.0	9.8	13.0	7.6
SEN Support Gap	**-34.0**	**-31.2**	**-43.0**	**-41.5**	**-31.0**	**-36.3**	**-39.0**	**-39.7**
Statement/EHCP Gap	**-45.0**	**-60.0**	**-59.0**	**-69.3**	**-51.0**	**-62.5**	**-43.0**	**-52.9**

(Data for 2016/17 Unvalidated)

Table 14

Changes for performance headline measures changed in 2016/17. The new 1 - 9 grading structure for English and Maths came into effect.

35. The proportion of students accessing SEN support in 2 of the 3 headline measures improved. The percentage of students with an Education, Health and Care Plan improved in all 3 headline measure, significantly narrowing the gap. See table below:

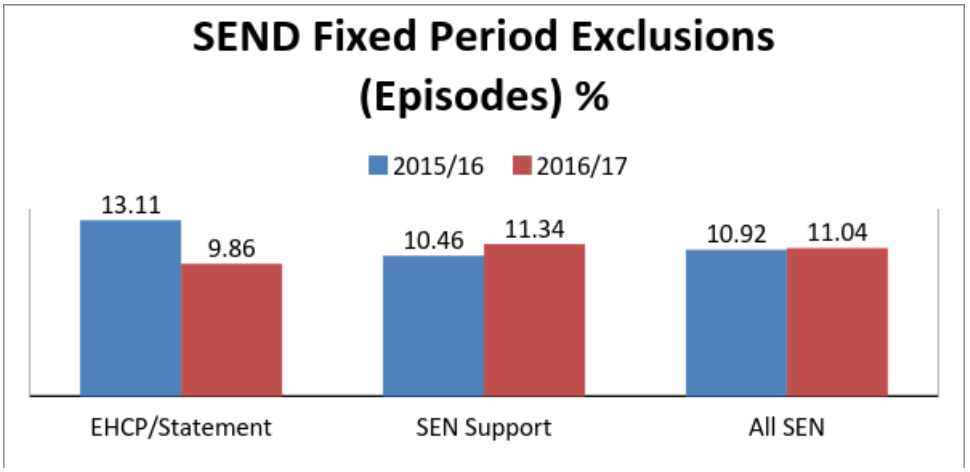
	KS4								
	% Acheving Ebacc (A*-C/4+)			% Acheving A*-C (4+) in English & Maths (Basics)			% Acheving 5+ A*-C (4+) including English & Maths		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
All Pupils	22.0	19.0	16.6	59.0	61.0	57.1	57.0	55.3	51.2
No SEN	25.0	22.0	16.8	68.0	69.0	58.0	65.0	62.6	52.0
SEN Support	4.0	2.0	2.7	22.0	22.0	24.0	19.0	17.2	16.5
Statement/EHCP	2.0	0.0	3.3	10.0	12.0	21.9	9.0	9.9	14.2
SEN Support Gap	**-18.0**	**-17.0**	**-13.9**	**-37.0**	**-39.0**	**-33.1**	**-38.0**	**-38.1**	**-34.7**
Statement/EHCP Gap	**-20.0**	**-19.0**	**-13.3**	**-49.0**	**-49.0**	**-35.2**	**-48.0**	**-45.4**	**-37.0**

(Data for 2016/17 Unvalidated)

Table 15

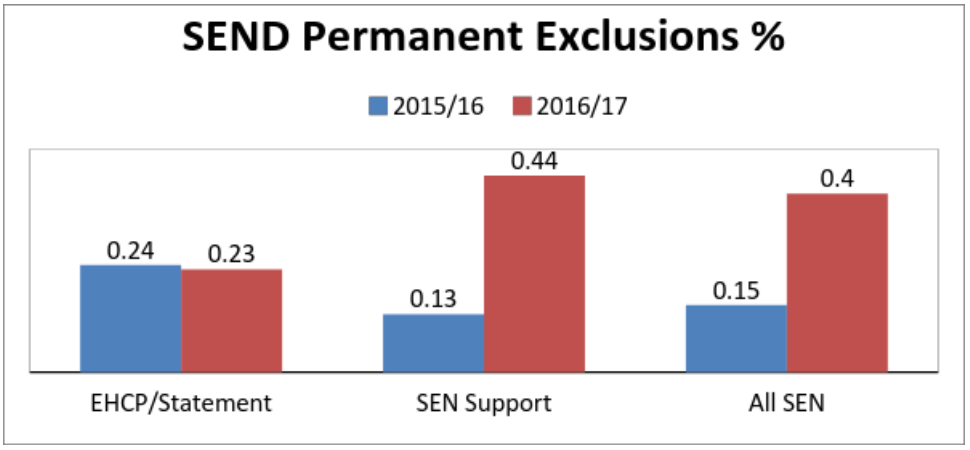
Absence and Exclusions

36. The % of fixed term exclusions for SEND Support and those students with an EHCP or Statement combined has risen from 10.46% in 2016 to 11.87% in 2017, however, those with an EHCP/Statement has fallen.



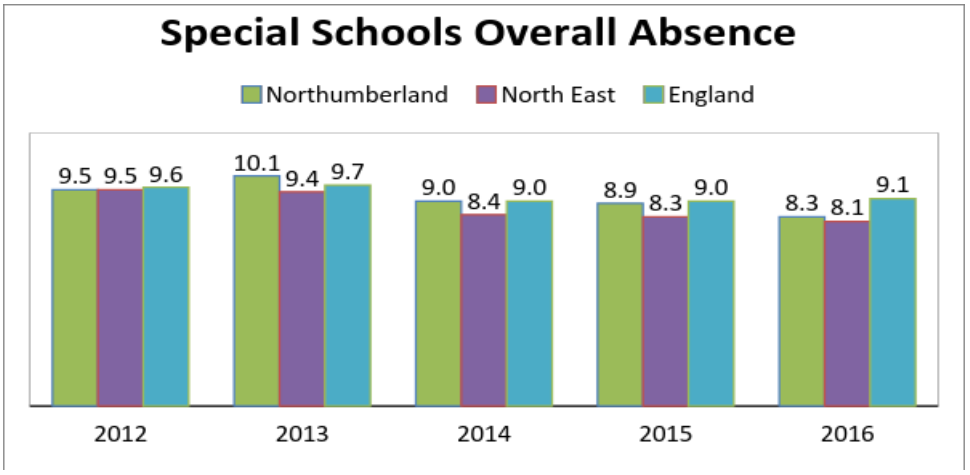
Graph 7 (Data taken from Schools Census 2016/17 - unvalidated)

37. In 2017 0.44% of SEN Support students were permanently excluded, this is an increase from 0.13% in 2016. The percentage of those students accessing SEN Support combined with an EHCP or Statement permanently excluded rose from 0.15% in 2016 to 0.40% in 2017



Graph 8 (Data taken from Schools Census 2016/17- unvalidated)

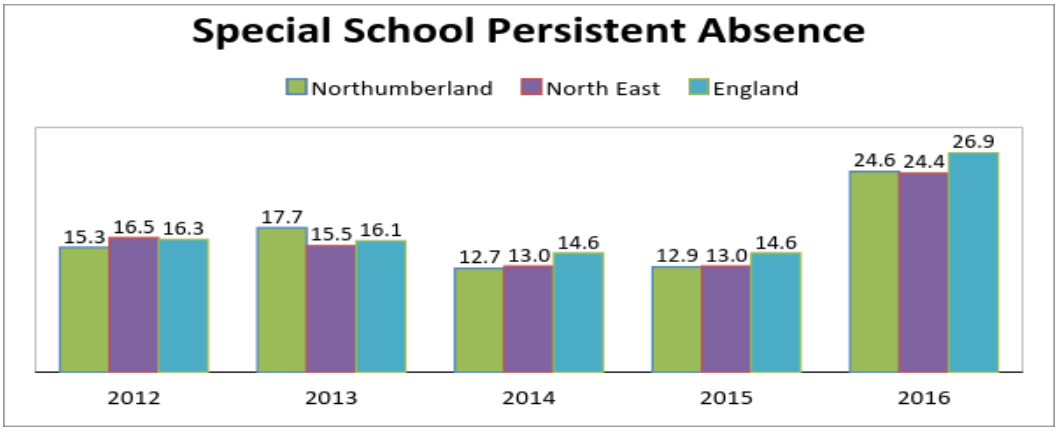
38. Absence in NCC Special Schools has continually fallen and is now below 10% following the overall national trend.



(Data for 2016/17 Unvalidated)

Graph 9

39. Persistent absence in Northumberland Special Schools is in line with the North East average and almost 2% below National.



(Data for 2016/17 Unvalidated)

Graph 10

40. Pupil enrolments in Northumberland with a statement of special educational needs (SEN) and those with an Education Health and Care Plan (EHCP) had an overall absence rate of 7.16% (7.7% NA) compared to those identified with no Special Educational Need.

41. The percentage of pupil enrolments in Northumberland with a statement or an EHC plan that are persistent absentees is at 19.78% (22.6% NA) this is more than three times higher than those with no identified SEN.

42. Due to recent SEN reforms, figures for 2015/16 are not directly comparable to years before 2014/15. The outcomes for those aged 19 qualified to level 2 and level 3 are poorer than the national average except for level 2 for those with an EHCP. However, all measures have shown an improvement between 2014 and 2015.

43. The outcomes for those aged 19 qualified to level 2 and level 3 are poorer than the national average except for level 2 for those with an EHCP. However, all measures have shown an improvement between 2014 and 2015.

7. Local data on disabled children from the register of disabled children in Northumberland (especially those with a vision or hearing impairment)

Current cases open to Disabled Children Team	Number of Cases
Active and Allocated Cases	282
Transition Cases	35

Table 16

Referrals have remained much the same for a number of years. The only difference is that the needs are more becoming more complex, so we potential have more children referred at a younger age. Especially for children with life limiting conditions.

Disabled Childrens Team Transition	Number of Cases
1/4/2017 to 31/3/2018	21
1/4/18 to 31/3/2019 35	35

Table 17

The above numbers include DCT 18-25 Pilot, West team. This figure will always be fluid as it is difficult to predicate how many families will request an assessment of need and at what age. There are 5 cases that will remain within the 0-25 pilot until it is appropriate to transition them into adult services. As the current caseloads stand this figure will not change in 2018/19. Based on the current ages of cases currently allocated in the West the figure for 2019/20 would be an additional five. However, it would difficult to predicate true number as some of the original five may have moved on to an Adult care manager 1 if they are settled into the next stage of their adult life

Direct Payments	Number of Cases
Children's Direct payments: 0-18	
Agency Support	35
Employing	116

Table 18

This is consistent in that parents choose to employ in most cases as they are then choosing exactly who comes into their homes ..and they can build up a trusting relationship with those people whereas with an agency, they are at the mercy of the agency's rotas.

Those parents who employ their own workers receive a high level of support to do so via the DP officer who helps with recruitment, DBS checks, contracts of employment and employers liability insurance. The parents also have their payroll, tax, and NI obligations performed by a payroll company and this is paid for via the DP so that the responsibilities of being an employer do not become onerous on top of caring for a disabled child.

A higher proportion of parents may employ due to the fact that there are not a lot of agencies out there who provide support specifically for children or in their particular geographical area.

Clients aged 18-25 in receipt of a Direct Payment

Client Category	LA-funded	NHS-funded	Joint-funded
LD Client	103	24	..
MH Client	15		
PDI Client	18	..	..
Total	**136**	**28**	**5**

Table 19

Children's Dynamic Risk Register	Number of Cases
DCT cases on register	..
Known to other locality teams	10

Table 20

Number varies over time, depending on challenging risks present by DCYP towards their parents. Any young person that goes into Ferndene for assessment is automatically referred to the Dynamic Risk register.

DCT Looked after Children	Number of Cases
9 - 17 yr Old LAC	10

Table 21

The number LAC-DCYP has remained around this figure for a number of years. We would not anticipate that this would change greatly.

This figure may increase once other LAC young people become 16, the next one will be 2019.

DCT Dols case work (deprivation of Liberty)	7

Table 22

A recent change has been made to which DCYP require a Deprivation of Liberty (DOL) assessment whereby if parents are deemed to have the child's best interests regards their management of a situation a full DOL assessment is no longer required.

Sensory Support Service	**Number of Cases**
Known to Service	432
Hearing Impairment	250
Visual Impairment	170
Multi Sensory Impairment	12
Open to Social Care	37
Open to DCT	23
Hearing Impairment	9
Visual Impairment	..
Multi Sensory Impairment	..

Table 23

This figure may change over time as other children are born or acquire a sensory loss. Not all children with a sensory loss require the support of a social worker.

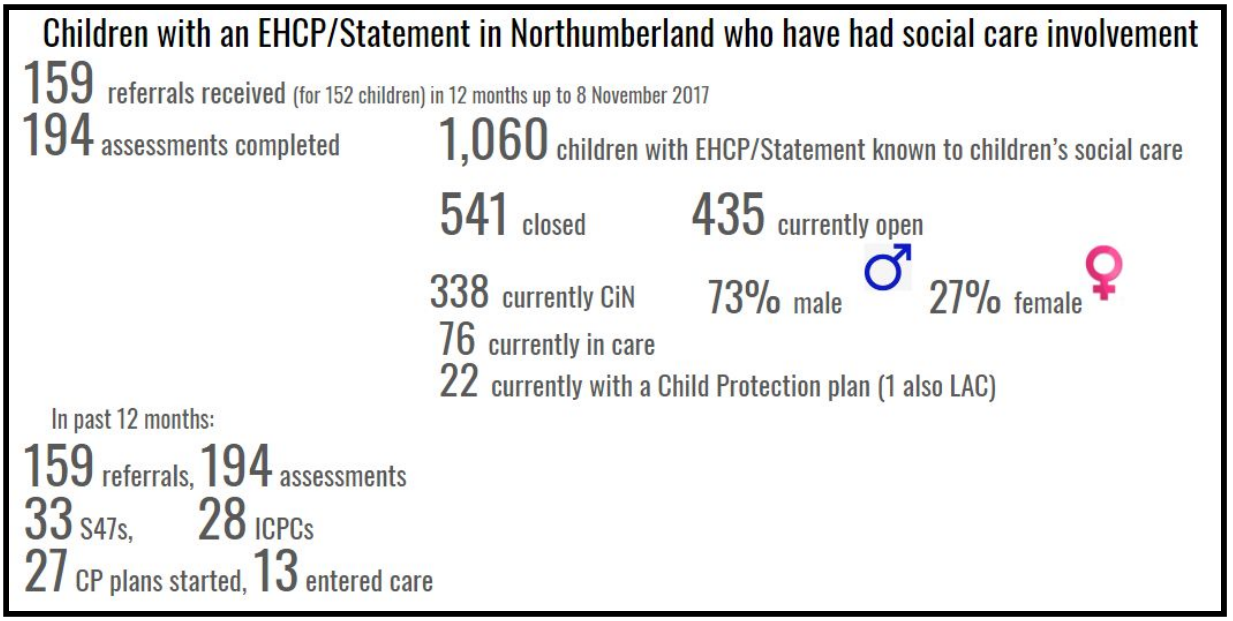
Within the Complex housing needs process, young people can be on the register up to the age of 25. The total for children's service including Disabled Children's Team is 28.

DCT Overnight respite - Referrals for overnight support are expected to remain within the current range of on average 60. This includes overnight support into the home, Residential & the specialist provision of St Oswald's. The total for general short breaks is 271 and for overnights it is approximately 60. Some children will have overnights and other short break support such as holiday activity schemes.

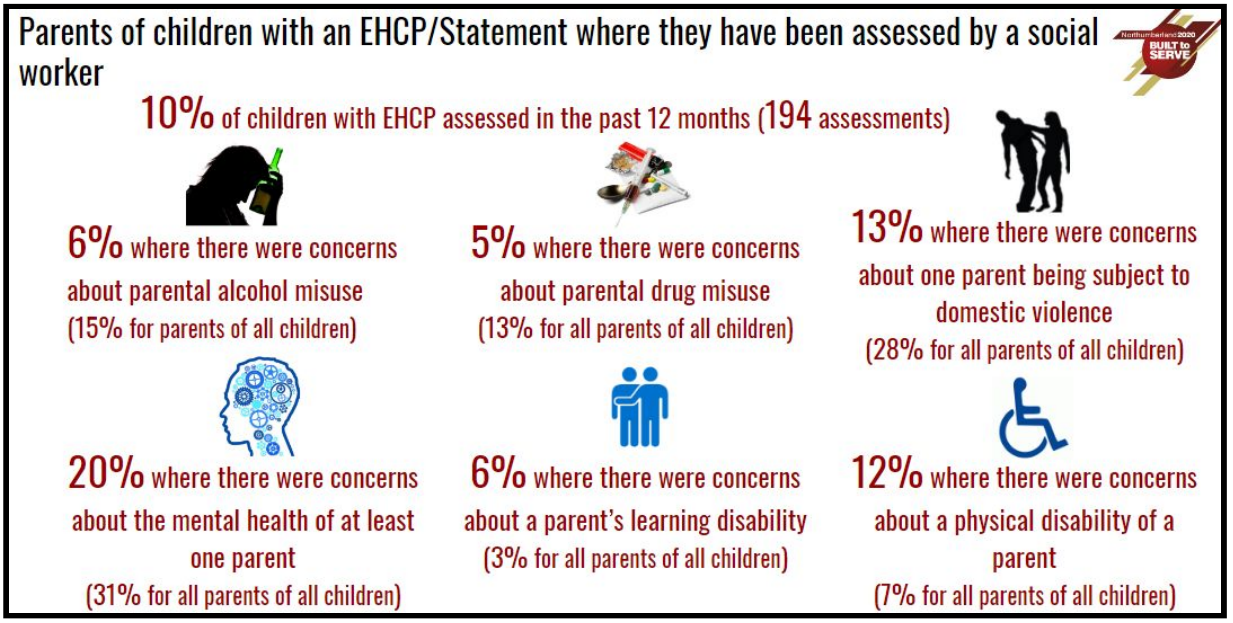
Potential college/special school leavers for yr 2018 - the number of young people identified as moving on from special school and or special further education college in 2018 totals 35.

8. Analysis of key performance indicators that are shared across health, education and social care

Childrens Social Care - EHCP/Statement Students



Slide 1



Slide 2

Children with an EHCP/Statement where they have been assessed by a social worker

10% of children with EHCP/Statement assessed in the past 12 months (**194** assessments)

3% where there were concerns about a child's alcohol misuse (4% for all children assessed)

6% where there were concerns about a child's drug misuse (4% for all children assessed)

4% where there were concerns about a child being subject to domestic violence (10% for all children assessed)

34% where there were concerns about the mental health of a child (19% for all children assessed)

55% where there were concerns about a child's learning disability (9% for all children assessed)

17% where there were concerns about a physical disability of a child (4% for all children assessed)

Slide 3

Children with an EHCP/Statement where they have been assessed by a social worker

10% of children with EHCP/Statement assessed in the past 12 months (**194** assessments)

5% concerns about a child's health or development being impaired due to them being a young carer (3% for all children assessed)

0.5% where services may be required or the child may be at risk as a privately fostered child (0.2% for all children assessed)

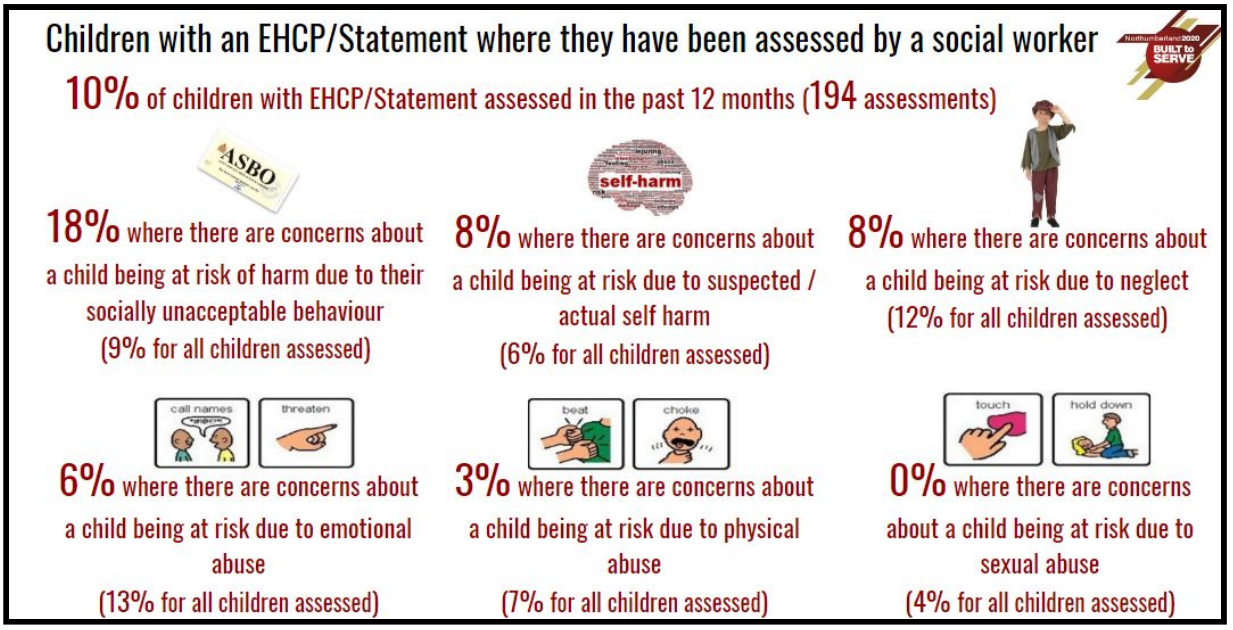
3% where services may be required or the child may be at risk due to going / being missing (3% for all children assessed)

2% where services may be required or the child may be at risk due to child sexual exploitation (3% for all children assessed)

0% where services may be required or the child may be at risk due to trafficking (0.2% for all children assessed)

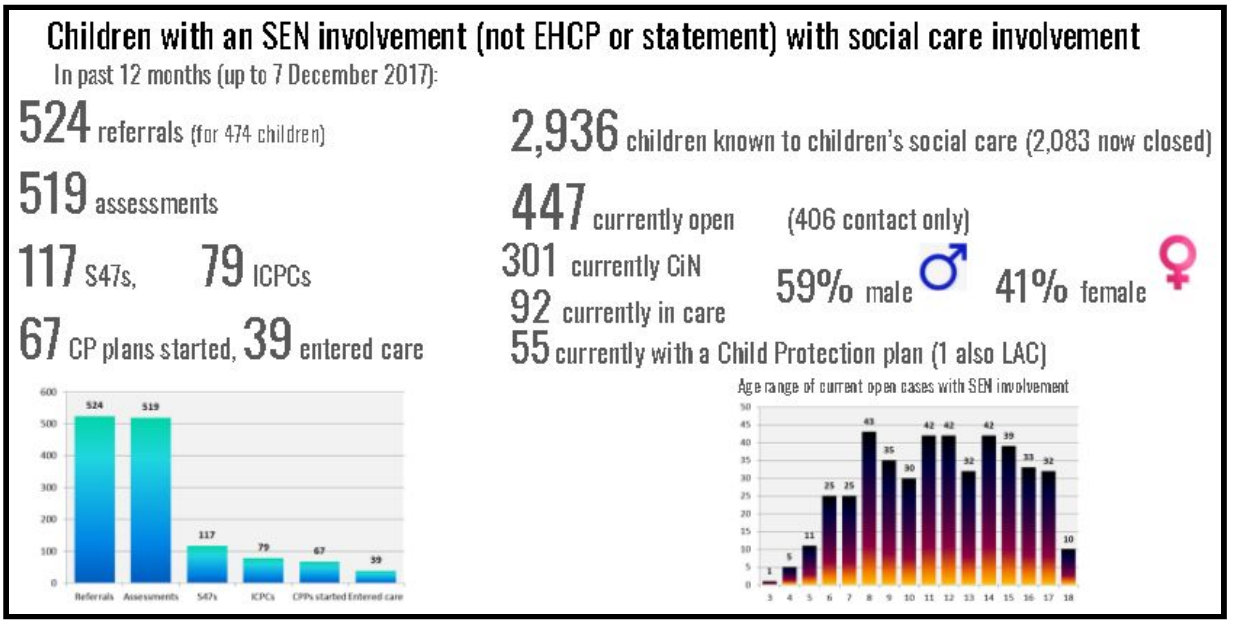
0% where services may be required or the child may be at risk due to involvement with gangs (0.2% for all children assessed)

Slide 4

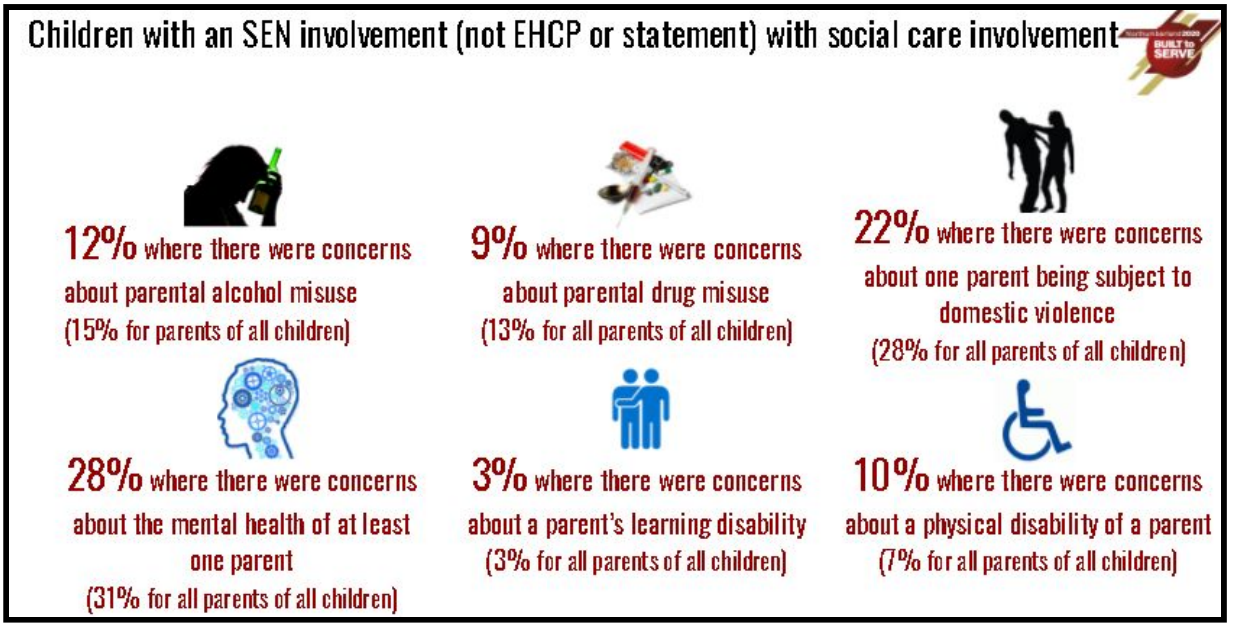


Slide 5

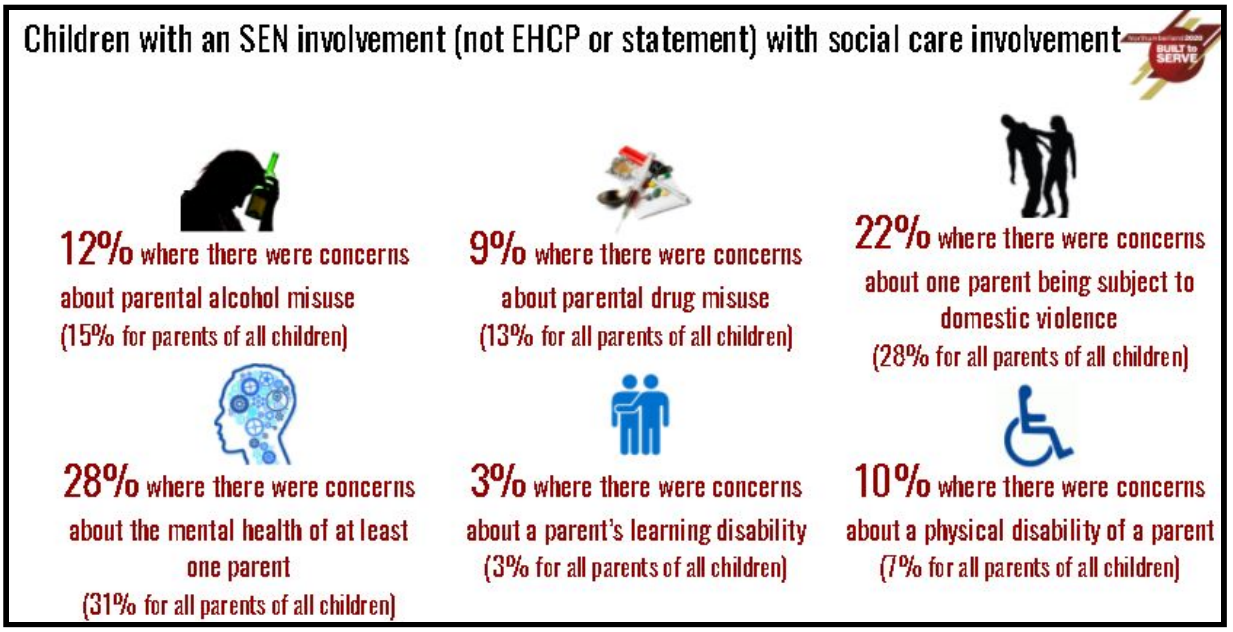
Childrens Social Care - SEN Support



Slide 6



Slide 7



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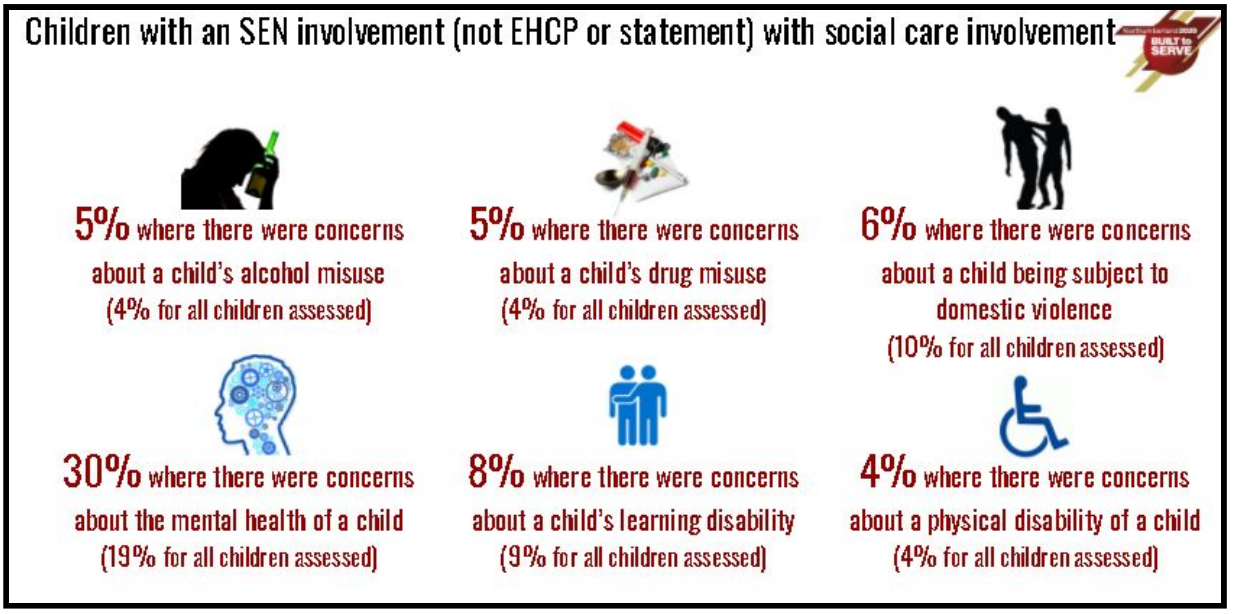

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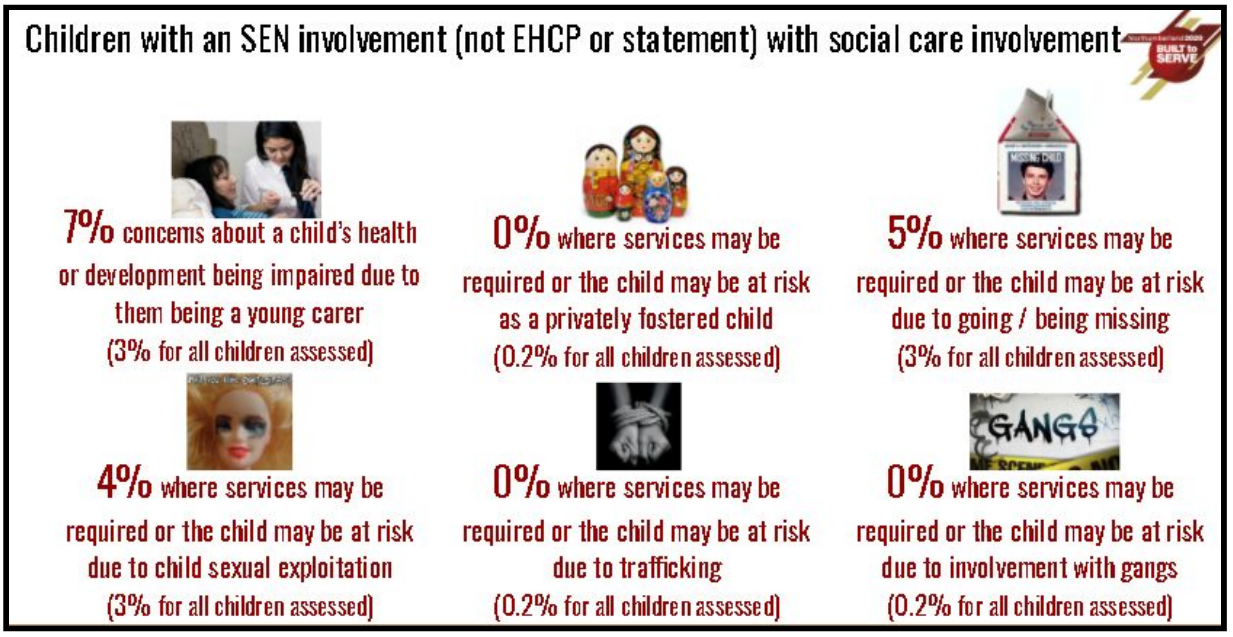
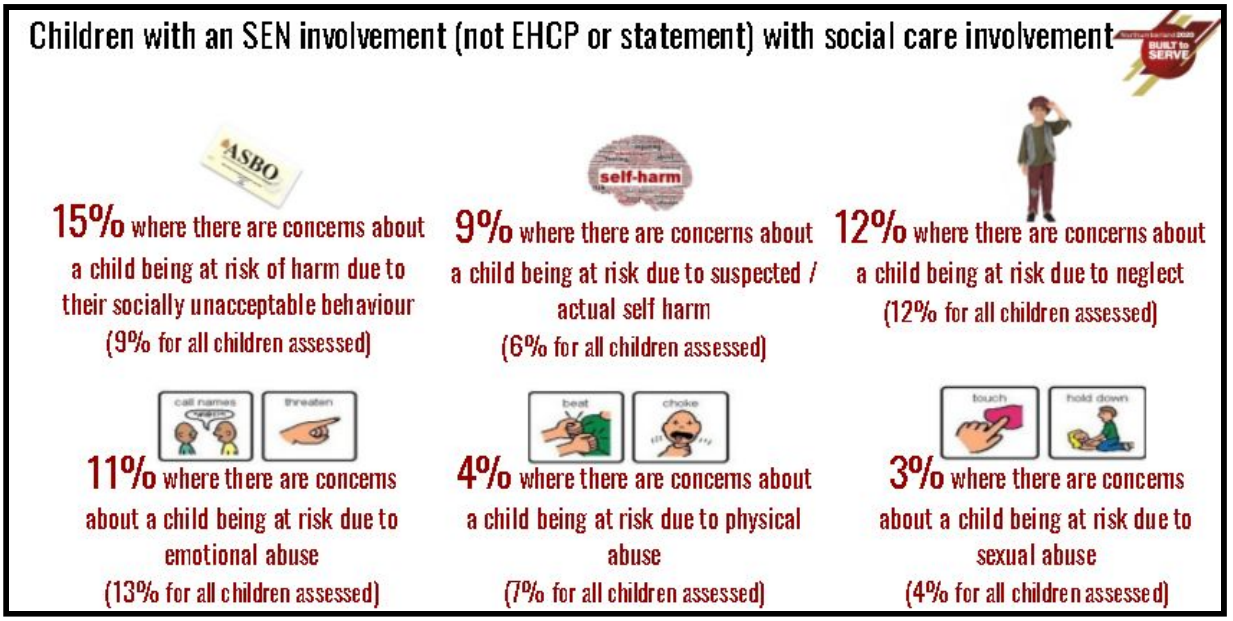


Slide 10



Slide 11

44. How the needs of these children and young people are met compared to all those on the social work caseload is monitored in a dashboard. Outcomes on the improvement indicators are better on 8 and equal on 5 of the 17 indicators (October 2017). Key messages are that those with SEN and subject to child protection investigations and plans are visited by their social workers frequently and have their investigations concluded in a timely way. The LA is developing a report that links data on its ICS and EMS systems so that social workers receive prompt notification when a SEN client of theirs has an EHCP, and thereby they can incorporate those needs into their work those children and their families.

45. **Anti-natal health visits.** Health promotional interview and includes preparation for parenthood on a one to one basis. Provides access to parenting and child health information and guidance (telephone helplines, websites, NHS Direct, etc.) and information on Sure Start Children's Centres and Family Information Services. Advice on smoking cessation and generic advice for a healthy birth

46. **New born/birth visits within 14 days (mother and baby assessment).** Public health promotion of infant feeding, sensitive parenting, assessment of maternal mental health, advice on keeping safe including Sudden Infant Death Syndrome (SIDS) prevention including promoting safe sleep, contraceptive advice and where appropriate support to access services. Also includes an assessment of baby's growth and health, promotion of secure attachment, and assessment of safeguarding concerns. Smoking cessation advice and support.

47. **A 6-8 week checks (both mother and baby).** On-going support with breastfeeding involving both parents, and assessment of maternal mental health according to NICE guidance, additional information on oral health, dietary advice and child safety in the home and in cars. Temperament-based anticipatory guidance (practical guidance on managing crying and healthy sleep practices, promoting development through encouragement to use books, music and interactive activities to promote parent–baby relationship (e.g. media-based materials such as Bookstart). Also HCPs are alerted to risk factors and signs and symptoms of child or domestic abuse and follow local safeguarding procedures where there is cause for concern.

48. **12 month Health review.** Assessment of the baby's physical, emotional and social development and needs in the context of their family using evidence based tools, for example, Ages and Stages 3 (ASQ) and Social and Emotional (SE) questionnaires. Provide parents with information about attachment and developmental and parenting issues, monitor growth, offer health promotion, raise awareness of dental health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice), healthy eating, injury and accident prevention relating to mobility, car and sun safety, check newborn blood spot status and arrange for urgent offer of screening if child is under 1 year and adherence to vaccination schedule and final serology results for babies born to women who are Hepatitis B positive; status of MMR vaccination for women non-immune to Rubella

49. **12 month check by 15 months.** Review with parents the child's social, emotional, behavioural and language development using ASQ 3 and SE. Respond to any parental concerns about physical health, growth, development, hearing and vision, offer parents guidance on behaviour management and opportunity to share concerns if worried about their child. Promote language development, encourage and support to take up early years education, give health information and guidance, review immunisation status, offer advice on nutrition and physical activity for the family, support positive dental health and promote SSCC campaigns. Additional advice to raise awareness of accident prevention, sleep management, toilet training and sources of parenting advice and family information and promote SSCC campaigns and promote and facilitate access to age appropriate immunisations.

This review should be integrated with the Early Years Foundation Stage two year old summary from 2015 as appropriate to the needs of children and families. This is also a crucial stage in supporting the Special Educational Need (SEN) agenda and should link to robust pathways of early referrals to specialised services for advice and assessment.

The 3-4 month and 15 month reviews are not mandated touch points so we do not routinely request data for those and the ASQ tool is now fully embedded into the monitoring so we no longer request data on that either.

Healthy Child Programme	Q1	Q2	Q3	Q4
Ante-Natal Health Promoting Visits**	654	728	699	657
Birth Receiving a Face to Face Visit Within 14 Days**	87%	87%	88%	90%
6 - 8 week Health Review	89%	91%	96%	98%
12 Month Health Visitor Assessment	74%	75%	79%	77%
12 Month Check by 15 Months	93%	94%	95%	94%
2 - 2.5 Year Health Visitor Check**	91%	86%	92%	91%
2 - 2.5 Year Health Visitor Check Completed Using ASQ** (Ages and Stage Questionnaire)	94%	94%	94%	95%

Table 24

50. SEND SUPPORT SERVICES ACTIVITY AND PERFORMANCE FRAMEWORKS - SEND Communication Support

Service	SEND Communication Support			
	2016 / 17			
Measure	Qtr 1	Qtr 2	Qtr 3	Qtr 4
		Winter term	Spring term	Summer term
Number of referrals *		325	140	107
Number of cases closed		41	78	327

Table 25

A higher number of referrals in the Autumn arose due to the need to maximise the cascading benefit for children and young people across the school year through earlier intervention. Referral numbers do not capture service delivery information. Last year, the Speech and Language element of the SEND Communication Support had around 4000 contacts (ie direct interactions face to face with child and/or parent), of which over 2000 were in the Early Years. A continuum of support is offered including the use of specialist teaching assistants who can deliver speech and language interventions directly. Cases closed in the summer term are also high, reflecting the transition of some SEND services to requiring a Service Level Agreement from September 2017. Last year, around 650-700 staff benefited from direct training sessions. EHCP input

is not routinely sought but does occur on occasion.Schools have been encouraged to use specialist assessment information to support an application for a Plan but the direct involvement of this Service, whilst likely to be useful, is not part of the statutory process.

51. **SEND SUPPORT SERVICES ACTIVITY AND PERFORMANCE FRAMEWORKS - SEND Autism Support**

Service	*Autism Support Service*		
	2016 / 17		
Measure	**Autumn Term**	**Spring Term**	**Summer Term**
Number of cases worked	130	73	56
Number of referrals	136	72	52
Number of cases closed	28	61	170
Number of requests for input into EHCPs	0	0	0
Of these, number responded to within timescale	N/A	N/A	N/A

Table 26

52. The Autism Support Service provides support predominantly into mainstream schools across Northumberland. During the academic school year 2016-17 the service received 260 new requests for support from schools. Of the 260 requests for support received 252 cases were accepted by the service and input provided by a Specialist Teacher. 8 requests were not accepted by the service for a variety of reasons such as no evidence of a graduated response, not being an appropriate request for the team or due to the request not having parental consent.7 cases were carried forward from the previous academic school year 2015-16. The number of cases closed during 2016-17 was 259. All open cases were closed at the end of July 2017 due to the changes to service funding and the introduction of service level agreements from 1st September 2017. The service received no requests for input as part of the EHC statutory assessment process although reports from this service are submitted as part of the application process by schools.

53. **SEND SUPPORT SERVICES ACTIVITY AND PERFORMANCE FRAMEWORKS - SEND Behaviour Support**

Service	*Behaviour Support Service*		
	2016 / 17		
Measure	**Autumn Term**	**Spring Term**	**Summer Term**
Number of cases worked	158	69	58
Number of referrals	175	78	47
Number of cases closed	39	64	182
Number of requests for input into EHCPs	0	0	0
Of these, number responded to within timescale	N/A	N/A	N/A

Table 27

54. The Behaviour Support Service provides support predominantly into mainstream schools across Northumberland. During the academic school year 2016-17 the service received 300 new requests for support from schools. Of the 300 requests for support received 285 cases were accepted by the service and input provided by a Specialist Teacher. 15 requests were not accepted by the service for a variety of reasons such as no evidence of a graduated response, not being an appropriate request for the team, the child moved out of the area or due to the request not having parental consent. The number of cases closed during 2016-17 was 285. All open cases were closed at the end of July 2017 due to the changes to service funding and the introduction of service level agreements from 1st September 2017. The service received no requests for input as part of the EHC statutory assessment process although reports from this service are routinely submitted as part of the EHCP/Top Up application process by schools

55. **SEND SUPPORT SERVICES ACTIVITY AND PERFORMANCE FRAMEWORKS - SEND Sensory Support**

Service	***Sensory Support Service***			
	2016 / 17			
Measure	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**
		Winter term	**Spring term**	**Summer term**
Number of cases worked		412	433	444
Number of referrals		30	30	20
Number of cases closed		0	0	*25
Number of requests for input into EHCPs		4	5	2
Of these, number responded to within timescale		4	5	2
Number of requests for input into Transfers		8	11	16
Of these, number responded to within timescale		8	11	16
*School/College leavers plus some moving away from the area				

Table 28

56. The variation in cases worked from term to term reflects new referrals that come in through the year, some of whom move onto the active caseload. The cases closed are all in the summer term as they are the school leavers who leave active caseload. Where young people become 'active' they generally do not close until they leave school, although the level of intervention and support may change over time. A number of requests for advice relating to EHCP assessments were received from the SEND team and all were responded to within the correct timescale.

57. **SEND SUPPORT SERVICES ACTIVITY AND PERFORMANCE FRAMEWORKS - SEND Psychological Services**

Service	*Psychological Services*			
	2016 / 17			
Measure	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**
		Winter term	**Spring term**	**Summer term**
Number of cases worked		356	200	141
Number of referrals		356	200	141
Number of cases closed		92	76	333
Number of requests for input into EHCPs		82	61	133
Of these, number responded to within timescale		78	59	132
Number of requests for input into Transfers		inc in figures above		
Of these, number responded to within timescale				

Table 29

58. In the 2016/2017 academic year Psychological Services worked with 697 individuals, alongside delivering training and development work with schools, children's homes and the Virtual School. The majority of involvements were opened and closed within the academic year. The high closure rate in the Summer Term reflects involvements with ongoing review of young people's progress and closure when no further support has been required by the end of the academic year.

59. There were 276 requests to provide statutory advice for Education Health and Care Assessments.This included advices for transfer reviews. Despite a great increase in requests for statutory advice compared to the previous academic year, the proportion of advice submitted within statutory timescales remained high (97%). An evaluation conducted in the Summer term highlighted high parental satisfaction with the quality of advice written.

60. **SEND Portage**

SEND SUPPORT SERVICES ACTIVITY AND PERFORMANCE FRAMEWORK

Service	*Portage*			
	2016 / 17			
Measure	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**
		Winter term	**Spring term**	**Summer term**
Number of cases worked		95	109	122
Number of referrals		43	39	35
Number of cases closed		27	31	29
Number of requests for input into EHCPs		2	5	14
Of these, number responded to within timescale				
Number of requests for input into Transfers				
Of these, number responded to within timescale				

Table 30

CYPS (aka CAMHS) WAITING TIMES

As of 6th November 2017, the service currently has a waiting list of 412 young people. 75% (308 cases) of these have been waiting less than 18 weeks – however, the remaining 25% (104 cases) have been waiting for more than 18 weeks. The service has an action plan in place and is working with the CCG to look at how collectively we can further reduce waiting times. The service continues to see those in most urgent need within 72 hours and those with an eating disorder within the national access standards (1 week for urgent and 4 weeks for routine).

The service will work with a young person and their family and will inform those where consent has been given to do so. Usually information is shared following assessment on the outcome of the assessment and to share the treatment plan, periodically during treatment and then on discharge. If the care is complex then more regular updates may be provided such as a change in medication. A summary is sent on discharge.

All waits are waits to treatment and not to first appointment therefore many young people appearing on the “waiting list” will have already been in contact with the service and may well have had a number of appointments for assessment. There are no internal waits so once young people have started treatment this will continue until discharge from the service. If a young person moves from one pathway to another e.g. from ADHD to ASD for assessment there may be an initial wait for the new assessment to commence, however, contact will continue with the original clinician and treatment will be ongoing in the interim. Waiting times are reviewed weekly at an organisational level and daily at team level.

The following extract is from NTW’s Q2 2017 report:

There were 6 cases missed. The team have reviewed the cases that were not seen in the specified timeframe. In 4 cases the family requested a later date for the appointment. In one case the team were unable to make contact despite numerous efforts to do so and had to contact the family by letter in the end. One case was seen in time but there was a data error in recording the appointment outcome.

9. Analysis of local challenges and sources of health inequalities – eg. Level of economic deprivation

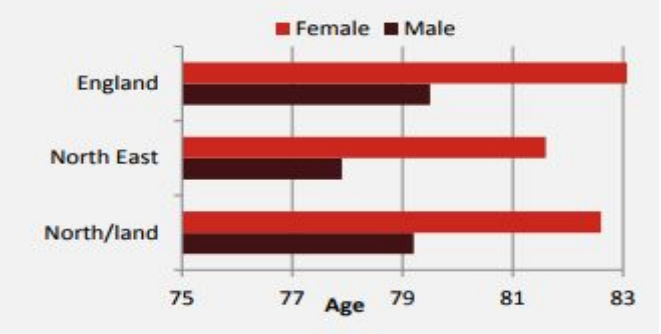
61. Health inequalities are avoidable differences in health status or determinants between population groups. Reducing health inequalities requires a universal approach.To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.' (Marmot, 2010)

Reducing inequalities will have a wider impact than just those who have poorer health or social circumstances. For instance, addressing issues around substance misuse, mental illness and violence will have a beneficial effect on families, friends, communities and society in general. Although some interventions improve health benefits for the whole population without actually reducing the differences between those in different social groups some, such as fluoridation, provide the most benefit for those with the greatest need, in this case, those with the highest rates of tooth decay.

Health inequalities are not usually the result of a single factor but rather a complex matrix of lifestyle choices, personal history and circumstances, and access to services.
Inequalities begin before birth, can adversely impact health throughout adult life, and can persist across generations. Inequalities can impact on pregnancy, including maternal and perinatal death.

13.2% of the population live in one of the 10% most deprived areas of England compared to 16.98% in the North East and 9.9% across England (2015). 20.8% of the population are classed as income deprived and 25.4% are employment deprived. (2015 IMD)

Life expectancy is 9.6 years lower for men and 7.2 years lower for women in the most deprived areas of Northumberland than in the least deprived areas.For Northumberland in 2013/15, the life expectancy at birth for males was 79.2 years which is the highest of 12 Upper tier local authorities in North East. The life expectancy at birth for females is 82.6 years. There is no significant difference in life expectancy at birth for males in Northumberland and in England. The life expectancy at birth for females in Northumberland (82.6 years) is greater than that for North East (81.6 years), but lower than that of England (83.2).



Source: North East Public Health Observatory

10. Groups who have additional vulnerabilities

62. There has been a significant increase in pupils requiring SEN Support who are eligible for Free School Meals (FSM). The current data is:

	Number of those learners with SEND in September 2016	Those at SEN Support level of need	Those at SEN Statement / EHC Plan level of need
SEND and FSM	1913	1528	385

Table 31

63. Children of Service Personnel are considered a vulnerable group as they need to move schools more often than other children

	Number of those learners with SEND in September 2016	Those at SEN Support level of need	Those at SEN Statement / EHC Plan level of need
Children of Service Personnel	45	39	6

Table 32

64. Many of the school-age children listed above are also entitled to Pupil Premium payments. This includes Looked after Children, those eligible for Free School Meals and Children of Service Personnel.

We also monitor the number of those young people who are known to youth offending services

Category of vulnerable learner	Number of those learners with SEND in September 2016	Those at SEN Support level of need	Those at SEN Statement / EHC Plan level of need
Young Offenders – active cases	73	53	20

Table 33

11. Next Steps

- Recommendations for Commissioners - 31.1.18
- Data and intelligence review - 31.7.18