Children with Disabilities and/or Special Educational Needs

A Needs Assessment for Nottinghamshire

September 2012

"I am very grateful for the respite and play services my son receives and would feel far less anxious if I could be assured that planners were assessing needs for the growing population……..coming through the system and that provision, recruitment and training of staff should be happening now to meet their needs once they reach adulthood."

Local parent

Developed by the Nottinghamshire Joint Commissioning Group for Children with Disabilities and/or Special Educational Needs

Contributors

Ann Berry	Public Health, NHS Nottinghamshire County
David Pearce	Public Health, NHS Nottinghamshire County
Denis McCarthy	Nottinghamshire Futures
Edwina Cosgrove	Parent Partnership
Fran Arnold	Children’s Social Care, Nottinghamshire County Council
Geoff Hamilton	Policy & Planning, Nottinghamshire County Council
Helen Crowder	SEND Service, Nottinghamshire County Council
Irene Kakoullis	Health Partnerships, Nottinghamshire County Council
Kirti Shah	Policy & Planning, Nottinghamshire County Council
Liz Marshall	Early Years & Early Intervention, Nottinghamshire County Council
Louise Benson	Nottinghamshire Futures
Michelle Crunkhorn	Business & Administration, Nottinghamshire County Council
Richard Fisher	SEND Service, Nottinghamshire County Council
Sally Moorcroft	NAVO
Sarah Everest	Public Health, NHS Nottinghamshire County
Scott Smith	SEND Service, Nottinghamshire County Council
Simon Bernacki	Disability Nottinghamshire
Sue Bold	Data Management, Nottinghamshire County Council
Sue Gill	NHS Bassetlaw
Tom Moffat	14-19 Strategy, Nottinghamshire County Council
Tracie Dodd	Early Years & Early Intervention, Nottinghamshire County Council
William Hurst	Statistical Review, Nottinghamshire County Council

Glossary of Terms

ACT	Association For Children's Palliative Care
ADHD	Attention Deficit & Hyperactivity Disorder
AfA	Achievement for All
AHDC	Aiming High for Disabled Children
APTCOO	A Place to Call Our Own
ASD	Autistic Spectrum Disorders
BESD	Behaviour, Emotional and Social Difficulties
BME	Black & Minority Ethnic
BWH	Bluebell Wood Hospice
C/C	Continuing Care
C4F	C.A.R.I.N 4 Families
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CC	Children Centre
CCA	Continuing Care Assessment
CCN	Children's Community Nursing
CCNu	Continuing Care Nurse
CDC	Children's Development Centre
CDR	Children's Development Review
ChiMat	Child & Maternal Health Observatory
CHN	Complex Healthcare Needs
CHP	County Health Partnership
CWDC	Children's Workforce Development Council
CYP	Children and Young People
DBH	Doncaster and Bassetlaw Hospital Trust
DCATCH	Disabled Children's Access to Childcare
DCSF	Department for Children, Schools and Families
DDA	Disability Discrimination Act
DEA	Disability Employment Advisors
DfE	Department for Education
DfES	Department for Education and Skills
DH	Department of Health
DLA	Disability Living Allowance
ECM	Every Child Matters
EDCM	Every Disabled Child Matters
EET	Education, Training, Employment
EMPHO	East Midlands Public Health Observatory
EoL	End of Life
FE	Further Education
FIS	Family Information Service
FL	Foundation Learning
FSM	Free School Meals
GCSE	General Certificate of Education
HE	Higher Education
HfH	Home from Home
HV	Health Visitor
IAG	Information Advice and Guidance
ICES	Integrated Community Equipment Store
ISC	Independent Specialist College
ISP	Independent Specialist Provider
JAT	Joint Access Team
LA	Local Authority
LAC	Looked After Children

LC	Leisure Centre
LDD	Learning Difficulties and/or Disabilities
LLDD	Learners with learning difficulties and or disabilities
LLTI	Long Term Limiting Illness
LOS	Life Opportunity Survey
MH	Mental Health
NCC	Nottinghamshire County Council
NEET	Not in Education, Training or Employment
NHS	National Health Service
NHS B	NHS Bassetlaw
NHS NC	NHS Nottinghamshire County
NICE	National Institute for Health & Clinical Excellence
NLC	Nottinghamshire Learning Centre
NSF	National Service Framework
NUH	Nottingham University Hospital
OT	Occupational Therapy
PA	Personal Advisor
PC	Palliative Care
PCT	Primary Care Trust
PPS	Parent Partnership Service
PT	Part time
QOF	Quality and Outcomes Framework
RCN	Royal College of Nursing
SB	Short Breaks
SBAPs	School Behaviour and Attendance Partnerships
SCIE	Social Care Institute for Excellence
SEN	Special Educational Needs
SENCO	Special Educational Needs Coordinator
SFHT	Sherwood Forest Hospital Trust
TTS	Transport & Travel Services
TYS	Targeted Youth Support
UCAS	Universities and Colleges Admissions Service
WTE	Whole Time Equivalent
YPLA	Young People’s Learning Agency

Contents

Appendices

1. Introduction

The Nottinghamshire Children's Trust has developed this needs assessment to identify the needs of children, and young people with disabilities and/or Special Educational Needs (SEN) and their families within the county. Findings from this needs assessment will be used to influence a local joint commissioning strategy, which will make sure that the partner agencies work together, align resources to deliver their services effectively, provide good value for money and improve the experience and outcomes for people who use these services.

Establishing joint commissioning arrangements and processes around key target groups such as disabled children and young people will help to improve co-ordinated packages of support, streamline processes, reduce duplication and costs, as well as improve outcomes.

The SEN and Disability Green Paper 2011 also promotes the need to jointly commission: "*By developing stronger local strategic planning and commissioning arrangements, local authorities and local health services will play a pivotal role in ensuring that children and young people with SEN or who are disabled receive high quality support, and that parents are able to make informed choices about what is right for their family*[1]*".*

We are working to achieve the following ambition:

We want Nottinghamshire to be a place for everyone to enjoy a good quality of life and realise their potential; and for our children to be safe and happy. In particular we want children with a disability and/or special needs to have the same access of opportunity as other children, to aspire, and be empowered to do so.

To achieve this ambition we are working with partners to identify the needs of children, young people and families with disabilities in Nottinghamshire, we will identify gaps in service provision, review what children and families tell us and ensure our interventions and services are based on evidence based practice to improve outcomes.

Every child deserves a fair start in life, with the very best opportunity to succeed. Currently, life chances for the approximately two million children and young people in England who are identified as having a special educational need, or who are disabled, are disproportionately poor[2].

"The assessment of children and families' needs and the development of services to meet those needs are vital steps towards well being. Having a complete picture of the numbers and circumstances of disabled children is part of this process, yet there is no current complete information in the UK to guide local areas." [3]

---

[1] Department for Education (2011) *Support and aspiration: A new approach to special educational needs and disability* - a consultation

[2] Department for Education (2011) *Support and aspiration: A new approach to special educational needs and disability* - a consultation'
https://www.education.gov.uk/publications/eOrderingDownload/Green-Paper-SEN.pdf

[3] Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice

The data used in this needs assessment is based in the main on national and local estimates of needs, as well as data stemming from which groups access the services available locally. In addition, most children have more than one disability, with severely disabled children commonly having physical, sensory and learning disabilities. So planning which focuses on just one disability or the 'main' disability can be problematic.

It is also notoriously difficult to gather and analyse data on disability, as there is no comprehensive register of disabled children in the county. Data is collected by numerous health and social care agencies, as well as education, and the different categories, definitions and thresholds used across the system add complexity to the process. For example, routine data is collected by local authorities on children with statements of special educational needs, but this does not reflect the spectrum of disability and is only a weak proxy measure for severity. Some agencies classify a 'young person' as being up to the age of 16, others up to 19, and others up to 25. In addition, information about individuals may be held in care records that are not linked, and even where data might be available, it is difficult to extrapolate and translate individual experiences into the population estimates needed for effective commissioning.

This needs assessment is therefore imperfect. It is a best effort, which contains incomplete data and gaps in information, synthetic estimates and 'educated guesses'. For example, data on school aged children is much more readily available than for children in the early years or post 16, so much more work needs to be done to 'drill down' into these areas. However, through the analysis of as much available intelligence as possible from a range of stakeholders, a picture of need has been formed, along with recommendations for more effective planning and commissioning.

There are a range of opportunities for joint work and joint commissioning for children and young people with SEN or disabilities. The development of this needs assessment is part of a phased approach and further information will be collected and analysed as the work is progressed and the strategy is developed and implemented.

1.1 Aims of Needs Assessment

- To identify the population of children who have a disability in Nottinghamshire
- To understand the current demand for services alongside the current levels of provision
- To provide an evidence base and understanding of need for the forthcoming joint commissioning strategy
- To identify improvements in relation to data collection, analysis and use.

1.2 Definitions

Nottinghamshire County Council and its partners have adopted the Disability Discrimination Act[4] (DDA) 2005 definition of disability:

---

[4] For the purposes of the DDA Act, references to disabilities that are substantial and long term means that the effect of the impairment has lasted or is likely to last for at least 12 months and affects normal day-to-day activities including everyday things like eating, washing, walking and going shopping. A normal day-to-day activity must affect one of the 'capacities' listed in the Act which include mobility, manual dexterity, speech, hearing, seeing and memory.

“A child or young person is disabled if they have a physical or mental impairment which has substantial and long term adverse effect on his / her ability to carry out normal day to day activities”

This can include children and young people with long-term conditions such as diabetes mellitus and cystic fibrosis, in addition to those children and young people with learning and physical disabilities. A significant number of these children and young people will have complex, continuing and/or palliative[5] care needs. The definition ‘*complex, continuing and palliative*’ encapsulates children and young people with serious transient, short term and/or more long term/enduring needs such as degenerative or progressive genetic conditions, potentially life limiting or life threatening conditions.

The term is also used in this context to include children and young people who are defined as having one or more SEN. *“The term 'special educational needs' has a legal definition. Children with SEN all have learning difficulties or disabilities that make it more difficult for them to learn or access education than most children of the same age. These children may need extra or different help from that given to other children of the same age… They may have difficulties in thinking and understanding, physical or sensory difficulties, emotional and behavioural difficulties, difficulties with speech and language or how they relate to and behave with other people. Many children will have SEN at some time during their education. Schools can help most children overcome their difficulties quickly and easily but some children will need extra help for some or all of their time in school”.* [6]

This definition is also reinforced for children aged 0-3 years: *“A child under 3 years of age shall be considered disabled if he/she i) is experiencing significiant developmental impairement or delays, in one or more of the areas of cognitiiove development, sensory or physical development, communication development, social, behavioural or emotional development, or ii) has a condition which has a high probablity of resulting in developmental delay”.* [7]

1.3 National Policy Drivers

There is a wealth of national Policy Guidance and drivers available which guide practitioners to effective practice and the evidence base, including the list of national guidance documents which are included in Appendix One

---

[5] There are four broad definitions of groups of children and young people requiring palliative care: (1) children with life-threatening conditions where cure is possible but can fail e.g. cancer; (2) conditions which, though treated intensively over a period of time, inevitably lead to early death, such as cystic fibrosis; (3) progressive conditions where treatment is palliative over many years e.g. muscular dystrophy; (4) irreversible but non-progressive conditions giving rise to severe disability and sometimes premature death.

[6] DfE (2010) Special Educational Need: What Does it Mean?

[7] DfES & DH (2003) Together from the Start – Practical Guidance for professionals working with disabled children (birth to third birthday) and their families

2. How many children and young people in Nottinghamshire have a disability or SEN?

Estimated numbers of children and young people experiencing some form of disability in Nottinghamshire:

Thomas Coram Research Unit (2010):	**5,300-9,600 (0-19 year olds)**
Child and Maternal Health Observatory (2000):	**12,526 (0-19 year olds)**
Census (2001):	**7,615 (0-19 year olds)**
Disability Living Allowance (2011):	**7,210 (0-24 year olds)**
School SEN (Statements & School Action Plus) (2011):	**6,095 (3-19 year olds)**

As discussed in the introduction, it is problematic to collate accurate, timely data in relation to disabled children and young people both locally and nationally, and definitions of disability vary widely. Information is collected by different agencies, is often out-of-date and is not shared routinely. Obstacles around information sharing make commissioning services based on local needs challenging and reduce the opportunity for effective inter-agency working to minimise duplication. Since detail on the numbers of children and young people with specific disabilities/long-term conditions is difficult to access, there is often a reliance on synthetic data to estimate prevalence. Although synthetic data has its limitations, it can be useful in planning and commissioning services in the absence of more accurate local data.

The total number of disabled children in England is estimated to be between 288,000 and 513,000 by the Thomas Coram Research Unit[8]. The mean percentage of disabled children in English local authorities has likewise been estimated to be between 3.0 percent and 5.4 percent. If applied to the population of Nottinghamshire, this would equate to between 5,300 and 9,600 children (0-19) experiencing some form of disability.

There is no full register in the county of Disabled Children, but a national formula for estimating demand for short break services for severely disabled children multiplies the total 0-19 population by 1.2%, which in Nottinghamshire currently equates to 2,136 children and young people.

Applying prevalence data from elsewhere to local populations, in Nottinghamshire it is estimated that at any one time there will be:

- 70 children/young people with Cystic Fibrosis[9]
- 70 children/young people with Sickle Cell Disease[10]
- 240 children/young people with Crohn's Disease[11]

---

[8] Lewis J et al (2010) Disability and SEN: understanding local variations in service provision and support Research Report DCSF-RR211

[9] Based on UK, Cystic Fibrosis medicine, 2008, http://www.cysticfibrosismedicine.com/htmldocs/CFText/genetics.htm

[10] Based on England figures, http://www.patient.co.uk/health/Sickle-Cell-Disease-and-Sickle-Cell-Anaemia.htm

- 360 children/young people with Diabetes Mellitus[12]
- 280 children/young people with a neoplasm such as Leukaemia[13]
- 10,690 with asthma characterised by persistent episodes of wheezing[14].

In addition, approximately one in every 33,000 Nottinghamshire 0-17 year olds are hard of hearing and one in every 17,000 are deaf. Around one in every 4,500 0-17 year olds are registered blind and one in every 1,900 are registered partially sighted[15].

The new Life Opportunity Survey (LOS) conducted by the Office for National Statistics details the prevalence rates of disabled adults aged 16 and above, and information is also collected on young people aged 11 to 15 from their parents. The LOS estimates that 9% of the 11-15 population and 8% of the 16-24 population have a disability or impairment. When applied to the Nottinghamshire population, this indicates there are approximately 10,800 disabled 11-24 year olds in the county.

Data from the national Child and Maternal Health Observatory (ChiMat) on disabled population estimates in Nottinghamshire in the year 2000 differentiates between 'mild' disability and 'severe' disability (Tables 2.1 and 2.2). Indications from this data are that disability numbers are higher than estimated elsewhere and that disability is more prevalent among boys than girls.

Table 2.1 Nottinghamshire prevalence of long standing illness or disability in children and young people (0-19) in 2000

	Male	Female
0-4	3,136	2,808
5-9	5,275	3,582
10-14	4,560	4,142
15-19	4,482	3,744
Total	17,453	14,276

Source: General Household Survey (2000)/ChiMat 2011

Table 2.2 Nottinghamshire prevalence of severely disabled children and young people (0-19) in 2000

	Male	Female
0-4	3,360	1,728
5-9	2,532	995
10-14	1,824	872
15-19	747	468
Total	8,463	4,063

Source: unpublished analysis of Family Fund Trust statistics/ChiMat, 2011

---

[11] Based on Cummings JR, Keshav S, Travis SP, Medical management of Crohn's Disease, cited in patient.co.uk, http://www.patient.co.uk/showdoc/40000896/#ref2

[12] Based on England prevalence, Royal College of Paediatrics and Child Health, 2009, http://www.diabetes.org.uk/Documents/ReportsChildre_Diabetes_Survey_Report.pdf

[13] Based on Children's Cancer web, http://www.cancerindex.org/ccw/guide2chtm#b1

[14] Based on QOF, GP contracts 2007/08 https://www.gpcontract.co.uk/pct.php?orgcode+5N8&year+815 ChiMat

[15] ChiMat, 2011

Limiting long term illness

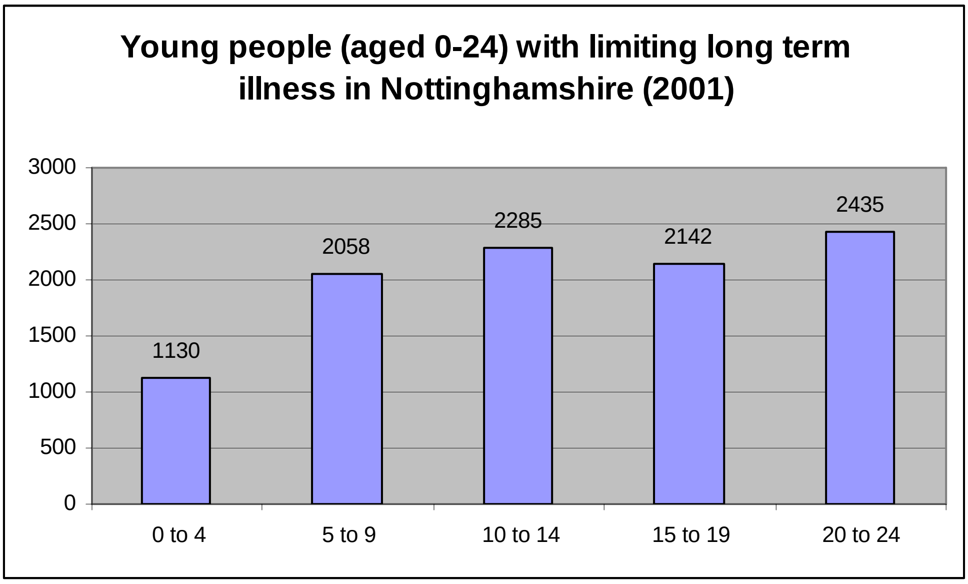
The census records the number of children described as having limiting long-term illness (LLTI) or disability which limits daily activity. This is a very broad definition, and might well include children whose level of disability would not mean they had a SEN requiring a statement.

Data from 2001 (most recent) indicates that there were 7,615 children and young people (aged 0-19) with LLTI in Nottinghamshire (Figure 2.3). This represented 4.2% of the 2001 (0-19) population. 15 to 19 year olds represented the highest proportion of young people with LLTI (5% of the 2001 15 to 19 year old population), followed by the 10 to 14 age group (4.6% of the 2001 10 to 14 population) and the 5 to 9's (4.4% of the 2001 5 to 9 population). The lowest proportion was the 0 to 4 age group (2.7% of the 2001 0 to 4 population).

Some agencies define young disabled people as being 0-24 years of age. Analysis of this age range indicates that in 2001 there were 10,050 children and young people aged 0-24 with LLTI in Nottinghamshire, 4.6% of the 2001 0-24 population. Indeed, the 20-24 group had the highest proportion of people with limiting long term illness out of all of the age groups in Nottinghamshire (6.5% of the 2001 20 to 24 year old population).

2011 census data will be available in 2013.

Figure 2.3



Source: 2001 Census

Disability Living Allowance

Census figures are self-reported (or parental reported), with no validity check. Disability Living Allowance (DLA) is possibly more robust, because recipients have to provide evidence of disability. However, an unknown number of children who would be eligible for DLA may not be claiming or receiving it, so the figures below are an under-estimate, but to what degree is unknown.

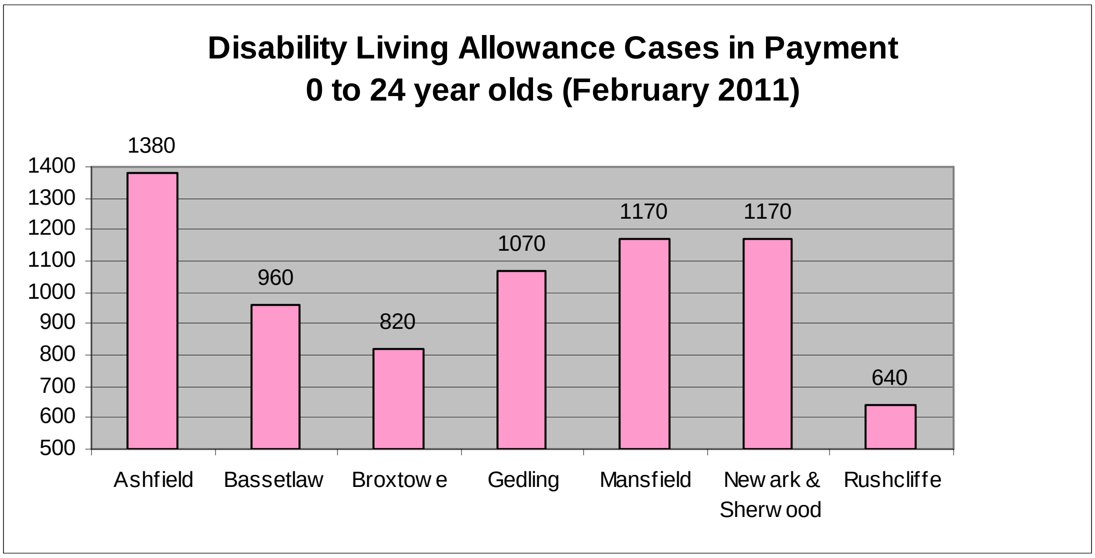
DLA is paid to people who have difficulties walking or need help with their personal care. As of February 2011, there were 7,210 children and young people aged 0 to 24 claiming DLA in Nottinghamshire (Table 2.4 and Figure 2.5), with the highest numbers in Ashfield (1,380), Mansfield and Newark & Sherwood (both 1,170), and the lowest in Rushcliffe (640). There is a recognised correlation nationally between deprivation and levels of DLA claims[16], and this is generally reflected in these figures.

Table 2.4 Disability Living Allowance Caseload - Cases in Payment - Feb 2011

	Under 5	5 to under 11	11 to under 16	16 to 17	18 to 24	**Total 0 to 24**
Ashfield	110	350	420	120	380	**1380**
Bassetlaw	80	270	260	100	250	**960**
Broxtowe	60	200	220	110	230	**820**
Gedling	100	280	340	100	250	**1070**
Mansfield	80	280	340	130	340	**1170**
Newark & Sherwood	80	310	380	130	270	**1170**
Rushcliffe	60	170	170	60	180	**640**
Nottinghamshire	**570**	**1860**	**2130**	**750**	**1900**	**7210**

Source: Department for Work and Pensions, 2011 (Numbers rounded to nearest 10)

Figure 2.5



Source: Department for Work and Pensions, 2011 (Numbers rounded to nearest 10)

There has been a significant increase in young claimants in Nottinghamshire over the last decade, from 4,500 in May 2002 to 7,210 in February 2011, a rise of 60% (Table 2.6 and Figure 2.7). The steepest rise has been in the 16-17 age range, which has more than doubled (121% increase). This is closely followed by the 11-16 group (increase of 92%) and 18-24's (increase of 65%).

---

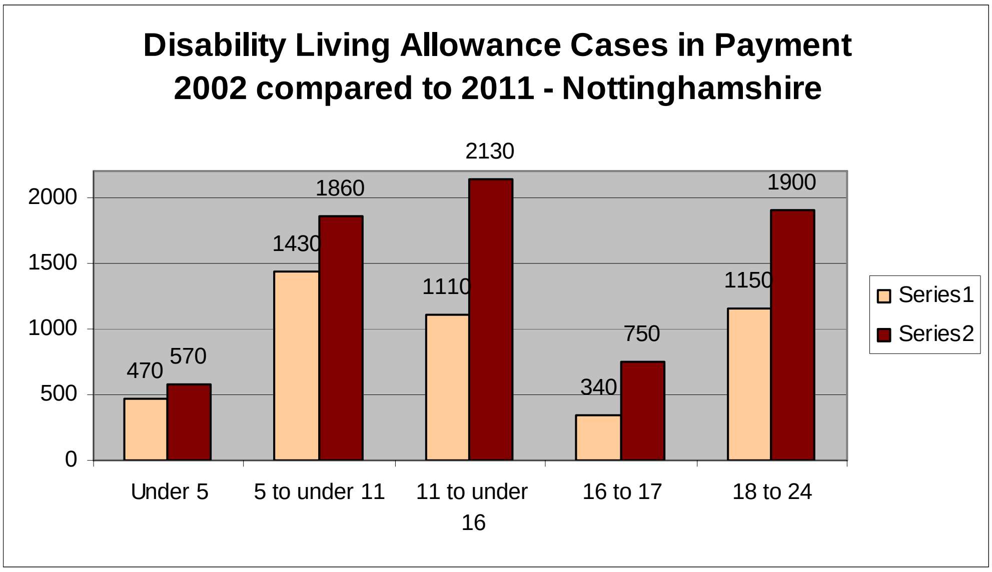
[16] Special Educational Needs and Disability: Understanding local variation in prevalence, service provision and support, Jane Lewis et al, DCSF, 2010

Table 2.6 Disability Living Allowance Caseload - Cases in Payment - May 2002

	Under 5	5 to under 11	11 to under 16	16 to 17	18 to 24	**Total 0 to 24**
Ashfield	90	250	180	60	230	**810**
Bassetlaw	60	200	150	40	170	**620**
Broxtowe	60	190	160	40	150	**600**
Gedling	50	200	140	40	140	**570**
Mansfield	90	220	190	70	190	**760**
Newark & Sherwood	70	230	170	50	160	**680**
Rushcliffe	50	140	120	40	110	**460**
Nottinghamshire	**470**	**1430**	**1110**	**340**	**1150**	**4500**

Source: Department for Work and Pensions, 2011 (Numbers rounded to nearest 10)

Figure 2.7



Source: Department for Work and Pensions, 2011 (Numbers rounded to nearest 10)

Since July 2007, 396 children and their families known to Nottinghamshire's disabled children social work teams have received help from the Disabled Children's Welfare Rights Officer at the County Council to maximise incomes relating to DLA.

Population forecasts

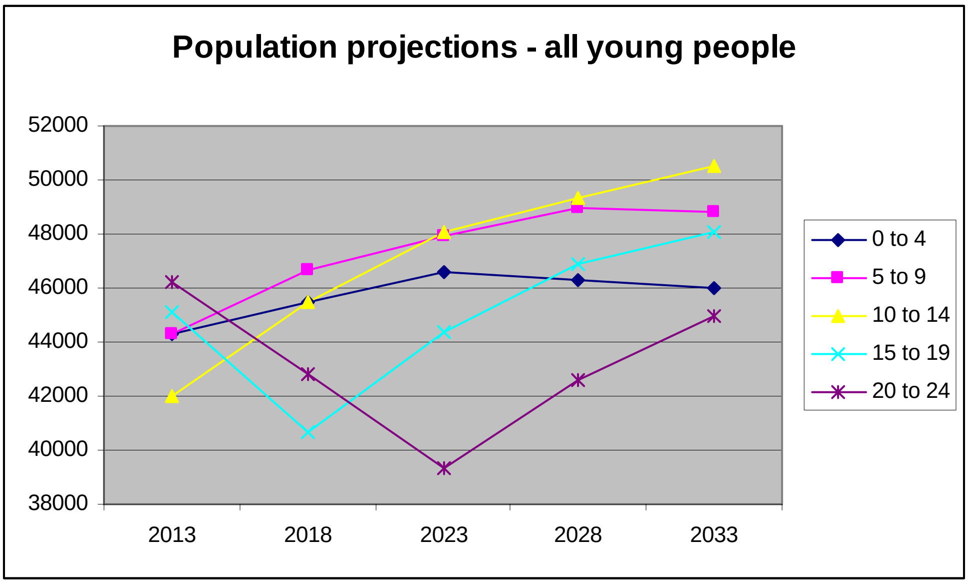
Population forecasts over the next 20 years based on Office of National Statistics projections can be used as a rough proxy for increases in the disabled population, although they do not take into account higher survival rates of babies and children with congenital anomalies, trauma or illness; a trend towards more high risk pregnancies; and also more rigorous diagnosis. Overall forecasts indicate that the general 0-19 population will rise by 8.7% between 2011 and 2033, with the largest rise being in the 10-14 age group (Table 2.8 and Figure 2.9), which is set to increase by 20.2% between 2013 and 2033. By applying the Thomas Coram estimates to these projections, it can be assumed that the population of disabled young people (0-19) in Nottinghamshire in 2033 will be between 5,760 and 10,435 - although, as mentioned above, the numbers are likely to be higher than this.

Table 2.8 Population projections by age in Nottinghamshire – all young people

	2013	2018	2023	2028	2033	% increase 2013 - 2033
0 to 4	44,300	45,500	46,600	46,300	46,000	3.8%
5 to 9	44,300	46,700	47,900	49,000	48,800	10.2%
10 to 14	42,000	45,500	48,100	49,300	50,500	20.2%
15 to 19	45,100	40,700	44,400	46,900	48,100	6.7%
20 to 24	46,200	42,800	39,300	42,600	45,000	-2.6%

Source: Office of National Statistics, 2011

Figure 2.9



Source: Office of National Statistics, 2011

Special Educational Needs

Data on children with Special Educational Needs[17] (SEN) as reported by schools gives an indication of numbers in the county. Pupils with SEN have learning difficulties or disabilities that make it harder for them to learn than most pupils of the same age. It is estimated that one in every five pupils[18] nationally has a special educational need. Pupils with SEN are categorised as follows:

- **School Action** – where extra or different help is given from that provided as part of the school's usual curriculum
- **School Action Plus** – where the class teacher and the SEN coordinator receive advice or support from outside specialists
- **Statement** – a pupil has a statement of SEN when a formal assessment has been made. A document setting out the child's needs and the extra help they should receive is in place.

There is a strong correlation nationally between deprivation and the percentage of pupils with SEN, but no correlation between deprivation and the rate of pupils with a

---

[17] The Nottinghamshire County Council Review of Special Educational Needs and Inclusion (2009) provides a very detailed picture of SEN in the county and can be accessed at: http://www.nottinghamshire.gov.uk/senandinclusionreviewreport2009.pdf

[18] Children with Special Educational Needs 2009: An Analysis, DCSF

statement – this is because of differing local authority practices relating to statementing[19].

Table 2.10 Numbers of children with special educational needs (January 2011)

District	Number on roll*	SEN Status							
		No provision		**School Action**		**School Action Plus**		**Statemented**	
		Number	%	Number	%	Number	%	Number	%
Ashfield	18,269	14,364	78.6%	2,935	16.1%	750	4.1%	220	1.2%
Bassetlaw	16,375	12,887	78.7%	2,471	15.1%	835	5.1%	182	1.1%
Broxtowe	14,358	11,817	82.3%	1,907	13.3%	500	3.5%	134	0.9%
Gedling	16,655	13,547	81.3%	2,156	13.0%	800	4.8%	152	0.9%
Mansfield	16,921	12,849	75.9%	3,046	18.0%	764	4.5%	262	1.6%
Newark & Sherwood	15,323	12,249	80.0%	2,240	14.6%	689	4.5%	145	1.0%
Rushcliffe	16,706	14,321	85.7%	1,723	10.3%	534	3.2%	128	0.8%
NOTTINGHAMSHIRE	**114,607**	**92,034**	**80.3%**	**16,478**	**14.4%**	**4,872**	**4.3%**	**1,223**	**1.1%**

Source: School Census, 2011 (3-19 year olds)
[*Note that the number on roll is different from that published by the DfE as this only includes pupils attending mainstream schools, academies and special schools]

One in five Nottinghamshire pupils has some kind of SEN (Table 2.10). Boroughs/districts with the highest percentages of children on roll with an SEN status are Mansfield (24.1%), Ashfield (21.4%), and Bassetlaw (21.3%). Rushcliffe has the lowest rate (14.3%).

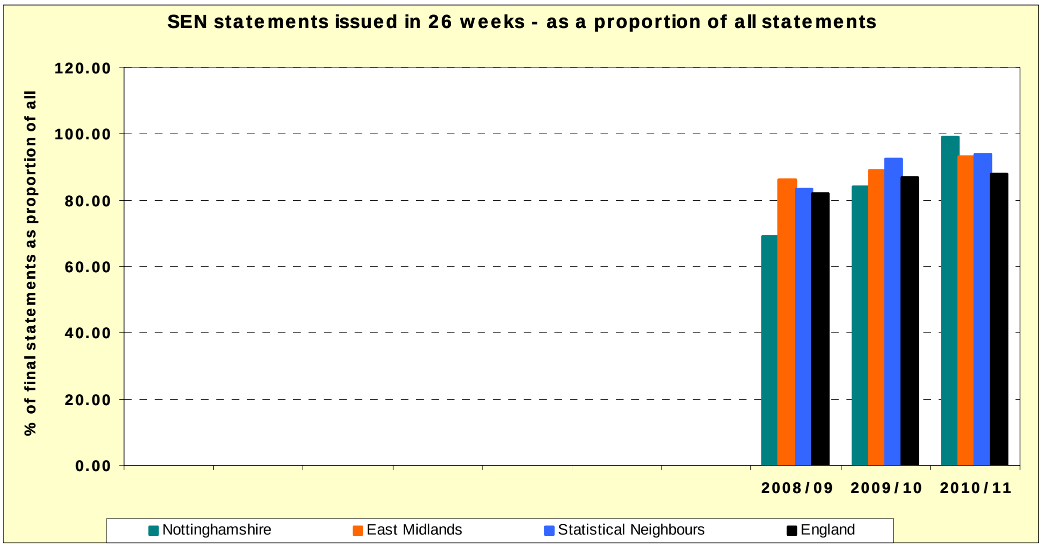
The total number of children with a statement of SEN in Nottinghamshire stands at 1.1%, which has remained stable for the last seven years - the 2011 national figure is 2.7%. The highest percentage of statements was issued in Mansfield (1.6%) and the lowest in Rushcliffe (0.8%). Nottinghamshire is different from most local authorities in that it does not use statements as a mechanism for distributing resources for pupils with SEN. However, a statement is required in order to access special school provision or where an individual child's needs are particularly complex and require systematic monitoring.

Nottinghamshire is currently in the top quartile of local authorities in terms of issuing SEN statements within 26 weeks, with a figure of 99% in 2010/11, up from 69% in 2008/09. This compares favourably against statistical neighbours (94%) and the England average (88%) (Figure 2.11).

---

[19] Special Educational Needs and Disability: Understanding local variation in prevalence, service provision and support, Jane Lewis et al, DCSF

Figure 2.11



Source: Local Area Interactive Tool, Department for Education, 2011

When comparing the percentage of Nottinghamshire school pupils identified as having SEN against statistical neighbours and the national average, it can be seen that Nottinghamshire's data is interesting. Only 16% of Nottinghamshire's primary school cohort is SEN, compared with 19.3% nationally and 19.35% amongst statistical neighbours (Table 2.12, labelled in red). In contrast, Nottinghamshire SEN levels amongst the secondary cohort (22.8%) are slightly above national (21.3%) and statistical neighbour (20.08%) averages (Table 2.13, labelled in red). There is therefore a substantial disparity between the percentage of pupils identified as having SEN within primary and secondary phases in Nottinghamshire (6.8%), compared to a gap of 2% nationally and 0.7% amongst statistical neighbours (Figure 2.14).

Table 2.12 Number of pupils identified as having special educational needs in maintained primary schools

2011	Local Authority	Total Pupils	School Action		School Action Plus		Statemented		Total SEN	
			No.	%	No.	%	No.	%	No.	%
Maintained Primary Schools	**ENGLAND**	**4,137,755**	**467,615**	**11.3%**	**274,950**	**6.6%**	**57,855**	1.4%	**800,420**	**19.3%**
	Nottinghamshire	62,784	7,411	11.8%	2,483	4.0%	170	0.3%	10,065	16.0%
	Derbyshire	58,653	5,885	10.0%	3,306	5.6%	935	1.6%	10,125	17.3%
	Staffordshire	61,235	5,740	9.4%	3,550	5.8%	472	0.8%	9,760	15.9%
	Lancashire	90,255	7,746	8.6%	5,691	6.3%	1,398	1.5%	14,835	16.4%
	Cumbria	37,333	4,636	12.4%	2,316	6.2%	631	1.7%	7,585	20.3%
	Northamptonshire	56,329	6,574	11.7%	3,005	5.3%	1070	1.9%	10,650	18.9%
	Swindon	16,542	1,789	10.8%	923	5.6%	293	1.8%	3,005	18.2%
	Kent	109,567	17,172	15.7%	8,451	7.7%	1,188	1.1%	26,810	24.5%
	Dudley	26,764	2,527	9.4%	2,388	8.9%	487	1.8%	5,400	20.2%
	Wigan	25,450	2,593	10.2%	1,965	7.7%	281	1.1%	4,840	19.0%
	Lincolnshire	50,388	5,397	10.7%	3,811	7.6%	842	1.7%	10,050	19.9%
	Statistical Neighbours	532,516	60,059	11.28%	35,406	6.65%	7,597	1.43%	103,060	**19.35%**

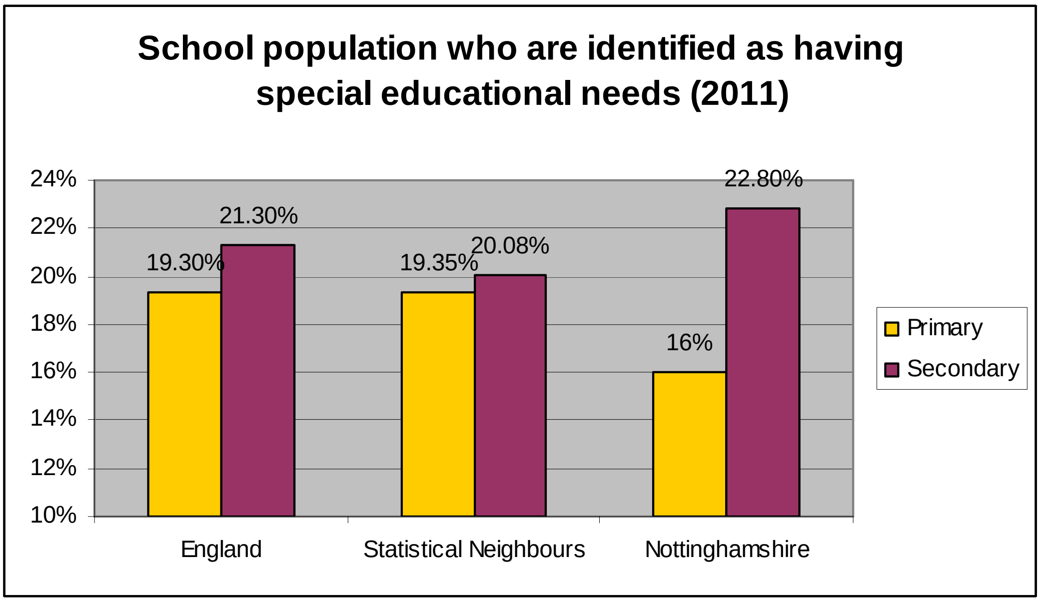
Source : School Census - January 2011 as published in DfE SFR14/2011, Table 16

Table 2.13 Number of pupils identified as having special educational needs in maintained secondary schools

2011	Local Authority	Total Pupils	School Action		School Action Plus		Statemented		Total SEN	
			No.	%	No.	%	No.	%	No.	%
State-Funded Secondary Schools	**ENGLAND**	**3,262,635**	**418,935**	**12.8%**	**212,480**	**6.5%**	**63,720**	2.0%	**695,135**	**21.3%**
	Nottinghamshire	50,869	9,042	17.8%	2,327	4.6%	236	0.5%	11,605	22.8%
	Derbyshire	48,319	6,151	12.7%	2,775	5.7%	1045	2.2%	9,970	20.6%
	Staffordshire	56,540	6,308	11.2%	2,329	4.1%	948	1.7%	9,585	17.0%
	Lancashire	68,963	6,802	9.9%	3,587	5.2%	1,587	2.3%	11,975	17.4%
	Cumbria	33,012	3,857	11.7%	943	2.9%	798	2.4%	5,600	17.0%
	Northamptonshire	47,841	6,204	13.0%	2,137	4.5%	1275	2.7%	9,615	20.1%
	Swindon	12,515	1,722	13.8%	866	6.9%	286	2.3%	2,875	23.0%
	Kent	101,180	14,558	14.4%	7,708	7.6%	1,533	1.5%	23,800	23.5%
	Dudley	19,414	2,369	12.2%	1,214	6.3%	436	2.2%	4,020	20.7%
	Wigan	18,861	1,920	10.2%	1,712	9.1%	381	2.0%	4,015	21.3%
	Lincolnshire	49,041	5,700	11.6%	3,151	6.4%	1,191	2.4%	10,040	20.5%
	Statistical Neighbours	455,686	55,591	12.20%	26,422	5.80%	9,480	2.08%	91,495	**20.08%**

Source: School Census - January 2011 as published in DfE SFR14/2011, Table 17

Figure 2.14



Source : School Census - January 2011 as published in DfE SFR14/2011

The vast majority of primary schools (85%) in the county identify less than a quarter of their pupils as being SEN, but at secondary level this figure drops to 58% (Table 2.15). Indeed, one in seven secondary schools identify between 30% and 50% of their pupils as being SEN, compared to one in seventeen primaries.

Table 2.15 Levels of identification of SEN pupils by primary and secondary schools (2011)

2011	Level of SEN identification	No. of schools
Primary	Less than 25%	242
	25% - 30%	26
	30% - 40%	16
	40% - 50%	1
	Over 50%	0
	Total	**285**

2011	Level of SEN identification	No. of schools
Secondary	Less than 25%	26
	25% - 30%	12
	30% - 40%	5
	40% - 50%	2
	Over 50%	0
	Total	**45**

Source: Nottinghamshire County Council, 2011

Trend data over the last five years indicates that in maintained primary schools, the percentage of SEN pupils in Nottinghamshire schools has decreased from 16.6% to 16.0% (down 0.6%) (Table 2.16). Statistical neighbours dropped slightly by 0.2%, while the national figure marginally increased from 19.2% to 19.3%. However, in state funded secondary schools there has been a significant increase, particularly between 2007 and 2010 (Table 2.17). Over the last five years, the percentage of SEN pupils in Nottinghamshire secondary schools increased from 15.9% to 22.8% (up 6.9%). Statistical neighbours saw a much smaller rise of 2.4%, while the national figure grew from 18.3% to 21.3%.

This data raises a number of questions and issues, not least what factors may have led to such a significant increase in the number of pupils being identified in Nottinghamshire secondary schools over the five year period; and why these factors do not seem to have impacted in Nottinghamshire primary schools.

Table 2.16 Number of pupils with special educational needs in maintained primary schools – comparison against statistical neighbours and England between 2007 and 2011

2007 v's 2011	Local Authority	Total Pupils	School Action		School Action Plus		Statemented		Total SEN	
			No.	%	No.	%	No.	%	No.	%
Maintained Primary Schools	**ENGLAND**	**30,075**	**-17,215**	**-0.5%**	**32,080**	**0.7%**	**-3,425**	-0.1%	**11,440**	**0.1%**
	Nottinghamshire	-640	-327	-0.4%	-136	-0.1%	7	0.0%	-455	-0.6%
	Derbyshire	-2,237	0	0.3%	220	0.5%	-55	0.0%	164	0.9%
	Staffordshire	-1,486	211	0.6%	969	1.7%	-205	-0.3%	973	1.9%
	Lancashire	-1,399	-995	-0.9%	1,100	1.3%	-699	-0.8%	-594	-0.4%
	Cumbria	-1,661	110	0.8%	281	1.0%	-339	-0.8%	54	1.0%
	Northamptonshire	232	-2,382	-4.3%	101	0.1%	48	0.1%	-2,232	-4.1%
	Swindon	-357	-340	-1.8%	73	0.6%	46	0.3%	-221	-0.9%
	Kent	28	-494	-0.4%	353	0.3%	-58	0.0%	-200	-0.2%
	Dudley	-1,027	-728	-2.3%	292	1.4%	111	0.4%	-327	-0.4%
	Wigan	-154	295	1.2%	96	0.4%	-64	-0.2%	328	1.4%
	Lincolnshire	-1,568	-518	-0.7%	147	0.5%	-279	-0.5%	-650	-0.7%
	Statistical Neighbours	-9,629	-4,841	-0.69%	3,632	0.79%	-1,494	-0.25%	-2,705	-0.16%

Source: Nottinghamshire County Council, 2011

Table 2.17 Number of pupils with special educational needs in state-funded secondary schools – comparison against statistical neighbours and England between 2007 and 2011

2007 v's 2011	Local Authority	Total Pupils	School Action		School Action Plus		Statemented		Total SEN	
			No.	%	No.	%	No.	%	No.	%
State-Funded Secondary Schools	**ENGLAND**	**-5,855**	**54,275**	**1.6%**	**47,360**	**1.4%**	**-5,790**	-0.1%	**95,835**	**3.0%**
	Nottinghamshire	-3,168	2,530	5.7%	517	1.3%	-8	0.0%	3,039	6.9%
	Derbyshire	-2,627	1,204	3.0%	504	1.2%	53	0.3%	1,760	4.5%
	Staffordshire	-3,333	1,575	3.3%	171	0.5%	-525	-0.8%	1,221	3.0%
	Lancashire	-4,191	217	0.9%	1,122	1.8%	-507	-0.6%	831	2.2%
	Cumbria	-2,299	-102	0.5%	-70	0.0%	78	0.4%	-92	0.9%
	Northamptonshire	2,713	52	-0.6%	191	0.2%	82	0.1%	324	-0.5%
	Swindon	970	397	2.3%	289	1.9%	88	0.6%	775	4.8%
	Kent	2,263	1,326	1.0%	1,741	1.6%	-423	-0.5%	2,645	2.1%
	Dudley	-1,078	-31	0.5%	435	2.5%	71	0.4%	476	3.4%
	Wigan	-1,690	34	1.0%	141	1.5%	-187	-0.8%	-10	1.7%
	Lincolnshire	559	867	1.6%	716	1.4%	-103	-0.3%	1,478	2.8%
	Statistical Neighbours	-8,713	5,539	1.42%	5,240	1.24%	-1,373	-0.26%	9,408	2.40%

Source: Nottinghamshire County Council, 2011

Table 2.18 shows the primary needs for 2011. The highest numbers of pupils with SEN in the county had behavioural/emotional/social needs (1,555), which although a reduction on last year's figure is remaining stable as a percentage of the overall cohort with SEN. 60% of these are pupils in secondary schools. Numbers of pupils with some form of learning difficulty (around 1,880) decreased from the previous year (2,070), which is higher than the overall cohort reduction but children with a diagnosis of Autistic Spectrum Disorder (ASD) have increased by 14% since 2009 to over 1,000, which is consistent with the national picture.

Table 2.18 Numbers of children with special educational needs by primary need (January 2011)

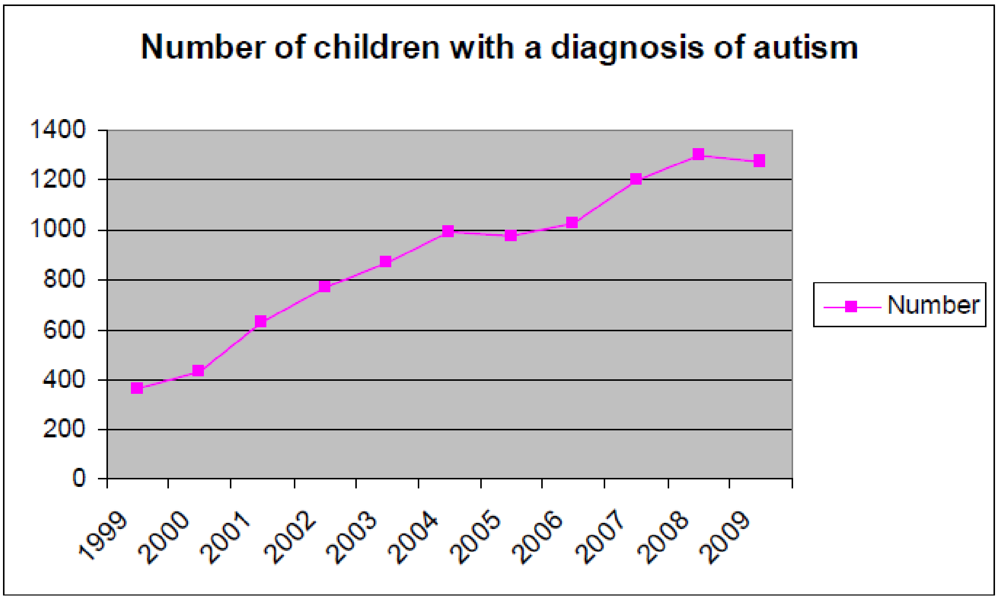
	Nursery	Primary	Secondary	Special	Total
Specific Learning Difficulty	-	151	230	12	393
Moderate Learning Difficulty	-	507	373	158	1,038
Severe Learning Difficulty	-	89	55	199	343
Profound & Multiple Learning Difficulty	-	35	*	75	110+*
Behaviour, Emotional & Social Difficulties	-	563	927	65	1,555
Speech, Language and Communication Needs	9	460	137	13	619
Autistic Spectrum Disorder	*	428	344	246	1,018+*
Visual Impairment	-	43	46	*	89+*
Hearing Impairment	-	62	42	*	104+*
Multi-Sensory Impairment	-	9	5	*	14+*
Physical Disability	-	189	118	61	368
Other Difficulty/Disability	-	117	115	10	242

Source: School Census, 2011 [*Numbers below five suppressed]

Estimates for the rate of ASD in a population range from 3 to 6 per 1,000 (Rutter, 2005) and a more recent study of prevalence in England found a much higher rate of 11.6 per 1,000 (Baird et al, 2006). An NHS information service study (Brugha et al, 2009) concluded that 0.98% of the population have ASD, with the ratio of men to women as 9:1. (This ratio is not consistent across other studies where the ratio has been found to be between 4 and 5 to 1.) Data cited in NICE in 2011 estimates a minimum prevalence of ASD in children and young people as 1% of the child population. Applying the 1% estimate to the 0-19 Nottinghamshire population would indicate that approximately 1,780 children and young people have ASD in the county.

The rise in the number of Nottinghamshire school pupils diagnosed with ASD can be seen in Figure 2.19. In addition, a breakdown by district (Table 2.20) shows the total number of Nottinghamshire school pupils with ASD in 2009 was 1,195.

Figure 2.19 Number of pupils in Nottinghamshire with a diagnosis of autism known to support services[20]



Source: Inclusion Support Service, Nottinghamshire County Council[21], 2010

Table 2.20 Numbers of pupils in Nottinghamshire schools diagnosed with ASD (2009)

Area	Number of children	Number with statement	% with statement
Ashfield	108	30	28%
Bassetlaw	59	40	68%
Broxtowe	96	45	47%
Gedling	212	47	22%
Mansfield	126	74	59%
Newark & Sherwood	112	41	37%
Rushcliffe	109	36	33%
Other	28	8	29%
No registered base/pre-school	274	0	0%
Other local authority	71	59	83%

Source: Education Management System Children Support Services Autism Summary, 2009

Complex Needs

In Nottinghamshire, a discrete data collection exercise was undertaken as part of a health needs assessment of children and young people with complex health care

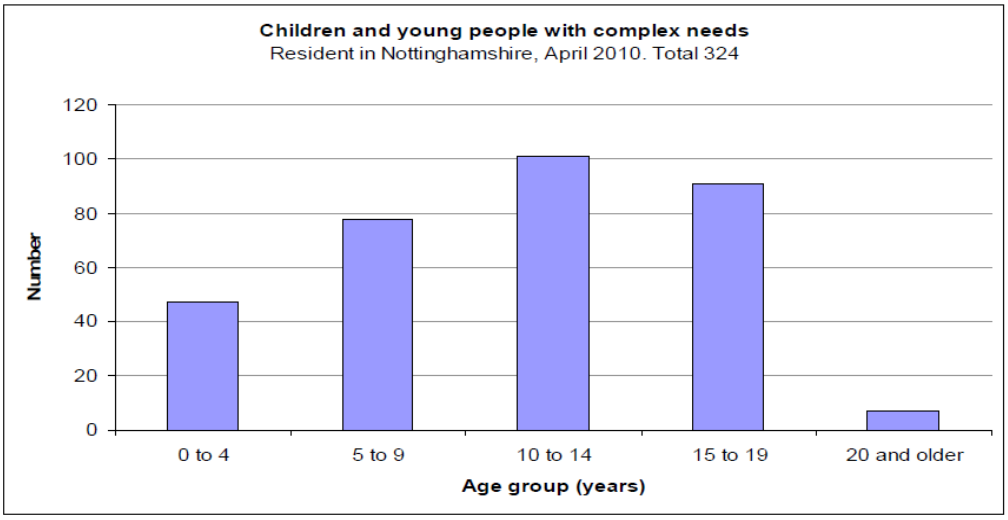
---

[20] The 2009 number of children and young people with ASD known to support services is greater in this diagram than the number shown in Table 2.20. This is partly due to a number of children known to support services who are preschool and are therefore without a census category, and partly due to their primary need not being recorded or attributed to another category of need.

[21] Referenced from 'Working together to support families of children with Autism in Nottinghamshire - progress report' (January 2010) by NORSACA, NHS Nottinghamshire County and Nottinghamshire County Council.

needs[22], which included comprehensive data that related to individual children and young people. Providers of specialised services including short breaks were asked to provide demographic and clinical information, consent having first been obtained from families/children. Information in relation to 324 children and young people was collated.

Figure 2.21 Children and young people with complex needs living in Nottinghamshire



Source: Health Needs assessment - children with complex health needs, NHS Nottinghamshire County, 2010

As can be seen in Figure 2.22, of the 324 children identified, the largest number was in the 10-14 year age range.

Interpretation of service user ethnicity must be considered with caution as a significant percentage (35%) of children and young people did not have ethnicity recorded. For those children and young people where ethnicity was recorded, 51% were White British, 5% British and 8% from black & minority ethnic (BME) groups, contrasting with an estimated 6.6% in this population. The current data does not enable analysis of whether this means more children and young people from BME groups are accessing these services or whether the underlying mechanisms are more complex.

A health needs assessment has also been undertaken of special schools in both Nottingham City and the county. This provides a valuable insight into individual pupil need across a number of areas (e.g. hearing, sleep, behaviour, feeding) and for a number of services (e.g. physiotherapy, continence). The full needs assessment can be accessed in Appendix Two.

Palliative Care

Children Palliative Care is complex with enormous overlap with services for children with disability. Research has shown that whilst most families would like their child to be supported in dying at home three-quarters of them dies in hospital.[23]

---

[22] Definition - 'Children and young people with complex health needs including those with disability and life limiting conditions, and/or those who require palliative care and/or those with associated impairments such as cognitive or sensory impairments and/or have moving/handling needs and/or require special equipment/ adaptations' (DCSF, 2009)

[23] Professor Sir Alan Craft and Sue Killen - palliative care services for children and young people in England

Locally, over a five year period (2006-2010), there were 64 non – accidental deaths in children under 1 with over 90% dying in hospital. This is not particularly unusual as the majority of children either die unexpectedly (e.g. Sudden Infant Death Syndrome) or have severe health problems relating to extreme prematurity or severe birth defects. The natures of their illnesses generally make them unsuitable for palliative care in the community.

In those aged 1 to 18 (over the same period) 78 children died non-accidental deaths of which only 25% died at home or in a hospice. When deaths that may be considered suitable for palliative care (i.e. excluding acute infections and other events that may be considered unexpected or unpredictable), the proportion that die in hospital is still high (69%). This suggests that there is a considerable challenge to be faced in improving access to palliative care services for children.

Figure 2.23 Non-accidental deaths in children aged 1 to 18 in Nottinghamshire 2006-2010 by location of death

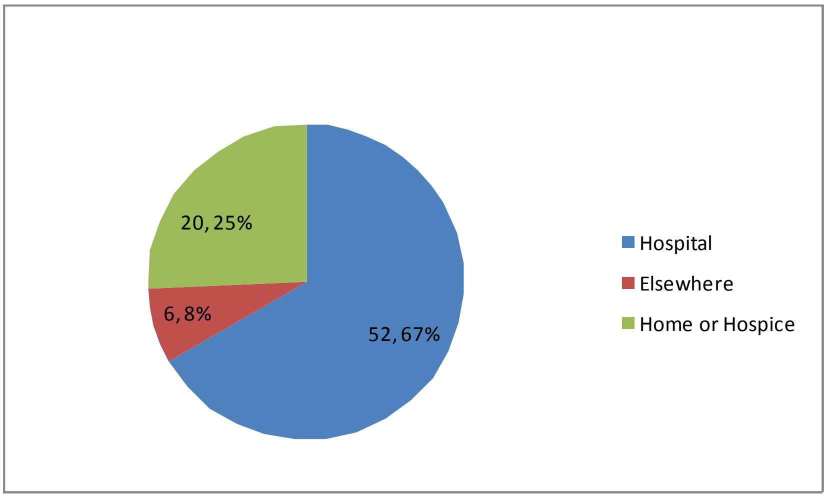
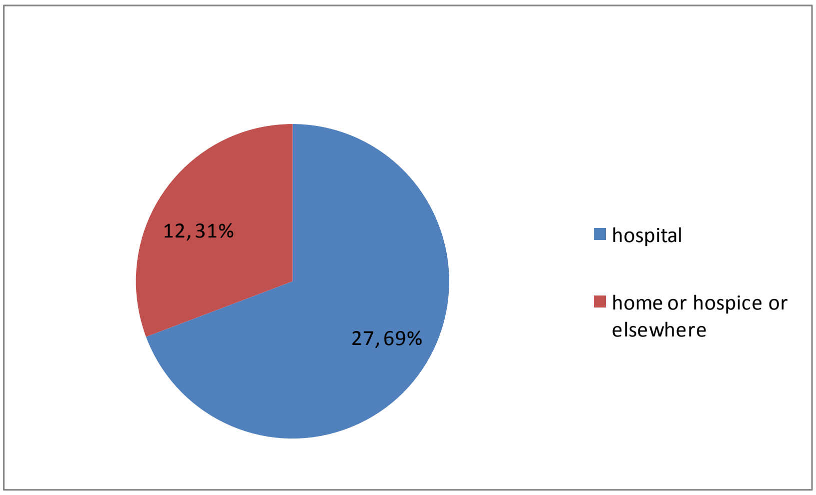


Figure 2.24 Deaths potentially amenable to palliative care deaths in children aged 1 to 18 in Nottinghamshire 2006-2010 by location of death



---

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074698.pdf

Data to identify numbers of children and young people with palliative care needs is a challenge locally. This has been highlighted by other Local Authority areas and an East Midlands Data Mapping project has begun to improve data mapping for easier identification of needs and service planning. Some work undertaken by University of York that is due to be published in April 2012, highlights that Children and Young People with Life Limiting and Life Threatening Conditions have doubled over the last ten years from 16 to 32 per 10000 population. Highlighting the increase in this group of children.

The final report of the independent Palliative Care Funding Review[24] (for Adults & Children) was published in July 2011. It set out a series of recommendations designed to create a fair and transparent funding system for palliative care, which delivers better outcomes for patients and provides better value for the NHS. It recommended that a number of pilots be set up to collect data and refine its proposals due to the lack of good quality data currently available.

Regional Data Mapping for Palliative Care

This project is a mapping exercise, stemming from there being little consistent data collected re life limited/life threatened children and young people, many of whom have complex care needs. The project builds on the data captured about this group of children and young people in a similar mapping exercise in 2009[25].

The data mapping project has developed a database/register to hold core information babies, children and young people using palliative care services across the region.

The project aimed to:

- Gather standardised data re life limiting /threatened children and young people from key acute and community palliative care providers in statutory and charitable sectors across the East Midlands.
- Gather information about existing services
- Assess local needs and gaps in services which will promote service development and inform commissioners.

This ongoing activity helps to meet a recommendation identified in the national Palliative Care Funding Review.

The minimum dataset which is based on the ACT Mapping Recommendations include:

- DOB
- NHS number
- Gender
- Home postcode
- Ethnicity
- Diagnosis based on ICD10 codes
- Service Provider (includes acute, community, school, social workers, GP, school, short breaks, community children's nursing and other palliative care service.
- End of life Plan

---

[24] Palliative Care Funding Review – Funding the Right Care and Support for Everyone (2011) T. Hughes-Hallet & A Craft

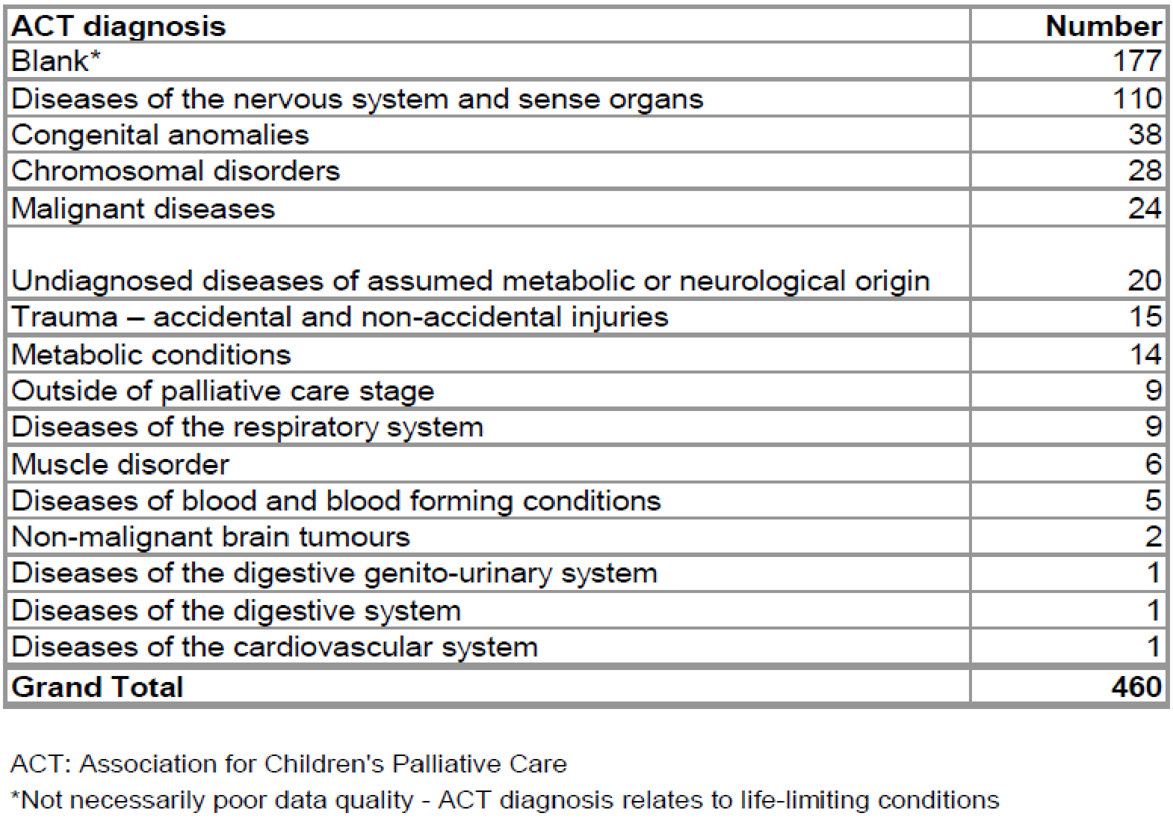
[25] Wilcock S & Atkin J (2009) Scoping Report for Children and Young People with Complex Health Care Needs, NHS Nottinghamshire County

This is an ongoing data collection exercise to identify children and young people with Palliative Care needs in the East Midlands.

The Association for Children's Palliative Care (ACT)[26] is a UK wide charity that works to achieve the best quality of life and care for children and young people who are not expected to reach adulthood, by supporting families, professionals and commissioners. The ACT minimum data set[27] comprises 20 items of epidemiological data relating to children and young people with palliative care needs; this data enables an effective estimate of the number of children and young people who might benefit from palliative care, not just those who currently receive services from the statutory and voluntary sector.

ACT diagnostic categories were recorded for the 324 children included in the aforementioned local data collection exercise (see Table 2.25). Where ACT diagnosis is left blank this may be because the children and young people that it relates to do not have a diagnosis that would fit within the ACT categories. There are more diagnoses recorded than children because some children have multiple diagnoses.

Table 2.25 Diagnoses of children & young people who have accessed specialist services including short breaks in Nottinghamshire (2009/10)



ACT diagnosis	**Number**
Blank*	177
Diseases of the nervous system and sense organs	110
Congenital anomalies	38
Chromosomal disorders	28
Malignant diseases	24
Undiagnosed diseases of assumed metabolic or neurological origin	20
Trauma – accidental and non-accidental injuries	15
Metabolic conditions	14
Outside of palliative care stage	9
Diseases of the respiratory system	9
Muscle disorder	6
Diseases of blood and blood forming conditions	5
Non-malignant brain tumours	2
Diseases of the digestive genito-urinary system	1
Diseases of the digestive system	1
Diseases of the cardiovascular system	1
Grand Total	**460**

ACT: Association for Children's Palliative Care

*Not necessarily poor data quality - ACT diagnosis relates to life-limiting conditions

Source: Health Needs Assessment, NHS Nottinghamshire, 2009/10

---

[26] ACT have recently merged with Children's Hospices UK & are now called Together for Short Lives

[27] Making life-limited children and young people count: A framework and guide for local implementation – Association for Children's Palliative Care 2009

3. What are the outcomes and life chances for children and young people with disabilities or SEN in Nottinghamshire?

National evidence has found a number of poor outcomes facing children and young people with disabilities:

- Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education.
- 29% of disabled children nationally live in poverty.
- The educational attainment of disabled children is unacceptably lower than that of non-disabled children and fewer than 50% of schools nationally have accessibility plans.
- Disabled young people aged 16-24 are less satisfied with their lives than their peers and there is a tendency for support to fall away at key transition points as young people move from child to adult services.
- Families with disabled children report particularly high levels of unmet needs, isolation and stress.
- Nationally only 4% of disabled children are supported by social care services. A report by the Audit Commission in 2003 found that there was a lottery of provision, inadequate strategic planning, confusing eligibility criteria, and that families were subject to long waits and had to jump through hoops to get support.
- The prevalence of severe disability is increasing.
- Youth Justice Board data (2009) suggests that, of young people in custody, 83 per cent were excluded from school, 86 per cent were involved in substance abuse, 38 per cent were diagnosed with ADHD and 31 per cent had diagnosed mental health conditions[28]'.
- Children in special schools for behavioural, emotional and social difficulties (BESD schools) or Pupil Referral Units (PRU) are significantly more likely to experience mental health difficulties than the general population.
- Over a third of children and young people with an identified learning disability also have a diagnosable psychiatric disorder[29]
- Children and young people with physical disabilities are twice as likely to develop psychological problems as those without, as are those who experience serious or chronic illness[30]

Local data suggests that disabled children and young people are more likely to self exclude and be excluded from school although the reasons for this are contested. Thus it may be challenging for these children and young people to access support through health services that are primarily delivered through schools.

---

[28] *The Teacher*, March 2010 p7

[29] Emerson and Hatton. 2007. *The Mental Health of Children and Adolescents with Learning Disabilities in Great Britain.* Lancaster: Institute for Health Research, Lancaster University.

[30] Parry-Langdon (ed.). 2008. *Three Years On: Survey of the development and emotional well-being of children and young people.* Cardiff: ONS.

The national picture indicates that more children and young people with profound disabilities and long-term conditions are living longer and surviving into adulthood[31]. Many of these children and young people have complex needs that require support from a range of professionals from diverse disciplines in order to achieve their potential. Transition to adult services can be particularly challenging for these children and young people.

Some of this group of children and young people require daily support as their health is dependent on interventions such as tracheostomies, enteral (tube) feeding, parenteral (intravenous) feeding, home oxygen therapy, indwelling venous devices, overnight oxygen saturation monitoring and/or ventilation. Most of this support is provided on a daily basis by parents/carers and, for many, caring responsibilities place pressure on relationships and wider family life. Providing ‘short breaks’ for children and young people can help to ease this pressure.

Disabled children and young people have many of the ‘universal needs’ of their non-disabled peers, including advice on healthy eating, support to remain emotionally healthy and access to contraception and sexual health information and services. In addition to this group, there are many more children and young people who have additional learning needs that can affect how they are able to access universal services such as GPs, health visitors and school nurses.

A young person’s view

“I’m really terrified of needles, not just a bit scared, really, really, really terrified and I just couldn’t bring myself to have my vaccinations even thought I know it’s really important as it stops you getting diseases. The nurse gave me some special cream to put on my arm before I had the needle and gave me lots of time to ask questions. I wouldn’t have had the needle if she hadn’t understood what being Asperger’s is like.”

J aged 15

A parent’s view

“Individual people have been fantastic but the system as a whole has let us down”.

A young person’s view

“I have just had some bad news that I might be going to have an operation on my skull because my epilepsy is so bad. My mother and I are going to see an epilepsy doctor at my local main hospital next February; I am not looking forward to it. I don’t’ mind reading and meeting other people who are also epileptic but when it comes to me having an operation it doesn’t sound very nice. I used to attend an epileptic group meeting on the first Monday of every month but since my epilepsy has gone so bad I have not been out at night.”

3.1 Causes of Childhood Disability

Understanding the causes of some disabilities is a critical contribution to Nottinghamshire’s early intervention approach and strategy. A number of factors are associated with a child having a disability or Special Educational Need, they include:

---

[31] Contact a Family (2006) ‘About Families with Disabled Children – UK’

Family history /genetics - a number of conditions such as Heart defects and Spina bifida can be related back to genetic factors.

Health of the mother during pregnancy - If the mother is ill during pregnancy either through a long term condition such as epilepsy or an infectious disease such as chicken pox or rubella can cause disability and developmental problems in the child.

Lifestyle of the mother during pregnancy - Lifestyle factors such as smoking, consumption of alcohol and poor diet are known to increase the risks of low birth weight, birth defects and disability in children.

Premature birth/ Low birth weight - It has been recognised for over half a century that low birth weight (LBW) (less than 2,500 grams) is a major risk factor for developmental delay, cognitive deficits, behavioural `adjustment and poor academic performance [32] and that children with low birth weight are 4 times as likely to have special educational needs[33].

Accidents and injury to the child - Childhood injuries through accidents such as falls and road traffic accidents are amongst the leading causes of disability and in a number of cases are preventable[34].

Infectious disease in childhood - Infectious diseases such as Meningitis and whooping cough can cause brain damage and disability in young children.

Prevention / early intervention - A number of the above factors are potentially preventable or their impact can be reduced by early diagnosis and treatment. NICE provides a range of guidance for care during pregnancy that recommends what staff and organisations should do to help reduce these risks. Ways of reducing risk of a child being born with a disability include:

- Stopping smoking before and during pregnancy[35]
- Not drinking alcohol whilst pregnant[36]
- Taking folic acid during pregnancy.

The NHS also has a number of screening programmes during the antenatal and newborn period that can help identify conditions or risk factors early and in some cases this allows the risk to the child to be reduced or the condition to be treated rapidly when the baby is born. In other cases it allows the parents to prepare for having a disabled child.

Vaccination of children reduces the risk of them develop conditions that are potentially disabling and it is important that uptake of vaccinations in the population is high to help ensure a high level of protection across the whole population.

Some childhood accidents and injuries can also be prevented and a number of organisations such as the Child Accident Prevention Trust, the Royal Society for the

---

[32] Marlow, N., Hennessy, E., Bracewell, M. and Wolke, D. (2007) 'Motor and executive function at 6 years of age after extremely preterm birth', Pediatrics, vol 120, no 4, pp 797-804

[33] C4EO June 2010 Improving the wellbeing of disabled children (up to age 8) and their families through increasing the quality and range of early years interventions http://www.c4eo.org.uk/themes/disabledchildren/increasingquality/files/c4eo_improving_the_wellbeing_through_early_years_full_knowlege_review.pdf

[34] World Health Organisation Europe 2008 - European report on child injury prevention.

[35] NICE June 2010 Quitting smoking in pregnancy and following childbirth http://guidance.nice.org.uk/PH26

[36] NICE March 2008 Antenatal Care http://www.nice.org.uk

Prevention of Accidents and the Collaboration for Accident Prevention and Injury Control have pulled together a number of evidence bases on the subject.

3.2 Child Poverty

National research[37] shows that disabled children are more likely to live in poverty:

- The income of families with disabled children averages £15,270, 23.5% below the UK mean income of £19,968, and 21.8% have incomes that are less than half the UK mean
- Only 16% of mothers with disabled children work, compared to 61% of other mothers
- It costs up to three times as much to raise a disabled child, as it does to raise a child without disabilities
- Childcare costs around £5.50 per hour for a disabled child, compared to around £3.50 for other children
- With lower than average incomes and higher than average expenditure, many families with disabled children are in debt. 22.6% have debts up to £5,000, 15.7% have debts of up to £10,000 and only 15.7% have no debts. In the general population, 53% have no debts
- Families with disabled children spend £27.61 on loan repayments a week, compared to the UK average of £3.10
- Only 8% of families get services from their local social services.

ChiMat data for Nottinghamshire indicates that the prevalence rates of children with mild disabilities were found to be higher for those from ‘semi-skilled manual’ and ‘unskilled manual’ family backgrounds. The rates for severe disability were greatest amongst children from ‘semi-skilled manual’ family backgrounds. The lowest rates for both mild and severe disability were in the ‘professional’ and ‘managerial’ categories.

Table 3.1 compares Free Schools Meals (FSM) eligibility between the entire cohort, those children at School Action Plus or statemented, and those children with a primary need of Behaviour, Emotional and Social Difficulties (BESD). Across Nottinghamshire schools 13% of pupils are eligible for FSM. For those at School Action Plus or who have a statement, the percentage more than doubles – to 28% of that cohort being eligible. Of the School Action Plus or statemented pupils in Nottinghamshire schools that have a primary need of BESD, 33% of them are eligible – one in three. In three districts, more than 40% of children with a primary need of BESD are also eligible for FSM.

---

[37] Contact a Family (http://www.cafamily.org.uk/professionals/research/statistics.html) [Accessed January 2010]

Table 3.1 Free School Meals eligibility of pupils with BESD

District	Total Cohort in Notts			SEND Cohort (SA+ or Statement)			BESD as Primary Need Cohort		
	Total	Eligible	%	**Total**	**Eligible**	**%**	**Total**	**Eligible**	**%**
Ashfield	18,273	3,143	17%	973	315	32%	256	106	41%
Bassetlaw	16,385	2,229	14%	1,017	251	25%	362	101	28%
Broxtowe	13,001	1,630	13%	597	171	29%	156	65	42%
Gedling	15,332	1,791	12%	881	235	27%	221	75	34%
Mansfield	16,130	2,766	17%	937	326	35%	201	81	40%
Newark	15,326	2,032	13%	834	243	29%	216	59	27%
Rushcliffe	16,710	1,044	6%	664	104	16%	143	29	20%
Notts	**111,157**	**14,635**	**13%**	**5,903**	**1,645**	**28%**	**1,555**	**516**	**33%**

Source: January 2011 School Census [NB: Data does not include secondary academies]

A comment from a member of Disability Nottinghamshire: *"Disabled people and their carers experience a higher cost of living due to their condition or long term illness. The extra costs and support associated with this for the child & parents are sometimes not addressed appropriately. The monetary benefits for both may need reviewing to ensure both of their needs are adequately met financially and support services can then be purchased to improve the quality of life, health and wellbeing of all parties."*

A comment from a service user: *"The assessment process must be speeded up and an appeal process implemented with an external (independent and impartial) organisation where possible to improve the delivery for service users. New service users should have better access to information, regulations and eligibility criteria."*

3.3 Children subject to a child protection plan and looked after children

Disabled children are over-represented in the population of Looked After Children (LAC) and they are more likely to experience abuse than their non-disabled peers, and those with multiple impairments are particularly vulnerable[38].

There are just under 100 Nottinghamshire school pupils who are both the subject of a child protection plan and have an SEN category (Table 3.2). Behavioural, emotional and social difficulties make up just under half of their primary SEN needs (47%), followed by moderate learning difficulties (22%) (Figure 3.3).

---

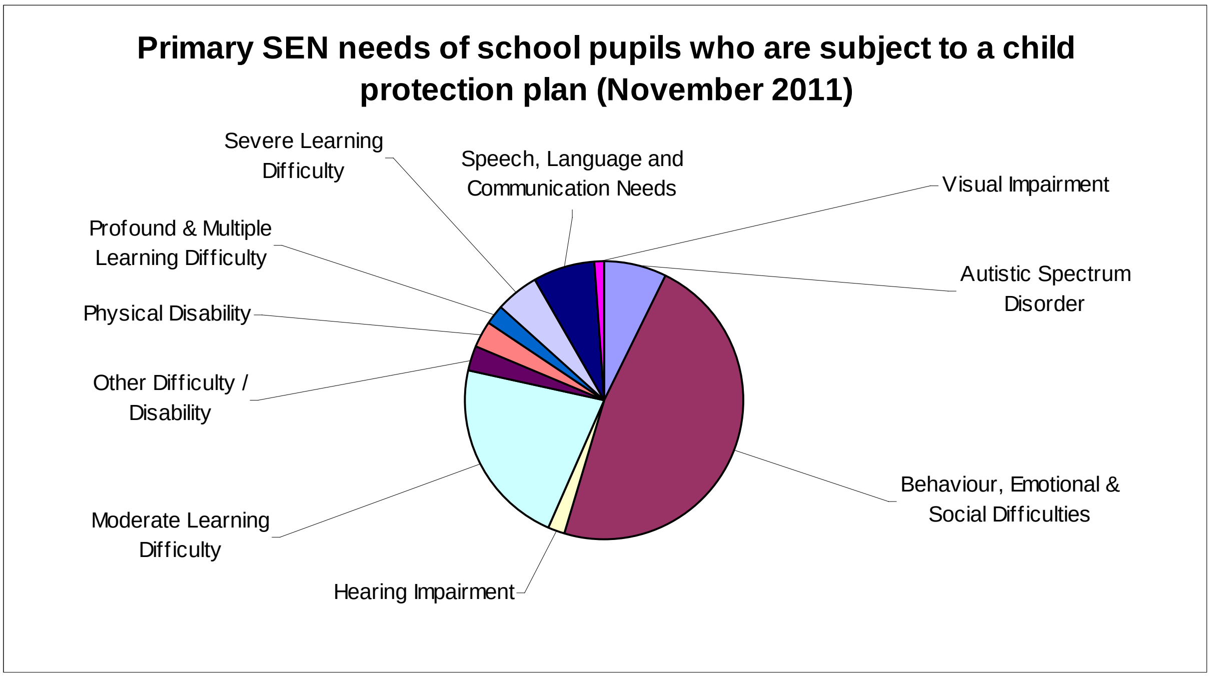
[38] Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice, available from http://www.uea.ac.uk/menu/acad_depts/swk/MRC_web/public_html/files/qpb6.pdf

Table 3.2 Number of Nottinghamshire School pupils with SEN who are also the subject of a child protection plan (October 2011)

Ashfield	19
Bassetlaw	18
Broxtowe	5
Gedling	9
Mansfield	12
Newark & Sherwood	22
Rushcliffe	*
Countywide	9
TOTAL	**94+***

Source: Nottinghamshire County Council (using January 2011 school census), 2011
* Number below five and suppressed

Figure 3.3



Source: Nottinghamshire County Council, 2011

In terms of looked after children (LAC), disabled children are over-represented in this population and are also more likely to be placed in residential settings[39]. The number of LAC who have a disability has remained steady in Nottinghamshire during 2011 at an average of 75 (Table 3.4), with the highest numbers in Mansfield and Ashfield (Figure 3.5).

---

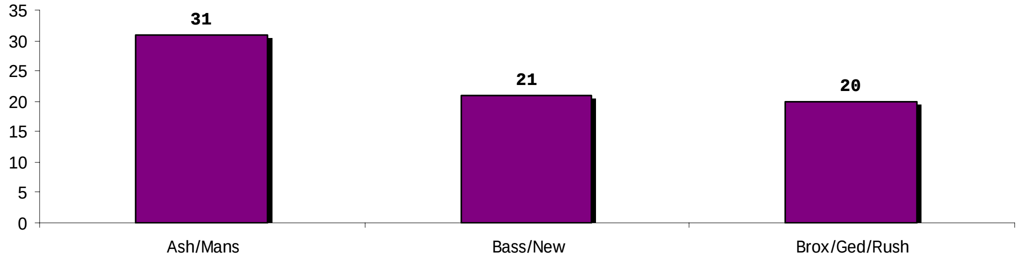
[39] Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice,

Table 3.4 Numbers of looked after children with a disability (2011)

Placement	Jan-11	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Fostering	38	37	39	38	37	36	35	34	33	34
Placed for adoption	5	*	*	5	6	6	6	6	6	6
Children's Home	17	15	16	18	18	18	17	17	17	16
Secure Unit	*	*	*	*	*	*	0	0	0	*
Other Residential Settings	12	11	13	12	12	13	14	14	12	13
Other Hostel	0	0	0	0	0	0	0	0	0	*
Other Placement	*	*	*	*	*	*	*	*	*	*
Nottinghamshire	**72+***	**63+***	**68+***	**73+***	**73+***	**73+***	**72+***	**71+***	**68+***	**69+***

Source: Nottinghamshire County Council, 2011
* Number below five and suppressed

Figure 3.5 Number of looked after children with a disability by locality (October 2011)



Source: Nottinghamshire County Council, 2011

The number of children (aged 5 to 15) in Nottinghamshire in 2010 who have been looked after continuously for at least twelve months and who have SEN (School Action, School Action Plus and statements) totals 180, which is 74.5% of that cohort[40]. This compares to 70.6% for statistical neighbours and 68.7% nationally. As there are approximately 20% of Nottinghamshire pupils with SEN altogether, this means looked after children are three and a half times more likely to have SEN compared to all pupils. National data[41] also shows that looked after children with statements are nearly three times more likely to have behavioural, emotional and social difficulty than all pupils with statements.

In terms of the educational attainment of looked after children with special educational needs in 2010, national data[42] indicates that children looked after for at least 12 months were generally less likely to achieve the expected level in both English and maths at Key Stage 2, compared to all pupils, regardless of SEN provision. The exception were those at School Action Plus, where looked after children were more likely to achieve expected standards. At Key Stage 4, looked after children were less likely to achieve the Level 2 threshold (including English and maths) compared to all pupils, regardless of SEN provision.

---

[40] SEND Policy & Provision, Nottinghamshire County Council, 2011. Figure excludes those in respite care.
[41] Special Educational Needs Information Act – An Analysis, DfE, 2011
[42] Ibid

National data clearly indicates that LAC have a worse level of health than their peers, in part due to the impact of poverty, abuse and neglect that they have been subjected to. LAC are more likely than their peers to experience problems, including speech and language difficulties, bedwetting, co-ordination, vision and or hearing difficulties[43],[44]. In addition, LAC experience significantly worse mental health - an estimated 45% of LAC aged 5 to 17 have mental health problems, over four times higher than for all children.

A national study of LAC found that 45% were assessed as having at least one psychiatric disorder and about 66% of those living in residential care were assessed as having a mental disorder (much higher than those living in foster care of with their parents)[45].

Under the Children Act (1989, 2004), PCTs have a duty to comply with requests from the local authority to address the health needs of children looked after. The following principles are taken into consideration when planning or conducting health assessments:

- Each child or young person should have a holistic health assessment on entering care. The first health assessment should be undertaken by a registered medical practitioner and review health assessments may be carried out by an appropriately qualified registered nurse/midwife.
- The first health assessment should result in a health care plan by the time of the first review of the child's care plan 28 days after becoming looked after).
- Children up to the age of five years should have bi-annual health assessments and developmental checks.

In Nottinghamshire, the Children in Care Health Service carried out health assessments for all LAC referred to the service. Between April 2009 and March 2010, the service received 333 referrals of LAC from the central Nottinghamshire area (Mansfield, Ashfield, Newark & Sherwood). Of this group, 313 had received a health assessment and were followed up as required (20 young people had refused). Of the 313 children and young people seen:

- 98% were registered with a GP
- 64% had been seen by an optician
- 70% were fully immunised
- 52% were recorded as having an emotional health issue
- 24% had developmental problems such as learning difficulties, being on the autistic spectrum and having ADHD
- 21% were recorded as having a physical disability or ill health (including asthma, epilepsy, spinal and cardiac problems)
- 12% were registered as disabled.

---

[43] Meltzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) The mental health of young people looked after by local authorities in England. London: The Stationery Office

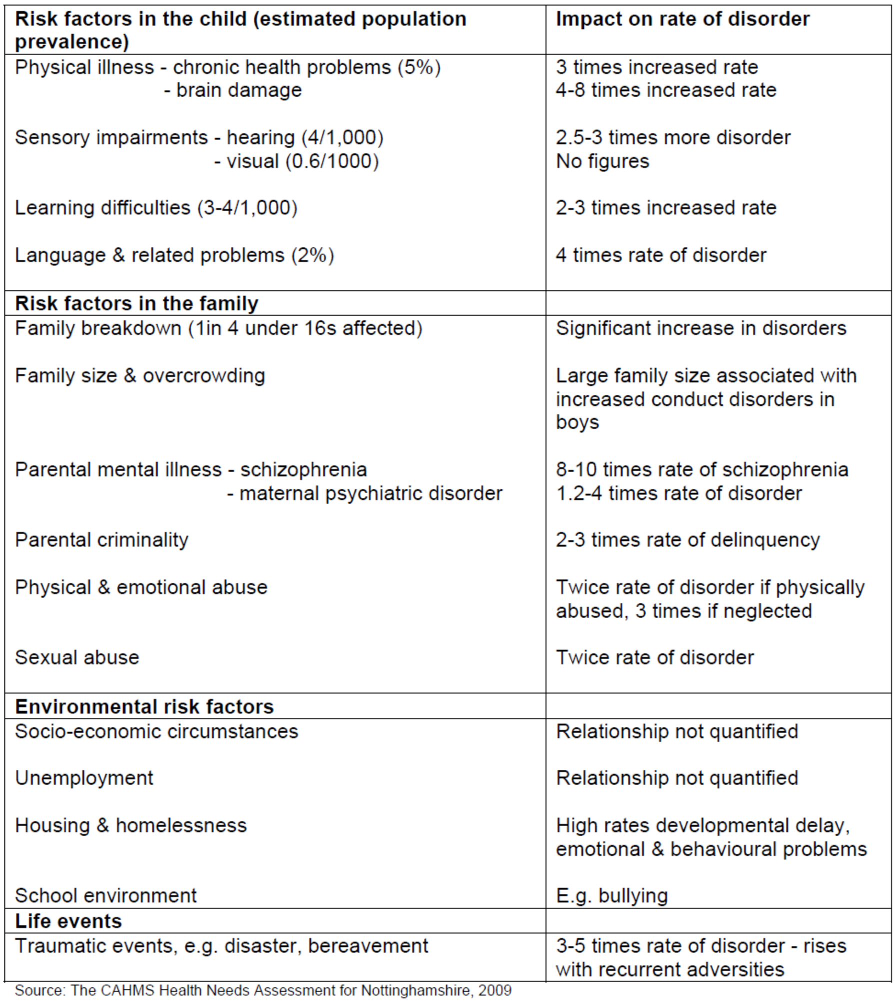
[44] National Children's Bureau (2008) Promoting the health of young people leaving care. Healthy Care Briefing. www.ncb.org.uk/healthycare

[45] Department for Education and Skills (2006) 'Health and Well-being: Physical Health' Research and Practice Briefings: Children and Young People

3.4 Links with Emotional Health and Well Being

The Nottinghamshire Child and Adolescent Mental Health Services (CAMHS) Needs Assessment carried out in 2009 identified that disability and/or special educational needs were risk factors for poorer emotional health and well being amongst children and young people as can be shown in the table below.

Table 3.6 Risk factors associated with emotional and mental health disorders



Risk factors in the child (estimated population prevalence)	**Impact on rate of disorder**
Physical illness - chronic health problems (5%) - brain damage	3 times increased rate 4-8 times increased rate
Sensory impairments - hearing (4/1,000) - visual (0.6/1000)	2.5-3 times more disorder No figures
Learning difficulties (3-4/1,000)	2-3 times increased rate
Language & related problems (2%)	4 times rate of disorder
Risk factors in the family	
Family breakdown (1in 4 under 16s affected)	Significant increase in disorders
Family size & overcrowding	Large family size associated with increased conduct disorders in boys
Parental mental illness - schizophrenia - maternal psychiatric disorder	8-10 times rate of schizophrenia 1.2-4 times rate of disorder
Parental criminality	2-3 times rate of delinquency
Physical & emotional abuse	Twice rate of disorder if physically abused, 3 times if neglected
Sexual abuse	Twice rate of disorder
Environmental risk factors	
Socio-economic circumstances	Relationship not quantified
Unemployment	Relationship not quantified
Housing & homelessness	High rates developmental delay, emotional & behavioural problems
School environment	E.g. bullying
Life events	
Traumatic events, e.g. disaster, bereavement	3-5 times rate of disorder - rises with recurrent adversities

Source: The CAHMS Health Needs Assessment for Nottinghamshire, 2009

As identified in the Health Needs Assessment in appendix two, Emotional health was not recorded by Special School head teachers as being a particular need amongst complex needs pupils. It is not clear if this is truly the case or because it is perceived that physical need is more important. The report recommends that the emotional health and wellbeing needs of pupils is explored in this group of children and young people i.e., CAHMS as this figure is surprisingly low.

3.5 Health Outcomes

Obesity

Children who have a limiting illness are more likely to be overweight or obese, particularly if they also have a learning disability. National data[46] shows that 40% of children aged under-8 with a limiting illness and learning disability are obese or overweight, compared to 22.4% of children who have neither condition. This figure increases to almost 45% in the 8 to 13 age group of children with a limiting illness and learning disability.

There is no local data on obesity and disability, as children unable to stand on scales are excluded from the National Child Measurement Programme. The national analysis above shows the importance of monitoring weight and height in the disabled population, to reduce both health inequalities and financial costs.

Furthermore, children with disabilities are also identified in NICE guidance[47] as a group who are unlikely to participate in at least one hour of moderate to vigorous physical activity a day and therefore should be considered as part of any physical activity plans.

Immunisations

Children with physical or learning disabilities have been identified by NICE as being at risk of not being fully immunised. NICE recommends that access to immunisation services should be improved for those with transport, language or communication difficulties and those with physical and learning disabilities (NICE PH21 reducing the difference in the uptake of immunisations recommendation 5). Obtaining local data for immunisation uptake in children with disabilities is highly difficult due to the lack of a register.

Planned and Unplanned Hospital Admissions

Children as a whole do not have particularly high levels of hospital admission and are generally quite healthy. Routine hospital statistics show that apart from the under ones children have some of the lowest levels of hospital admission compared to other age groups. It is difficult to identify disabled children attending hospital from routine data due to the lack of a systematic way of identifying and recording this status. Despite this, one of the issues that has been identified is disabled children who spend prolonged periods in hospital with chest infections. Work has been undertaken locally to develop a Rapid Response Physiotherapy service to assess and treat children's acute respiratory conditions in the community in order to prevent hospital admissions.

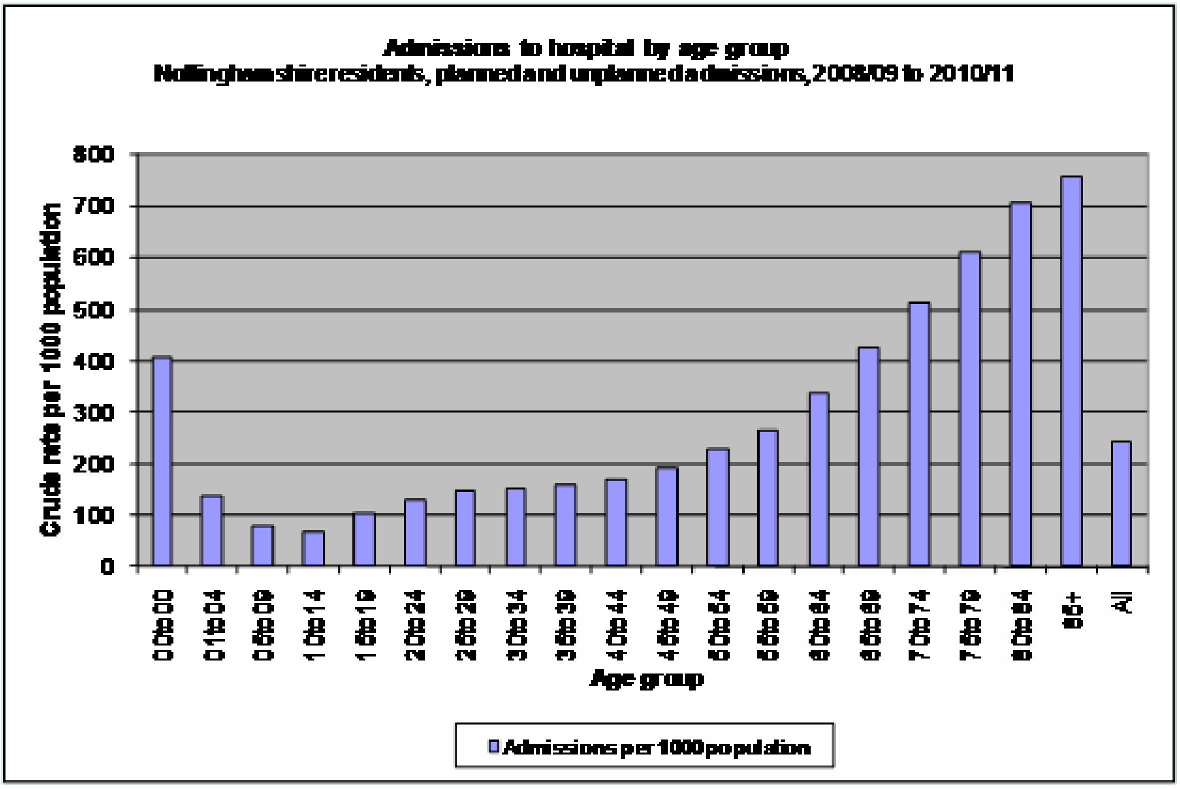
Figure 3.7 illustrates that children over the age of one year are unlikely to be admitted to hospital compared to the rest of the population. More specific local data local regarding child disability was not available for this needs assessment.

---

[46] Disability and obesity: the prevalence of obesity in disabled children, ChiMat 2011

[47] NICE January 2009 PH17 Promoting physical activity for children and young people http://guidance.nice.org.uk/PH17

Figure 3.7: Admissions to Hospital by age group of Nottinghamshire residents, planned and unplanned hospital admissions 2008/09 to 2010/11.



Access to Community Equipment

An independent consultants report commissioned by the Department of Health noted that in many areas commissioning and provision of children's equipment was poor. It concluded that improvement was required in 4 key areas, governance, pathways, sourcing strategies and management of equipment once bought.[48] No local data was available for this needs assessment however information regarding local service provision has been included in section four.

Anecdotally, there is increasing challenges with families accessing consumable equipment in primary care. Items such as suction catheters and trachesotomy tubes families and clinicians have to challenge GP's to ensure children get the consumable equipment they need. Work is being undertaken to resolve these challenges.

3.6 Bullying

There is evidence that a substantial amount of bullying is fuelled by prejudice – racial, religious, and homophobic – and against children with special educational needs or disabilities. Nationally in 2008/9, 61.4% of pupils with learning difficulties said they had experienced bullying, compared with 48% of all pupils[49].

---

[48] CSED Models and options for children's equipment and related services: CSED consultant's report http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111870

[49] Tellus 3 Survey (National Indicator 69)

Many disabled children fail to reach their full potential because they continue to be marginalised in schools, health and social care, according to research published in December 2011[50]. A study, found that disabled children continue to face discrimination, bullying and access problems, even after policies such as Aiming Higher for Disabled Children. Spanning 18 months, the study included interviews with disabled children, their families and children's professionals as well as observations of everyday life for young people with disabilities. It found that too often bullying by other children and discrimination were seen as inevitable for disabled children. Lack of transport, access and community groups misunderstanding health and safety laws continue to exclude many disabled children from school, leisure and community activities.

Local data yet is not available to identify how widespread bullying of disabled children in Nottinghamshire is. Schools however are encouraged to submit bullying incident data to the County Council's Anti-Bullying Co-ordinator.

The national Anti Bullying Alliance was commissioned to review the effectiveness of a range of approaches to preventing and tackling bullying of children with SEN and/or disabilities. They identified the following in their literature review[51]:

- Children with SEN and/or disabilities are disproportionately at risk. Reports indicate that 80% of children with learning difficulties; 70% of children with autism; and 40% of children with speech and language difficulties are bullied and/or victimised.
- The bullying of children with SEN and/or disabilities tends to be more relational than direct. Although both forms of bullying are present, peer isolation and peer difficulties are more common. Pupils with SEN and/or disabilities have extensive experience of being subjected to ridicule, social manipulation and name-calling. Newer forms of bullying – such as cyber bullying, sexual victimisation and social manipulation – also apply to pupils with SEN and/or disabilities.
- Children with SEN and/or disabilities have many characteristics that may make them more vulnerable to bullying. However, social skills, language and communication emerge as key issues in much of the bullying that affects pupils with SEN and/or disabilities.
- Schools face a number of challenges in identifying, responding to and preventing the bullying and victimisation of children with SEN and/or disabilities.

The report also identified key areas that should be considered to help reduce and prevent bullying:

- Communication and language should have a central role in the curriculum for pupils with SEN and/or disabilities as these help develop resilience and coping.
- The social aspects of education should have a central role in the curriculum for pupils with SEN and/or disabilities.
- Teachers need to be more aware of bullying of children with SEN and/or disabilities and consider when and how to intervene

---

[50] Economic and Social Research Council (2011) '*Does Every Child Matter, Post Blair?'*

[51] Anti Bullying Alliance (2011) SEN & Disability: Identifying Effective Anti-Bullying Practice http://www.anti-bullyingalliance.org.uk/send_bullying_project.

- Support staff need to be better trained in the personal, social and emotional aspects of learning and they need to be deployed in ways that do not increase the marginalisation of pupils with SEN and/or disabilities
- Pupils need to be helped to developing ‘voices’ and be able to engage in self advocacy
- Schools need to develop informed approaches to pupil grouping and extended responsibility for pupils with SEN and/or disabilities during the ‘non-teaching’ parts of the school day.

Further details are available at
www.antibullyingalliance.org.uk/send_bullying_project.aspx

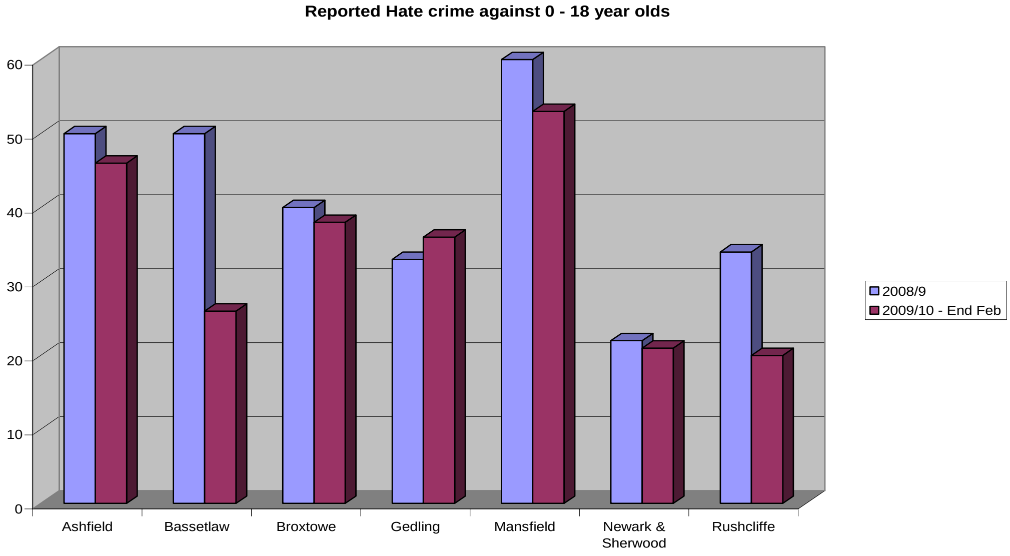
3.7 Hate Crime

Following the Pilkington case in 2007, the identification of vulnerability at the first point of call in hate crime incidents has become paramount in order to put in place measures to prevent repeat victimisation. A pilot is currently being run in the county to develop a Multi Agency Risk Assessment Conference style approach (as used for repeat incidents of domestic violence) to dealing with vulnerability to hate crime/anti-social behaviour and work is also being undertaken to set up a countywide single point of contact helpline for hate crime. In addition, a strategy is being developed by the Safeguarding Adults Board, the Safeguarding Children Board and the Safer Nottinghamshire Partnership to address hate crime against disabled people in Nottinghamshire.

Figure 3.8 shows the reported level of hate crime against children (0-18) in 2008/9 and 2009/10 (to end February 2010 only) in Nottinghamshire. Higher levels of reported hate crime do not necessarily represent an increase in hate crime, but may signify higher confidence levels or growing public confidence in reporting hate crime. Repeat victimisation of individuals is included in the data and therefore this does not represent the actual number of victims of hate crime.

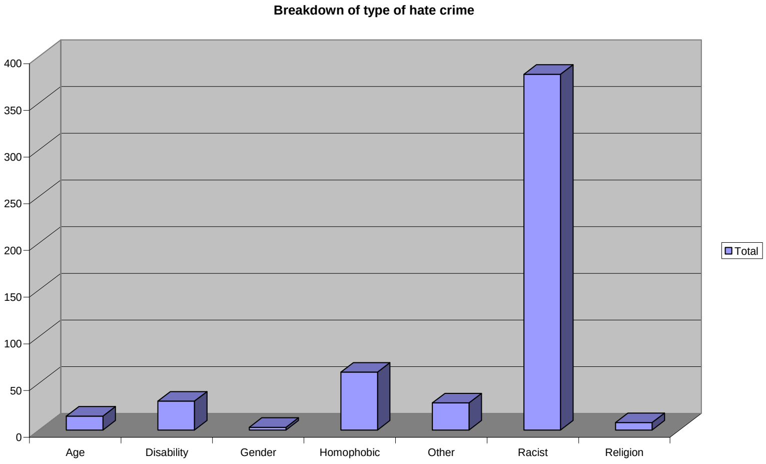
The highest levels of reported hate crime between April 2008 and February 2010 occurred in Ashfield and Mansfield, which also experienced the highest levels of repeat victimisation. Bassetlaw showed a drop in reported incidents since its high number in 2008/09 and the conurbation areas of Broxtowe, Gedling and (to a slightly lesser extent) Rushcliffe all registered significant levels. The lowest number of reported incidents during the time period was in Newark & Sherwood. The proportion of reported hate crime incidents relating specifically to disability can be seen in Figure 3.8.

Figure 3.8 Number of reported incidents of hate crime against children (0-18) in Nottinghamshire 2008/09 and 2009/10 (to end February 2010)



Source: Nottinghamshire Police/Safer Nottinghamshire Board Strategic Analytical Unit, 2010

Figure 3.9 Number of reported hate crime incidents in Nottinghamshire between April 2008 and February 2010 by type



Source: Nottinghamshire Police/Safer Nottinghamshire Board Strategic Analytical Unit, 2010

3.8 Educational Attainment

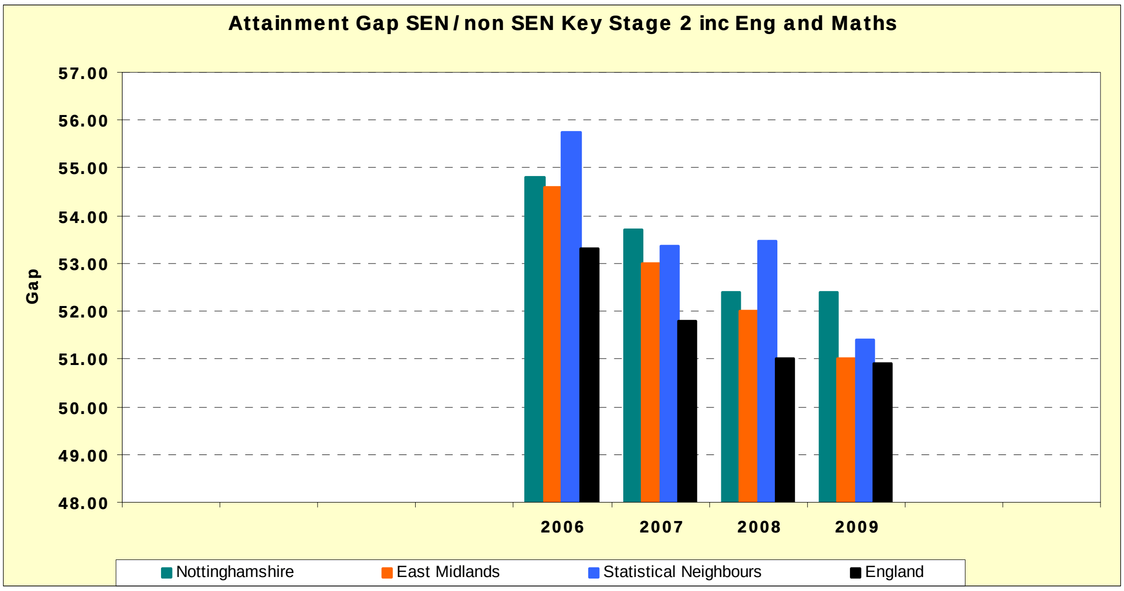
Educational attainment inequalities in Nottinghamshire remain a challenge. Although the achievement gap between SEN and non-SEN pupils at Key Stage 2 has narrowed over the last four years (from 54.8% in 2006 to 52.4% in 2009), Nottinghamshire does not perform as well as statistical neighbours (51.4%) or the national average (50.9%) at Key Stage 2 (Table 3.10 and Figure 3.10).

Table 3.10 Key Stage 2 SEN Gap (2006-2009)

	2006	2007	2008	2009	2009 Statistical Neighbours	20009 National Average
Special Educational Needs (SEN)/non-SEN gap – achieving KS2 English and Maths threshold	54.8%	53.7%	52.4%	52.4%	51.4%	50.9%

Source: Local Area Interactive Tool, Department for Education, 2011

Figure 3.11 Key Stage 2 SEN Gap 2006 to 2009



Source: Local Area Interactive Tool, Department for Education, 2011

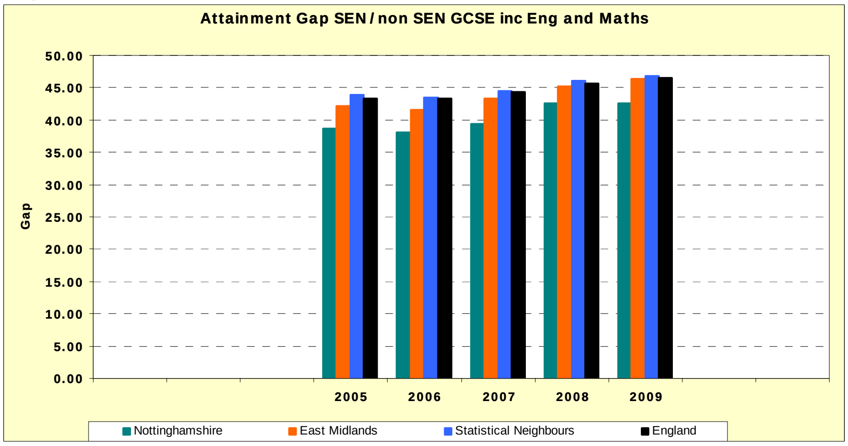
In terms of the attainment gap between SEN and non-SEN pupils at GCSE, the county’s performance against statistical neighbours and the rest of the country is good and in the top quartile nationally – a gap of 42.6% in 2009, compared to statistical neighbours at 46.8% and England at 46.5% (Table 3.12 and Figure 3.13). However, the gap is widening as non SEN pupils’ performance improves at a faster rate than SEN pupils – the 2005 gap in Nottinghamshire was 38.6% and in 2009 it moved to 42.6%.

Table 3.12 Key Stage 4 SEN Gap (2006-2009)

	2006	2007	2008	2009	2009 Statistical Neighbours	2009 National Average
Special Educational Needs (SEN)/non-SEN gap – achieving 5 A*-C GCSEs, including English and Maths	38.1%	39.4%	42.5%	42.6%	46.8%	46.5%

Source: Local Area Interactive Tool, Department for Education, 2011

Figure 3.13



Source: Local Area Interactive Tool, Department for Education, 2011

3.9 School Attendance

In Nottinghamshire we know that children with SEN have higher than average absences from school. In the autumn and spring terms of 2010/11 (Table 3.14), pupils with any form of SEN were absent for 7.97% of all possible sessions, compared to 4.98% for non-SEN pupils. During that timeframe, the SEN group with the highest rate of absence was School Action Plus, with an overall absence rate of 9.87%, almost double that of non-SEN pupils.

The data also shows that SEN pupils are four times more likely to be persistent absentees than non-SEN pupils. The persistent absence rate of School Action Plus pupils in primary schools is lower than that for statemented pupils (5.55% and 7.1% respectively), but at secondary level it is more than double (18.41% versus 8.12%).

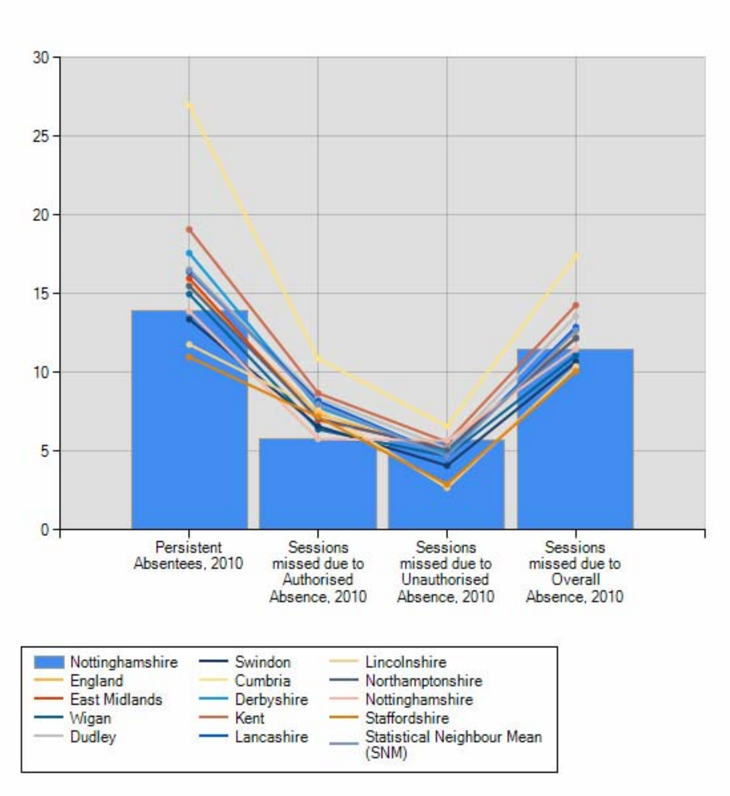
Table 3.14 Absence in Nottinghamshire schools by Special Educational Need (SEN) status (autumn & spring term 2010/11)

		of all pupil enrolments of the specified status				
SEN Status	Percentage of school population	Possible Sessions	% Authorised	% Unauthorised	**% Overall Absence**	**% Persistent Absentees**
			Primary Schools			
Pupils with SEN	**19.08%**	**2,467,833**	**5.31%**	**1.26%**	**6.57%**	**4.44%**
School Action (A)	*14.27%*	*1,849,130*	*5.03%*	*1.32%*	*6.35%*	*4.03%*
School Action Plus (P)	*4.46%*	*574,998*	*6.03%*	*1.11%*	*7.13%*	*5.55%*
Statement of SEN (S)	*0.34%*	*43,705*	*7.31%*	*0.88%*	*8.19%*	*7.10%*
Pupils with no SEN	**79.00%**	**10,270,111**	**4.13%**	**0.48%**	**4.61%**	**1.26%**
			Secondary Schools			
Pupils with SEN	**24.81%**	**2,590,263**	**5.64%**	**3.67%**	**9.31%**	**10.15%**
School Action (A)	*19.14%*	*2,009,475*	*5.32%*	*3.08%*	*8.40%*	*7.97%*
School Action Plus (P)	*5.18%*	*531,453*	*6.80%*	*6.03%*	*12.83%*	*18.41%*
Statement of SEN (S)	*0.48%*	*49,335*	*6.12%*	*2.17%*	*8.29%*	*8.12%*
Pupils with no SEN	**73.99%**	**7,637,817**	**4.29%**	**1.19%**	**5.47%**	**2.60%**
			All Nottinghamshire Schools			
Pupils with SEN	**21.66%**	**5,058,096**	**5.48%**	**2.49%**	**7.97%**	**7.39%**
School Action (A)	*16.46%*	*3,858,605*	*5.18%*	*2.23%*	*7.42%*	*6.09%*
School Action Plus (P)	*us (P)*	*4.79% 1,106,451*	*6.40%*	*3.47%*	*9.87%*	*11.81%*
Statement of SEN (S)	*0.40%*	*93,040*	*6.68%*	*1.56%*	*8.24%*	*7.65%*
Pupils with no SEN	**76.74%**	**17,907,928**	**4.19%**	**0.78%**	**4.98%**	**1.84%**

Source: Nottinghamshire County Council, 2011

When comparing absence from school amongst young people with SEN with statistical neighbours (in 2010) (Figure 3.15), Nottinghamshire was broadly in line with other local authorities. However further work should be done to engage children and young people who are identified as SEN to reduce levels of persistent and unauthorised absence.

Figure 3.15 Absence from School for children and young people on School Action Plus or statement (2010)



Source: C4EO (2011) [52]

3.10 School Exclusions

The latest DfE release relating to exclusions, *Permanent and Fixed Period Exclusions from Schools and Exclusion Appeals in England, 2009/10,* includes the following:

- The percentage of pupils with a statement of SEN that have been permanently excluded has decreased, from 0.24 per cent in 2008/09 to 0.20 per cent in 2009/10.
- Pupils with a statement are around eight times more likely to receive a permanent exclusion than those pupils with no SEN.
- The number of pupils receiving one or more fixed period exclusions with statements of SEN is six times higher than for pupils with no SEN.
- Children who are eligible for free school meals are around four times more likely to receive a permanent exclusion and around 3 times more likely to receive a fixed period exclusion than children who are not eligible for free school meals.

---

[52] Improving the well being of disabled children, interactive mapping website disability data tool http://www.c4eo.org.uk/IAS/profiles/profile?profileId=4&geoTypeId

These findings reflect the local picture. There were 129 permanent exclusions from primary, secondary and special schools in the 2010/11 academic year in Nottinghamshire, which represents 11 pupils in every 10,000. This is a very slight decrease on the previous year. The rate of exclusion was over seven times higher in secondary schools than in primary schools. Over a quarter (28.7%) of permanent exclusions were due to persistent disruptive behaviour, and a fifth (21.7%) were caused by physical assault against a pupil. In addition, there were 4,432 fixed period exclusions, which represents 390 pupils in every 10,000 - a decrease of nearly 12% on the previous year.

In 2010/11, Nottinghamshire pupils with special educational needs (SEN) were 10 times more likely to receive a fixed period exclusion from school than the rest of the school population, and 14.7 times more likely to be permanently excluded (Table 3.16). 25 in every 10,000 pupils with statements of SEN and 45 in every 10,000 with SEN without statements were permanently excluded in the county, compared to three in every 10,000 pupils with no SEN. In all, over 70% of all school exclusions in 2010/11 involved SEN pupils.

Table 3.16 Exclusions in Nottinghamshire schools by SEN status (2010/11)

		Percentage of school population					
	SEN status	**Fixed 1-5 days**	**Fixed 6-15 days**	**Fixed 16-45 days**	**Permanent**	**Total**	**Percentage of all exclusions**
Ashfield	Statement of SEN	14.1	0.45	-	0.91	15.5	**5.2**
	SEN without a statement	11.1	0.11	-	0.33	11.5	**65.0**
	No SEN provision	1.3	0.01	-	0.01	1.4	**29.8**
	Total	**3.5**	**0.03**	**-**	**0.08**	**3.6**	**100.0**
Bassetlaw	Statement of SEN	13.7	0.55	-	-	14.3	**2.8**
	SEN without a statement	20.0	0.12	-	0.64	20.8	**75.2**
	No SEN provision	1.5	0.02	-	-	1.6	**22.0**
	Total	**5.4**	**0.04**	**-**	**0.13**	**5.6**	**100.0**
Broxtowe	Statement of SEN	9.0	0.75	-	-	9.7	**2.8**
	SEN without a statement	11.3	0.12	-	0.50	12.0	**61.5**
	No SEN provision	1.3	0.03	-	0.05	1.4	**35.7**
	Total	**3.1**	**0.05**	**-**	**0.13**	**3.3**	**100.0**
Gedling	Statement of SEN	20.4	0.66	0.66	-	21.7	**5.7**
	SEN without a statement	10.6	1.12	-	0.64	12.6	**63.5**
	No SEN provision	1.2	0.09	0.01	0.08	1.3	**30.8**
	Total	**3.0**	**0.28**	**0.01**	**0.18**	**3.5**	**100.0**
Mansfield	Statement of SEN	15.3	2.67	-	0.38	18.3	**6.9**
	SEN without a statement	11.3	0.65	0.03	0.31	12.7	**70.3**
	No SEN provision	1.1	0.09	0.01	0.04	1.2	**22.8**
	Total	**3.6**	**0.25**	**0.01**	**0.11**	**4.1**	**100.0**
Newark	Statement of SEN	11.0	-	-	-	11.7	**2.9**
	SEN without a statement	13.6	0.44	0.07	0.41	14.7	**72.9**
	No SEN provision	1.1	0.02	-	0.02	1.2	**24.2**
	Total	**3.6**	**0.10**	**0.01**	**0.09**	**3.9**	**100.0**
Rushcliffe	Statement of SEN	7.0	-	-	-	7.8	**1.5**
	SEN without a statement	16.5	0.13	0.13	0.40	17.5	**60.2**
	No SEN provision	1.7	0.03	-	0.03	1.8	**38.3**
	Total	**3.7**	**0.04**	**0.02**	**0.08**	**3.9**	**100.0**
Notts	Statement of SEN	13.4	0.90	0.08	0.25	14.8	**4.0**
	SEN without a statement	13.4	0.40	0.03	0.45	14.4	**67.6**
	No SEN provision	1.3	0.04	0.002	0.03	1.4	**28.4**
	Total	**3.7**	**0.12**	**0.01**	**0.11**	**4.0**	**100.0**

Source: Nottinghamshire County Council, 2011

Table 3.17 shows the Ofsted judgements for pupils' behaviour in all Nottinghamshire schools. This is based on the schools' most recent Ofsted inspection. There is some variation around the county, with Rushcliffe having the highest percentage of 'Outstanding' judgements and Ashfield receiving the highest percentage of 'Satisfactory' judgements. Only one school in Nottinghamshire received a judgement of 'Inadequate' for pupils' behaviour.

Table 3.17 Ofsted judgments for pupil behaviour in Nottinghamshire schools (based on most recent inspection of each school)

District	1 - Outstanding		2 - Good		3 - Satisfactory		4 - Inadequate		Number of Schools
	Number	%	Number	%	Number	%	Number	%	
Ashfield	14	28%	28	56%	8	16%	0	0%	50
Bassetlaw	16	28%	33	58%	8	14%	0	0%	57
Broxtowe	15	33%	24	53%	6	13%	0	0%	45
Gedling	17	34%	31	62%	1	2%	1	2%	50
Mansfield	7	16%	35	78%	3	7%	0	0%	45
Newark	19	37%	26	50%	7	13%	0	0%	52
Rushcliffe	25	54%	19	41%	2	4%	0	0%	46
Nottinghamshire	**113**	**33%**	**196**	**57%**	**35**	**10%**	**1**	**0%**	**345**

Source: Monitoring and Accountability Board: SEND Data Profile; recent Ofsted inspection reports

3.11 Education, Training, Employment

Young people with learning difficulties and/or disabilities (LDD) are over-represented in NEET (Table 3.18). However, as the chart below shows, young people aged 16-18 who were 'School Action Plus' in Year 11 are even more significantly over-represented in NEET when compared to the whole cohort. This is a consistent trend. S139a Assessments are currently undertaken to assist transition, but this does not appear to be having the impact required and it is not clear why.

Table 3.18 Percentage of Nottinghamshire young people age 16 to 18 not in education, employment or training (October 2011)

Cohort (Actual Age 16-18)	% NEET
Whole 16-18 age cohort	4.3%
16-18 learning difficulties/disabilities	6.3%
School Action Plus in Year 11	14.9%

Source: Connexions, 2011

Connexions Nottinghamshire has undertaken surveys of young people who are NEET and their feedback underlines some of the reasons why they became NEET. These include:

- Leaving learning early because they were on the wrong course
- Being asked to leave learning
- Having low or limited qualifications on leaving school meaning they couldn’t do what they wanted
- Childcare responsibilities and not wanting to leave their child with someone they don’t know
- Having lots of personal issues to sort out before they can start to think seriously about entering learning
- Not wanting to continue in learning but not able to find work during the recession
- Poor experiences of school limiting engagement in continuing in learning
- Insufficient flexible start dates
- Financial reasons.

Learners with LDD are defined in Section 13 of the Learning and Skills Act 2000 as a person who:

a. Has a significantly greater difficulty in learning than the majority of people of his or her age
b. Has a disability that either prevents or hinders him or her from making use of facilities of a kind generally provided by institutions providing post 16 education or training.

Case Study - Volunteering

Disability Nottinghamshire can assist individuals with additional needs to achieve goals which were otherwise previously unobtainable. They are a user led organisation and the majority of their services are delivered by disabled people or carers. There is direct peer support for new volunteers to improve their skills, confidence and employability.

“Writing as a volunteer at Disability Nottinghamshire, I have gained experience of working in an office and increased my confidence working with other adults. It’s not easy to find voluntary work when you have a mixed disability.”

3.12 Further and Higher Education

The proportion of Nottinghamshire 16-19 residents in further education (FE) and sixth form colleges with learning difficulties or disabilities (LDD), at 22%, was above the regional average (19%) in 2009/10. Half of all learning aims (50%) studied by learners with LDD were in Preparation for Life and Work, compared to 35% for non-LDD learners. Similarly, a higher proportion of learners with LDD studied entry level and level 1 learning aims (42%) than non-LDD learners (22%).

The number of Nottinghamshire residents aged 19-24[53] with a learning needs assessment in FE and sixth form colleges has increased over the last three years from 64 learners in 2007/08 to 74 in 2009/10. In 2009/10, 77% of enrolments by

---

[53] The YPLA funds learners aged 19-24 with a learning needs assessment, for whom providers draw down Additional Learner Support funding of over £5,500

these learners were in Preparation for Life and 8% in Information and Communication Technology. Nearly two-thirds of enrolments (65%) were at entry level or level 1.

Overall, 8% of 16-19 Nottinghamshire residents in school sixth forms and academies were identified with some form of SEN, compared to 5% in the East Midlands.

- The proportions of learners receiving SEN support under School Action (7%), School Action Plus (1%) or with a statement (0.4%) were close to the regional average in 2009/10.
- A slightly lower proportion of Science and Mathematics learning aims were studied by young people with SEN (23%) compared with young people without SEN (27%). A higher proportion of young people with SEN were studying aims within Preparation for Life and Work (11%) compared with young people without SEN (8%).
- A lower proportion of young people with SEN were studying at level 3 (84%) compared to young people without SEN (97%); with a higher proportion studying at level 2 (11%) compared with (2%).

Disability presents one of the biggest obstacles to participating in higher education (HE) (Woodrow 2001[54]). A report by the National Disability Team in 2004 suggested that, despite the introduction of disability discrimination legislation, some disabled people are still unable to fully participate in HE, which has obvious implications for the post-16 educational aspirations of disabled people[55].

Trend data (Table 3.19) indicates that between 2001/02 and 2010/11, there was a 72% increase in the number of accepted disabled UCAS applicants in Nottinghamshire (city and county), compared to a 16% increase in the non-disabled population. Those declaring a disability for the 2010/11 entry accounted for 7.4% of all accepted applicants, up from 5.1% in 2001/02.

Table 3.19 Number of accepted applicants by declared disability (all age groups), 2001/02 to 2010/11: Nottinghamshire (city and county) residents

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
No declared disability	4,369	4,596	4,477	4,520	4,839	4,602	4,866	5,147	5,326	5,051
Declared disability	234	269	274	248	351	298	320	349	345	403
Total	**4,603**	**4,865**	**4,751**	**4,768**	**5,190**	**4,900**	**5,186**	**5,496**	**5,671**	**5,454**

Source: Post-16 Progression & HE Participation Trends Nottinghamshire (2001/02 to 2010/11), Aim Higher in the East Midlands (April 2011)

3.13 Transition

More children with complex health needs are surviving into adult life, so transition is an increasing issue for all social care services. For disabled children and those with SEN, the move from children's services to adult services can be a challenging and anxious time. The process of supporting disabled young people in their transition to adulthood must be individual to the needs and aspirations of each young person. This can be spread out over a number of years and support may not always be

---

[54] Woodrow, M. (2001), 'Politics not paper – why monitoring matters', in Update on inclusion, Issue 3, Spring 2011

[55] This paragraph is taken from 'Attainment and higher education progression: a study of widening participation trends in Nottinghamshire', Michael Kerrigan: Aim Higher East Midlands, 2006

consistent. This may be compounded by young people's moves from one service to another at different ages – for example, a disabled young person may move from paediatric to adult health services at 16, then at 18 move from children's to adult social care, and up to 19 move from school to college-based education. Families may have to repeatedly deal with new agencies and professionals, re-telling their story each time.

It is therefore vital that public services work together to:

- Develop a strategic transition protocol on how local services work to meet the needs of disabled young people
- Develop a local transition pathway to give the protocol operational detail and map how local services can work most effectively together
- Put in place transition reviews that lead to transition plans, which set out the wishes and aspirations of individual disabled young people, as well as the support that they need.
- Key agencies involved are schools, children's and adults' social care, health services and Connexions. For the transition process to be truly person-centred, young people must have access to information that helps them understand what happens at transition, how to participate in the planning and how to make informed decisions about their future. Family members and friends should also be involved in planning.

Local intelligence from the voluntary sector[56] indicates that parents/carers sometimes do not know what support or information is available to them or how to access it, especially if they do not have access to a social worker. If parents do not know what support is available, they will have to struggle through adulthood with their disabled child and no support. It is also felt that carers' assessments should be mandatory for all parents as their disabled child grows and gets stronger, since there are often issues around aggression and violence towards the parents, and they are not allowed to access training to help them deal with the violence effectively. Parents often report struggling when their children move to adult services as they have been left to do everything for their child for so long, and they are not consulted and feel cast aside when their children move. There needs to be effective communication with the parents and the support to help them let go.

The necessity for greater involvement of young people and their families, as well as the essential need for timely, person-centred planning and effective, coordinated public services has also been recognised through national consultation. All parents consulted found transition planning a very difficult process and commented about the uncertainty they felt.

3.14 Travel and Transport

Transport is often an issue identified by children, young people and their families, alongside costs and having someone to go with or not[57]. Addressing transport issues, for example by providing door-to-door support is an indicator of inclusive services.

---

[56] A Place to Call Our Own (APTCOO)

[57] Beresford B, Clarke S (2009) *Improving the wellbeing of disabled children and young people through improving access to positive and inclusive activities,* Social Policy Research Unit, University of York, published by Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)

Many families find they have to travel out of their local area to find suitable facilities or activities for their child[58]. Some play and leisure schemes report parents find accessing a scheme difficult because of the cost of transport or difficulties using public transport with their child.[59,60,61]

Transport, including the inflexibility of school transport services, was also been identified as a barrier to accessing extended school activities[62,63;64]) and mainstream leisure services[65]. In addition, some parents participating in Shelley's (2002) survey of out-of-school activities reported that lack of supervised transport was a barrier to their child participating in such activities. Murray[66] reports that young people perceived public transport as 'unwelcoming' and limited in that it did not provide door-to-door transport.

National evidence suggests commissioners and providers need to address transport issues. A lack of 'door to door' transport, either through school transport services or public transport, is a key barrier to participation in out of school opportunities and activities for many children and young people.

3.15 Housing and Homelessness

A report from the Joseph Rowntree Foundation[67] summarising the evidence around housing needs for disabled children and their families identifies a number of key issues that they face.

---

[58] Shelley, P. (2002) *Everybody here? Play and leisure for disabled children and young people. A Contact a Family survey of families' experiences in the UK*, London: Contact a Family (available at www.cafamily.org.uk/pdfs/leisure.pdf, accessed 15 April 2009). (Cited in Beresford 2009)

[59] Thompson, B., Taylor, H. and McConkey, R. (2000) 'Promoting inclusive play and leisure opportunities for children with disabilities', *Child care in practice*, vol 6, no 2, pp 108–123.

[60] Ludvigsen, A., Creegan, C. and Mills, H. (2005) *Let's play together: evaluation of Better Play round three*, Ilford: Barnardo's (available at www.playscotland.org/pdfs/LetsPlayTogetherFeb2006.pdf, accessed 15 April 2009). (Cited in Beresford 2009)

[61] Buttimer, J. and Tierney, E. (2005) 'Patterns of leisure participation among adolescents with a mild intellectual disability', *Journal of intellectual disabilities*, vol 9, no 1, pp 25–42

[62] Pinney, A. (2007) *A better start: children and families with special needs and disabilities in Sure Start local programmes* (DfES research report NESS/2006/FR/019), London: DfES (available at www.dcsf.gov.uk/research/data/uploadfiles/NESS2007FR019.pdf, accessed 15 April 2009. (as cited in Beresford 2009)

[63] East Together and Sure Start Project (2005) *Joining in: accessing extracurricular activities in mainstream schools for children with special educational needs and disabilities in the Eastern Region, final report* (available at www.continyou.org.uk/files/documents/documents/doc_822.doc, accessed 15 April 2009). (as cited in Beresford 2009)

[64] Petrie, P., Knight, A., Zuurmond, M. and Potts, P. (2007) *On holiday! Policy and provision for disabled children and their families: final report,* London: University of London, Institute of Education, Thomas Coram Research Unit.

[65] Petrie, P., Knight, A., Zuurmond, M. and Potts, P. (2007) *On holiday! Policy and provision for disabled children and their families: final report,* London: University of London, Institute of Education, Thomas Coram Research Unit.

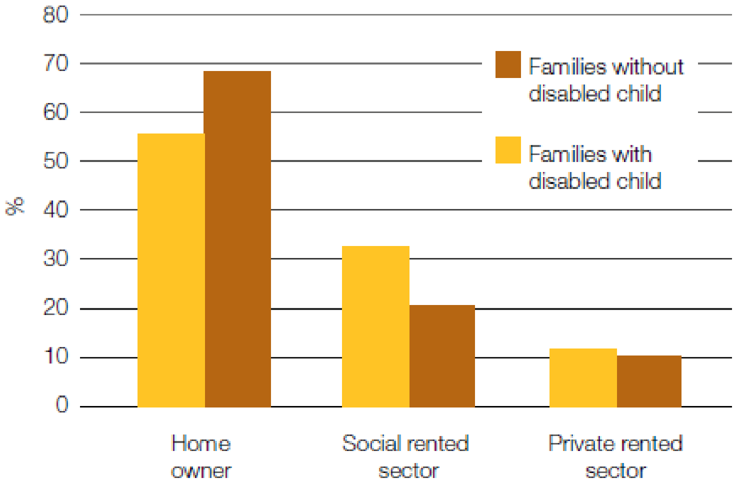
[66] Murray, P. (2002) *Hello! Are you listening? Disabled teenagers experience of access to inclusive leisure*, York: Joseph Rowntree Foundation.

[67] Joseph Rowntree Foundation June 2008 Housing and disabled children: round up http://www.jrf.org.uk/sites/files/jrf/220*n 2002*.

The following key points were identified:

- Families with a disabled child are more likely to be renting their homes than families with non-disabled children.
- Families with a disabled child are less likely to be living in a decent home compared to families with a non-disabled child. Those with a disabled child are 50% more likely than other families to live in overcrowded accommodation, to rate their home as being in a poor state of repair, and to report problems with wiring, draughts and damp in the child's bedroom.
- Compared to other groups of disabled people, disabled children requiring specifically adapted homes are the least likely to be living in suitable accommodation. All disabled children and their families, not just children with physical disabilities, are likely to experience difficulties with their housing.
- The sorts of problems with housing most frequently reported by families include lack of family space, and lack of space for storing and using therapeutic equipment. Other common problems are difficulties with location and unsuitable or inaccessible kitchens, toilets and bathrooms.
- Improvements in families' housing situation can lead to increased independence, more confidence and greater self-reliance among disabled children. However, families can experience significant difficulties accessing support and services to help them address the problems with their housing.
- Living in unsuitable housing has been found to be associated with increased levels of parental stress. Parents describe the negative impact living in unsuitable housing has on their child's well-being and development as well as on their own, and their other children's, physical and emotional well-being.

Figure 3.20 Tenure among families with and without a disabled child (2008)



Source: Joseph Rowntree Foundation, 2011

Table 3.21 Comparison of housing condition reported by families with a disabled child and families without a disabled child

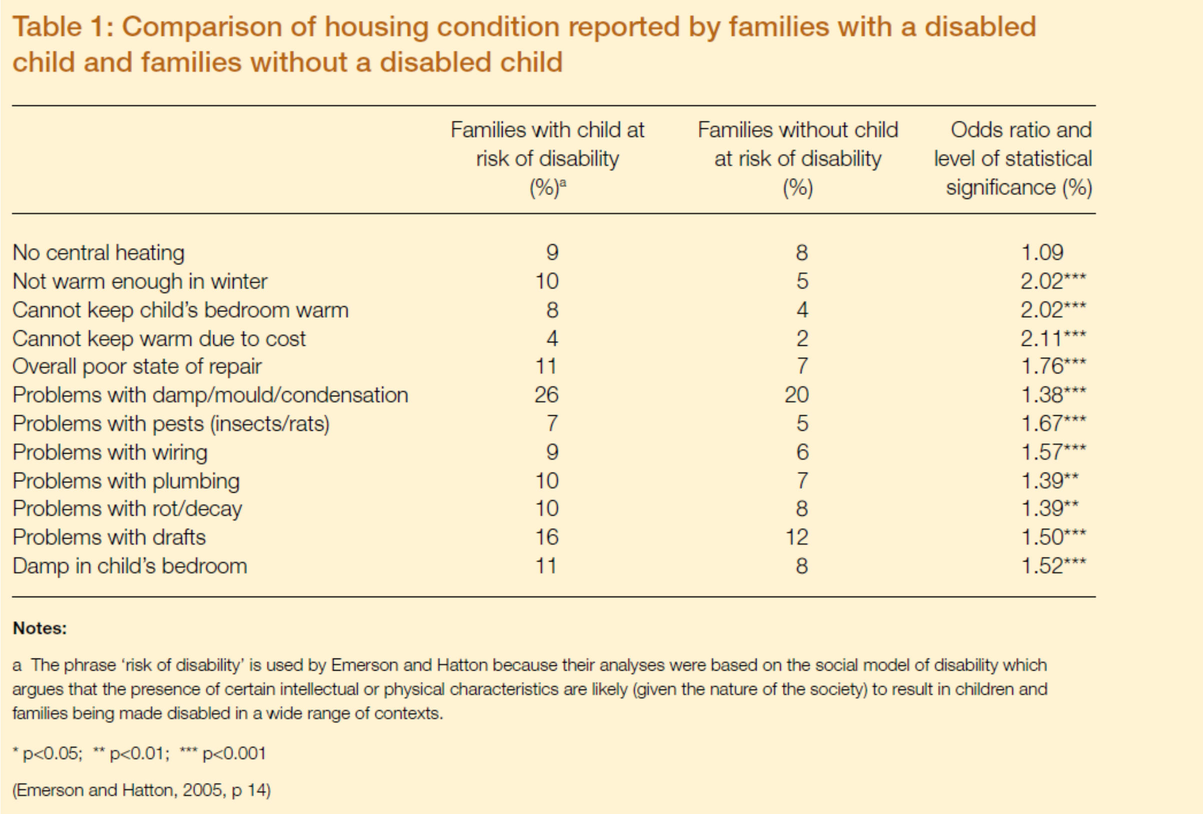


Table 1: Comparison of housing condition reported by families with a disabled child and families without a disabled child

	Families with child at risk of disability (%)[a]	Families without child at risk of disabilit (%)	Odds ratio and level of statistical significance (%)
No central heating	9	8	1.09
Not warm enough in winter	10	5	2.02***
Cannot keep child's bedroom warm	8	4	2.02***
Cannot keep warm due to cost	4	2	2.11***
Overall poor state of repair	11	7	1.76***
Problems with damp/mould/condensation	26	20	1.38***
Problems with pests (insects/rats)	7	5	1.67***
Problems with wiring	9	6	1.57***
Problems with plumbing	10	7	1.39**
Problems with rot/decay	10	8	1.39**
Problems with drafts	16	12	1.50***
Damp in child's bedroom	11	8	1.52***

Notes:

[a] The phrase 'risk of disability' is used by Emerson and Hatton because their analyses were based on the social model of disability which argues that the presence of certain intellectual or physical characteristics are likely (given the nature of the society) to result in children and families being made disabled in a wide range of contexts.

* p<0.05; ** p<0.01; *** p<0.001

(Emerson and Hatton, 2005, p 14)

Source: Emerson, E. and Hatton, C. (2005) *The socio-economic circumstances of families supporting a child at risk of disability in Britain in 2002*

We were unable to source local data from all seven district councils that would help identify if the national picture is reflected also in Nottinghamshire.

3.16 Caring Responsibilities

"The majority of parents with disabled children provide care well in excess of that of other parents[68]". A national study of families with children with profound and multiple disabilities found that 60% of parents spend more than ten hours per day on basic physical care; one third of these were providing 24 hour care. These demands deter parents and carers from accessing employment. The study found that mothers with disabled children are much less likely to have paid employment than other mothers and father's employment and earnings are also affected. They are also therefore a target group for the Nottinghamshire Child and Family Poverty Strategy.

A national survey in the UK identified that approximately 100,000 grandparents take on caring responsibilities for raising grandchildren with multiple disabilities, long term

---

[68] Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice

conditions or a serious illness. This was backed up by another national report[69] that identified the following:

- Over nine out of 10 family and friends carers responding to the survey were grandparents.
- 57% gave up work or reduced their hours to take on the care of a child.
- 88% are under the age of 65 and 42% are under 55. Over 8 out of 10 (83%) are women.
- Two out of three (64.5%) family and friends carers say they have a household income of under £300 a week.
- 52% of carers are working or have a partner who is working. One in three cite welfare benefits as a main source of income, and one in four (27%) rely on the basic state pension. Only a third (36%) gets an allowance from their local authority for looking after their grandchild/children.
- 47% of carers say the reason for taking on the care of a child or children is parental drug or alcohol misuse. Nearly four in ten have been looking after the children for more than five years, with eight in ten having a court order.
- Almost half are looking after a child with special needs or a disability.

Grandparents struggle for information, services and money. They face additional challenges in elation to their age, health and wider family circumstances and greater isolation[70]. The following quotes are taken from the survey findings:

- *“most carers can struggle but when you’re older it can be harder due to your own health problems”*
- *“I care for my husband, he is disabled, and a granddaughter, she is disabled.”*
- *“Caring for him is a full time occupation as he needs constant watching. It can be wearing at times as my husband is disabled and I am not very fit”.*
- *“We are in our 50s and should be saving for old age. As it stands we are spending that on our grandson”.*
- *“I am disabled myself so living on Incapacity Benefit and Disability Living Allowance. I don’t get Carers Allowance because I’m on Incapacity Benefit.”*
- *“It is difficult to know what support is available”.*
- *“It is important to have some time away from home”.*
- *“There is a rollercoaster of emotions sometimes good and sometimes far from good. The intensity of demands leaves you drained both from the child’s needs and the various agencies who quite often fail to communicate effectively with each other”.*

---

[69] Wellard S & Wheatley B (2010) ‘What if we said No?’ Grandparents Plus http://www.grandparentsplus.org.uk/wp-content/uploads/2011/03/Findings2010_ONLINE_NEW.pdf

[70] Family Fund (2011) ‘I wish I could just be Grandma - Parenting again when you have a grandchild with a disability’ http://www.familyfund.org.uk/sites/default/files/I%20wish%20I%20could%20just%20be%20Grandma_0.pdf

A report ‘What if we said no’ developed by the national charity Grandparent Plus showed that without the dedicated work of many grandparents the cost to the UK care system would be £12 billion.

The picture is similar in Nottinghamshire. The following case studies have been collated by Parent Partnership who advocate for parents who have children with disabilities and /or SEN.

Parent Partnership Case Study 1

M is a Yr8 boy at a special school. He has complex physical and medical needs and some associated learning needs. M has recently had his statement amended as it was several years old and this threw up some very difficult discussions between parents, school and health professionals (physiotherapy). There are several health professionals involved with different areas of M’s care and it appears that their opinion of appropriate care regimes differed.

Parents asked for a particular type of physiotherapy input to be increased, as per advice from the longest-involved professional, but were told that this could not be done; it was a simple flat refusal with no discussion as to any other route to pursue. School was caught in the middle as they could not provide the therapy except via health programmes.

The Parent Partnership Service (PPS) supporter took advice from a health professional previously involved with children with complex care needs (nothing to do with the case, just a person we know) who suggested that perhaps a Continuing Care Assessment (CCA) would be a way forward. This was put to parents who agreed and M has now been referred for a CCA. Meanwhile, M’s parents are so stressed by the whole thing that they are writing inflammatory letters to school and damaging what was left of any working relationship between them.

Parent Partnership Case Study 2

Several cases have arisen where children leaving nursery to go into full-time school in September have not been offered a full-time placement. Often these are children with needs around ASD.

One particular case involves a 4 year old (R) who was refused a place at the school where he had been at nursery because the HT did not feel they could meet his needs. R has ASD and some less significant medical needs.

Following an appeal, at which mum was supported by the PPS Choice Adviser and won, and a bit of heavy negotiation with the head teacher, R started at school for 2 hours per day. He has had several informal exclusions (ie mum has been called to take him home) during this term and the head teacher explicitly stated that R will not have his time at school extended. R is now to start at a special school in January after pressure from education and health professionals when R’s mum was perceived to be at breaking point.

There is no involvement from Social Care despite pleas from the family, although R does have some small support via Early Intervention.

The complexity of accessing a range of services is an issue highlighted for many parents and carers. The following case studies have been sourced from the Nottinghamshire Short Breaks Service.

Short Breaks Case Study - CHILD H

On initial discharge from hospital mum acted as the key worker. Mum does not feel comfortable with social care being involved. She also does not like the fact that some professionals expect her to discuss personal things in a meeting forum.

The family received support from health until H went to school. However when her health needs deteriorated social care (who were involved) failed to refer for some additional support.

The family feels that there are some limitations to the flexibility of services they receive and would like two carers at each visit. Mum feels that the Continuing Care Nurse (CCNu) Service is responsive to H's needs.

There is a lack of information about services and feels a parent's directory may be useful. Mum also feel there is a gap with children with children with complex health needs not being referred to appropriate services.

Parents with disabled children are at increased risk of stress compared to other parents and stress levels are strongly linked to child behaviour and sleeping problems. It is important therefore to up skills professionals to identify and support parents and carers with stress, as well as provide opportunities for parents and carers to seek respite care and help including short breaks, domiciliary services, and accessible and appropriate play and leisure services are all central to supporting families effectively.

3.17 Participation in Positive Activities

Disabled children and young people do not participate in sport and leisure activities as much as non-disabled children. Older children in particular report difficulties assessing social and leisure facilities. The lack of inclusive activities leads to boredom and loneliness and mans that disable children spend more time at home and more time watching television than non-disabled children[71].

Participating in positive activities is associated with improved outcomes for disabled children's health and wellbeing. They experience enjoyment, achievement and a sense of belonging. Not all services are genuinely and actively inclusive, and there are different interpretations of what inclusion means. Inclusion needs planning, resources and the active involvement of trained, skilled staff. Disabled children and their families want inclusive services where disabled children and non-disabled children meet, as well as some specialist 'segregated' services exclusively for disabled children. Improving participation is as important as improving access[72].

---

[71] Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice

[72] Beresford B, Clarke S, Borthwick R (2010) 'Improving the wellbeing of disabled children and young people through improving access to positive and inclusive activities' Social Policy Research Unit, University of York and C4EO www.c4eo.

The right for children to equal access to play and recreation is enshrined in United Nations legislation on the rights of the child. Taking part helps children to form positive social interactions, have fun and get active. However, disabled children find it difficult to access play and leisure activities which non-disabled children take for granted. They are less likely to take part and can be perceived by practitioners as a 'hard to reach group' who present 'additional challenges'.

3.19 Links with Offending Behaviour

Limited published work is currently available in the area of autism and offending and most work focuses on adults rather than children and young people. However, within the limited research available, there is some general agreement around a number of key themes. Firstly, most researchers agree that media reports tend to sensationalise specific individual incidents giving the impression of much higher offending rates among the ASD population than is actually the case[73], [74], [75].

One particular small scale study[76] found that commonly held beliefs about offending rates and the link with autism were unsubstantiated and this is specifically cited as an unexpected outcome of their research.

Where offending does occur, there is a general level of consensus about the types of young people and adults within the spectrum who engage in this type of behaviour, namely it is likely to be the most able group of young people who experience a greater degree of independence. Alongside this, other risk factors running concurrently with autism increase the likelihood of offending (for example, additional mental health difficulties, substance use, social isolation and complex family life). Most authors agree that these risk factors are the same as for the general population as a whole.

A large scale study[77] found low rates of offending behaviour generally amongst those with ASD. However, he did note that those young people with the most significant learning difficulties were less likely to be criminalised even where high levels of violence were reported towards families, care and school staff. In these instances, the incidents were more likely to be interpreted and recorded as 'challenging behaviour' as opposed to 'criminal behaviour'. This then raises questions about the ways in which behaviour can be interpreted and recorded and the subsequent implications of this for a wide range of children.

A recent Prison Reform Trust report[78], claims that over half, around 60%, of children in the Youth Justice System have communication difficulties. However, a very broad definition of communication difficulties is deployed here, referring to those with 'poor communication skills' through to those with much more complex communication needs. The report does not specify communication difficulty by type and it would be difficult to ascertain with any certainty what proportion of these children and young

---

[73] Mills, R (2009) High Risk Offending Behaviour in Autism. Director of Research. The National Autistic Society. Unpublished paper presented at a conference in Jersey in 2009.

[74] Bishop, D. (2008) An Examination of the Links between Autistic Spectrum Disorder and Offending Behaviour in Young People. Unpublished paper. 2008

[75] Woodbury- Smith. M, R. Clare, I.C.H. Holland, A.J. Kearns, A. (2009) High functioning autistic spectrum disorders, offending and other law-breaking: findings from a community sample. Informaworld.

[76] Woodbury- Smith. M, R. Clare, I.C.H. Holland, A.J. Kearns, A. (2009) High functioning autistic spectrum disorders, offending and other law-breaking: findings from a community sample. Informaworld.

[77] Mills, R (2009) High Risk Offending Behaviour in Autism. Director of Research. The National Autistic Society. Unpublished paper presented at a conference in Jersey in 2009.

[78] Talbot, J (2010) Seen and Heard: Supporting Vulnerable Children in the Youth Justice System. The Prison Reform Trust

people might be on the autism spectrum. This report concludes that better access to training in all areas of SEN for staff working in the Youth Justice System is much needed.

There is broad agreement in the literature that children and young people with ASD are also a very vulnerable group and are frequently the victims of crime in a wide range of contexts including in schools as well as in the wider community. Some[79] go on to argue that children and young people with autism are much more likely to be the victims of crime rather than the perpetrators.

The Nottinghamshire Youth Offending Service conducted a resettlement data set for young people released from custody in 2009. This revealed that 96% had an SEN category. However, the exact category of SEN is not known.

A SEN and Criminalisation working group has been brought together in Nottinghamshire to look at the impact of Special Educational Needs (SENs) on the criminal activity and or behaviour of young people who are currently known to the Nottinghamshire Youth Offending Service (YOS).

The working group cross referenced data between SEN services and YOS to obtain evidence to support the shared belief that large numbers of children with ASD are represented in YOS data. Given the wider constraints on time and general resources, it was agreed to limit the data search to young people in Key Stage 4. The working group also analysed identified case studies within the specified cohort.

General Emerging Themes

- Only three young people were identified in the initial data trawl where autism spectrum disorder was specified as a primary area of need. This was out of a total 812 children overall in the YOS data set and 1,500 children in the ISS data set. Whilst it must be recognised that this is a very small sample, it was felt that this would still provide an opportunity for in-depth review of each case study.
- In two of the three case studies there had been significant episodes of domestic violence within the family (information was very limited for the third case study and whilst Domestic Violence could not be ruled out completely there was no evidence at this stage). Family life was very complex in at least two of the three case studies.
- All three families were 'hard to reach' and difficult for services to engage with. Frequent references were made to missed appointments.
- All three were at the more able end of the autism spectrum, they had attended mainstream school and all had been permanently excluded as a result of their behaviour One young person had been achieving very well in school until his exclusion, however not enough information was available to make judgements about the academic achievements of the other two children.
- All had some involvement with Educational Psychology Services, in one case this was for a statutory assessment process to take place in order to establish a better understanding of the child's needs.

- All had referrals to Social Care Children's Disability Service and all resulted in a NFA decision as the criteria was not met. Most had multiple referrals for a wide range of services.

---

[79] Mills, R (2009) High Risk Offending Behaviour in Autism. Director of Research. The National Autistic Society. Unpublished paper presented at a conference in Jersey in 2009.

- Where a young person has a statement of SEN, one of the cases suggests that there appears to have been poor liaison between LAs for information transfer.
- In one case, the young person had been told about his diagnosis by a professional four days prior to the offence occurring. It is not clear how this took place nor how he made sense of the information.
- The diagnostic process is critical and in each case it appears to be unclear, conducted in isolation and occurred later in their school life. Professionals were left struggling to obtain information and gain clarity around the diagnosis and its implications for the needs of the individual young person. The process was not carried out in a joined up, collaborative way as advised by The Good Practice Guidance (2002) and NIASA Guidelines (2003) where a shared understanding of a child's needs and difficulties becomes the basis for a diagnosis as well as a planned care pathway. A multi-agency care pathway was not established for any of the young people following diagnosis.
- Multi-agency approaches appear to have been in parallel and plans not fully integrated. In one of the case studies, there is some evidence that there was disagreement about the young person's needs. For example, there appeared to be some confusion amongst family members and professionals about whether there had been a formal diagnosis and if there had been, what the child's individual needs were in relation to the diagnosis. A holistic and comprehensive understanding of the child's needs appears to be missing.
- In some instances, it was felt that having an ASD may also have been a protective factor from further offending behaviour. For example, where a young person prefers solitary pursuits and their own company they are less likely to associate with a 'certain crowd' and be influenced negatively by others.

The working group concluded that the original data set did not provide the results expected as the cross referencing exercise only revealed three case studies. It is likely that this could be a data quality and recording issue and further work would need to be done to verify this due to the nature of the information system in use. We are unable to say with confidence exactly how many young people involved in the Youth Justice System in Nottinghamshire have a diagnosis of an ASD. That withstanding, it seems that there is no obvious link between ASD and criminalisation. The risk factors for young people with ASD entering the youth justice system are no different from other young people. However, these children and their parents or families do receive services from YOT and it would be useful to review the nature of interventions offered to young people with Special Educational Needs (including ASD) to ensure that their individual needs are being addressed. This would be in keeping with recommendations from the Prison Reform Trust (2010).

The SEN and Criminalisation working group recommended the following:

- Further training opportunities for all staff should be made available possibly via the NCC induction programme with a module on autism. Other, accredited training and awareness raising events need to continue to be made available to a wide range of staff across the County Council.
- A cost effective way of providing professional development would be to offer a range of shadowing opportunities working alongside specialists. The role and remit of the Inclusion Support Service autism team is currently under review within the restructuring programme and needs to take account of the continued need for a comprehensive County wide training programme. A consultancy role should continue to be made available where staff from diverse disciplines can

obtain advice to support their work with individual children.

- Further training programmes for parents of children who have received a diagnosis should be available to empower and enable them to understand their children and engage in and supports their development in a positive way. This should ideally, be a multi-agency response.
- Diagnostic processes in autism should comply with the NIASA and Good Practice Guidelines, these should be joined up and information shared across a range of agencies and with parents and families in a way that is understood and holds meaning regarding the individual child. The diagnosis should be a trigger for a multi-agency care pathway for each child.
- Further work needs to be done with the police to consider using National Autistic Society cards that briefly explain the diagnosis (as occurs in other areas of the UK).
- Each team or service within Children's services could consider having an ASD or SEN champion and this would replicate the SENCO model in school settings and bring further specialist expertise to generic teams.
- Access to high quality training and awareness raising in SEN and autism for all children's services personnel remains key. With over 1,800 children with a diagnosis of autism in Nottinghamshire we would expect to find children and young people with autism in every setting and within every area of our work. An understanding of disability issues as it relates to autism should be an essential prerequisite for all staff in Children, Families and Cultural services. Good practice for children with autism is good practice for all children and learning to work with diverse needs can only enhance skills and build further capacity among the workforce. .

4. Understanding Current Service Provision for Children and Families in Nottinghamshire

Local Young Person's View of Services
"The people who run the organisations are always there to listen to anyone's problems… we need more of these organisations around and it might help out with most of the problems."

Local Parent's View of Services
H had a sibling who passed away a few years ago. Mum feels that this time round services have been much more improved and better coordinated. The family are happy with the services they receive from the CCN's, C4F and school.

Mum felt the timing of her daughter's referral was appropriate. She was initially reluctant to leave her daughter with other carers, but she knew her daughter was happy and safe.

4.1 An Overview of Services

Nottinghamshire offers a range of services to children and families affected by disability and SEN. Services include universal services and those that are very specialist, offering support and interventions to children and young people with complex care needs.

A number of service pathways are also available for specific disabilities including ADHD, ASD and palliative care.

Diagrams and a table of services by age group and tier of service are included in Appendix 4, detailing most services. This is not an exhaustive list of all services, and further information is available on a number of websites such as the Families Information Service and IRIS, which include all local services.

4.2 Education Services

There are eleven special schools in Nottinghamshire, with at least one located in each of Nottinghamshire's seven districts.

1.	**St Giles School**, Retford, Bassetlaw	Learning Difficulties, 3-19 years, 136 pupils on roll
2.	**Orchard School**, Newark, Newark & Sherwood	Learning Difficulties, 2-19 years, 88 pupils on roll
3.	**Cotgrave Ash Lea School**, Cotgrave, Rushcliffe	Learning Difficulties, 3-19 years, 78 pupils on roll
4.	**Foxwood Foundation School**, Bramcote, Broxtowe	Learning Difficulties, 3-19 years, 102 pupils on roll
5.	**Carlton Digby School**, Mapperley, Gedling	Learning Difficulties, 3-19 years, 58 pupils on roll
6.	**Derrymount School**, Arnold, Gedling	Learning Difficulties, 3-19 years, 51 pupils on roll
7.	**Bracken Hill School**, Kirkby-in-Ashfield, Ashfield	Learning Difficulties, 3-19 years, 97 pupils on roll

8.	**Fountaindale School**, Ashfield, Ashfield	Physical Difficulties, 3-19 years, 59 pupils on roll
9.	**Yeoman Park School**, Mansfield Woodhouse, Mansfield	Learning Difficulties, 3-19 years, 94 pupils on roll
10.	**Redgate School**, Mansfield	Learning Difficulties, 3-11 years, 22 pupils on roll
11.	**Beech Hill School**, Mansfield	Learning Difficulties, 11-19 years, 62 pupils on roll
Information sources: Edubase, Planning & Provision (CYP), Data Management (CYP) and Capita ONE.		

Figure 4.1 Nottinghamshire map highlighting the location of all special schools, 2011.

Source: Nottinghamshire County Council, 2011

Special school placements

The number of pupils in Nottinghamshire's special schools has risen slightly in recent years. In January 2011, 847 pupils attended one of the eleven special schools maintained by the County Council, compared to 820 in 2007 (Table 4.2). This equates to 0.72% of all Nottinghamshire school pupils (Table 4.3).

Table 4.2 Total number of pupils on roll at maintained special schools in Nottinghamshire

2007	2008	2009	2010	2011
820	830	806	827	847

Source: January school census returns [Includes pupils who are sole and dual main registrations]

Table 4.3 Percentage of pupils on roll at maintained special schools in Nottinghamshire

2007	2008	2009	2010	2011
0.67%	0.69%	0.68%	0.70%	0.72%

Source: January school census returns [Includes pupils who are sole and dual main registrations]

There are currently 84 Nottinghamshire pupils attending special schools in other local authorities (Table 4.4), down from 106 in 2008/09. Conversely, 103 pupils whose home address is outside Nottinghamshire attend special schools within the county (Table 4.5). This is a reduction on 124 in 2005/06.

Table 4.4 Number of Nottinghamshire pupils attending special schools in other local authorities

2008-2009	2009-2010	2010-2011	2011-2012	2008-2009
106	98	87	84	106

Source: Nottinghamshire County Council, 2011

Table 4.5 Number of pupils from other local authorities attending Nottinghamshire special schools

2005-2006	2006-2007	2007-2008	2008-2009	2010-2011	2011-2012*
106	98	87	84	106	103

Source: January school census returns [* Projected annual spend as at period 7]

Nottinghamshire also places pupils in independent or non-maintained special schools. Recently there has been an increase in the number of such placements, from 58 in 2005/06 to 132 in 2011/12 (Table 4.6), a rise of 128%.

Table 4.6 Number of pupils funded from the independent/non-maintained special schools budget during the financial year

2005-2006	2006-2007	2007-2008	2008-2009	2010-2011	2011-2012*
58	55	69	76	86	102

Source: Nottinghamshire County Council, 2011 [* Projected annual spend as at period 7]

This increase in independent/non-maintained special school placements has resulted in significantly higher costs, up from nearly £2m in 2005/06 to over £4.5m in 2011/12 (Table 4.7). This equates to a current cost per pupil in those placements of £33,880 (compared to £31,441 in 2005/06). The County Council has engaged in the development of effective partnerships and as a result has agreed more competitive placement costs with providers.

Table 4.7 Total expenditure on independent and non-maintained special schools

2005-2006	2006-2007	2007-2008	2008-2009	2010-2011	2011-2012*
£1.82m	£1.93m	£2.08m	£2.31m	£2.54m	£3.88m

Source: Nottinghamshire County Council, 2011 [*Projected annual spend as at period 7]

4.3 Education Otherwise than at School

Around 300 children and young people on the local authority roll were educated otherwise than at school as of January 2010. Of these, 78% were male and 22% female and the highest numbers of pupils were in Ashfield (26%). The lowest numbers were in Rushcliffe (8%). Health related issues accounted for 16% of the total and 13 out of the 65 girls were educated otherwise than at school because of pregnancy or motherhood. Fewer than five pupils were looked after children and 12% of the overall male total had complex and challenging needs, requiring one to one tuition.

4.4 Nottinghamshire Learning Centre

Every local authority is under a statutory obligation to ensure that all children and young people of compulsory school age are provided with suitable and sufficient education at school or otherwise than at school. In Nottinghamshire the responsibility for providing education other than at school falls mainly to the Nottinghamshire Learning Centre (NLC).

The NLC provides educational provision for children and young people of compulsory school age who experience a range of circumstances including those who:

- are admitted for medical treatment at Kings Mill and Bassetlaw Hospitals
- require home education for reasons of long term illness or convalescence, anxiety related difficulties or because they are pregnant or school girl mothers
- are looked after children with BESD, without a school place, at risk of exclusion or new to the county
- need long term provision due to their complex BESDs and who will usually have a statement of special educational needs

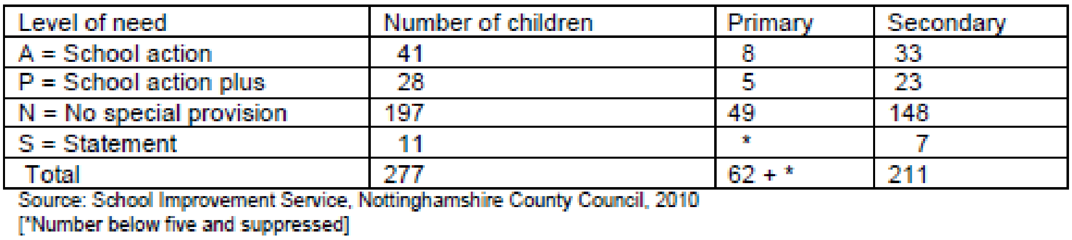
The NLC also manages five countywide specialist teams who provide education to a range of learners including those with severe BESD; there are dedicated teams for Hospital Education and Home Education.

4.5 Elective Home Education

In common with local authorities across the country, the number of parents exercising their right under Section 7 of the Education Act 1996 to educate their children other than at school has increased in recent years. Councils aim to work in partnership with parents who have elected to educate their children at home but the extent to which advice and support can be offered is limited. However, under Section 343 of the Education Act 1996, local authorities may intervene if it appears that parents are not providing a suitable education, and if elective home education teams are alerted to concerns about a child's welfare, relevant agencies are notified. The monitoring of reports and subsequent action taken suggests that Elective Home Education is meeting the needs of the child in 80% of the cases in which the local authority has been involved.

As at January 2010, 27% of the total population of children electively educated in Nottinghamshire were identified as having special educational needs (Table 4.8) and 10% of the total population were traveller children, a figure which is traditionally between 8% and 10%.

Table 4.8 Numbers of children with Special Educational Needs receiving elective home education (as at January 2010)



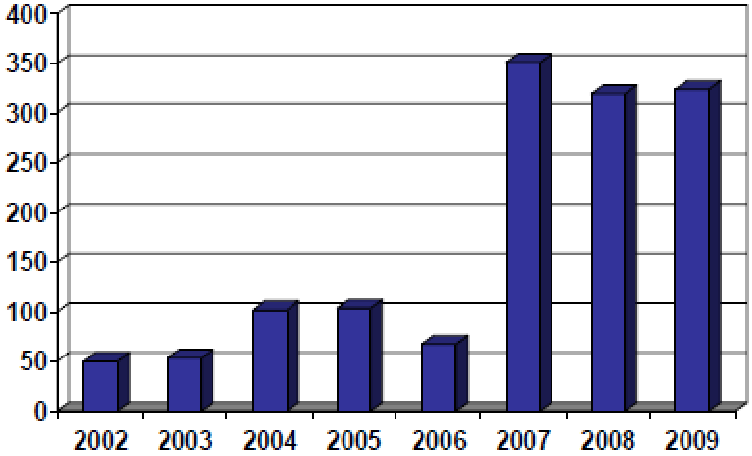
Level of need	Number of children	Primary	Secondary
A = School action	41	8	33
P = School action plus	28	5	23
N = No special provision	197	49	148
S = Statement	11	*	7
Total	277	62 + *	211

Source: School Improvement Service, Nottinghamshire County Council, 2010
[*Number below five and suppressed]

4.6 Autism Education Programmes

ASD impacts on all aspects of a child or young person's life including education and access to health services. There is a significantly growing demand and need for specialist advice, support and places for children with ASD following diagnosis, and parent programmes across the county are increasingly over-subscribed. Numbers of parents attending multi-agency autism education programmes is indicative of the demand (Figure 4.9). Provision for children with ASD was a key priority for parents and carers in consultation undertaken for the County Council's Review of SEN and Inclusion (2009), not only with regard to access to appropriate school placements, but also to wider extended services.

Figure 4.9 How many parents attended Autism Education Programmes?



Source: 'Working together to support families of children with Autism in Nottinghamshire - progress report' (January 2010) by NORSACA, NHS Nottinghamshire County and Nottinghamshire County Council

4.7 Post 16 Education

Learners with learning difficulties and or disabilities (LLDD) have a range of educational progression options post-16. The majority of learners with most profound challenges, evidenced by a Statement of Special Educational Needs, remain at special schools until the age of 19, so their post compulsory transition phase is later. LLDD leaving school at either 16 or 19 can, subject to meeting entry requirements, access mainstream Further Education provision.

Nottinghamshire Futures

Nottingham and Nottinghamshire Futures is a joint venture company owned by Nottinghamshire County Council and Nottingham City Council. It includes a range of services including Connexions; Education Business Futures and the post-16 commissioning unit.

Young people with significant learning difficulties and disabilities are supported by a member of Connexions specialist Disability and Inclusion Team, who will work with them from Year 9 onwards through key transition phases into post-school education and, if appropriate, adult services. The Post-16 Commissioning Team is responsible for approving applications to Independent Specialist Colleges and, in partnership with Connexions, for developing learning packages for challenging learners who need customised provision.

From April 2012 the Connexions Service ceases to exist nationally and there is no requirement on local authorities to fund universal Information Advice and Guidance provision for young people. Local authorities become responsible for supporting vulnerable groups and young people who are NEET and, consequently, Nottinghamshire County Council through its targeted support arrangements will continue to provide specialist support for young people with LLDD.

For young people with significant learning difficulties/disabilities, the Connexions Disability and Inclusion Advisor has been central to supporting appropriate transitions to post-compulsory education. In many cases, there will be a number of agencies, including for example health and social care professionals, involved and there is a commitment to work together to ensure effective transitions into post-compulsory destinations.

The Connexions Service currently provides a universal information, advice and guidance service to all young people in Year 11. They also have a dedicated website for parents (www.theparentpoint.com) which has a section specifically for parents whose children need additional support. The website explains the key phases in the transitions journey, the role of Connexions and other intermediaries and outlines the main post-16 progression options. The website contains a link to the Nottinghamshire Parent Partnership Service website.

Further Education (FE) Colleges

All of the general FE colleges in Nottinghamshire provide customised programmes for LLDD learners, typically comprising vocational qualifications, functional skills and skills to support independence. Learners can also access or progress to mainstream FE college courses if appropriate, or access these as a progression route on completion of customised provision.

There are five general FE colleges supporting Nottinghamshire learners:

- Lincoln College (Newark campus)
- NCN (City based)
- North Nottinghamshire College
- South Nottingham College (including the former Castle College)
- West Nottinghamshire College

In addition, the Brackenhurst campus of Nottingham Trent University offers FE funded foundation studies programmes for learners with learning difficulties/disabilities.

Bilborough 6th Form College, although located in Nottingham City, draws a significant number of learners from the county. It does not offer customised programmes for LLDD, but will support academically able learners with physical disabilities or high functioning learning difficulties on its mainstream programmes.

Each College has its own entry criteria – formal academic qualifications are seldom stipulated but the capacity and willingness to learn is generally a prerequisite. All general FE colleges receive Additional Learner Support funding to support learners with learning difficulties and/or disabilities to access provision. This is used to fund a range of services including one-to-one or small group support, specialist arrangements for examinations and assistance during breaks or to access other college sites.

The capacity of mainstream colleges to meet the needs of learners with complex learning, physical or emotional difficulties varies between institutions, with complex emotional/behavioural difficulties and physical disabilities requiring significant therapeutic and medical interventions generally proving more problematic to accommodate within mainstream. Colleges have specialist teams of staff dealing with additional learner support and work closely with course tutors to ensure that appropriate support packages are put in place. Colleges also deliver directly, or can signpost to, counselling services to support learners as required.

Young people aged 16 to 19 receiving both the Employment Support Allowance and Disability Living Allowance are one of the priority categories identified by the government to receive a payment of £1,200 a year under the Bursary Scheme, which has replaced the Education Maintenance Allowance. Education providers can, at their discretion, increase this amount and can also extend bursary eligibility (although not necessarily to the amount of £1,200 per annum) for learners with LLDD who do not meet the benefits criteria.

Independent Specialist Providers

Learners with complex physical disabilities/learning difficulties whose needs cannot be met within mainstream FE can apply to Independent Specialist Colleges (ISCs), which can support health and personal care needs as well as providing educational provision.

Independent Specialist Providers (ISPs) offer education packages for young people with profound and multiple learning difficulties/physical disabilities and in some cases emotional and behavioural difficulties.

ISCs provide customised support on either a day or residential basis for learners with complex needs. The majority provide a range of specialist interventions, such as speech and language therapy, hydrotherapy and physiotherapy, as well as educational provision, and are able to support learners requiring significant medical intervention and/or those with high personal care needs. Provision at such colleges is expensive – typically around £70,000 for residential placements – and local authority commissioners therefore stipulate that places at ISCs can only be considered if there are no appropriate mainstream options available. Nottinghamshire County Council, in common with most local authorities, is looking to reduce the number of out of area residential placements and to move away from the standard three year placement model operated previously by the Learning and Skills Council.

There are approaching 60 Young People's Learning Agency (YPLA) approved ISPs operating in England and Wales. Only one, Portland College, is based in Nottinghamshire but Landmarks (Creswell), RNIB (Loughborough) and Homefields (Leicestershire) can also be accessed on a non-residential basis.

There were 38 residents aged 16-24 with placements in ISPs in 2009/10. Figures to date for 2010/11 show an increase to 49 placements. Nottinghamshire is one of six local authorities in the East Midlands with 50% or more of their residents in ISPs placed in residential rather than day provision.

The planning assumption is that the ISP budget will not now transfer to the local authority until 2013 and until then the authority will remain responsible for ensuring that a place is found for all those for whom mainstream provision is inappropriate and for working closely with the YPLA to ensure that Nottinghamshire's indicative budget is not exceeded.

Nottinghamshire has a slightly higher proportion of resident school sixth form learners with SEN and of learners with learning difficulties and/or disabilities in FE than the regional averages. The process for placing learners at ISCs is being reviewed for 2012 -13. Subject to consultation, it will support more robust control over the budget by:

- Making application to an ISP subject to prior approval by a Connexions Disability & Inclusion Advisor
- More robust challenge to ISP assessments and developing the capacity of mainstream colleges to demonstrate that they can meet higher level need
- Increasing use of initial one year placements and sharper focus on progression outcomes
- Increasing contributions from health and social care partners, so that YPLA funding is focused on educational outcomes
- Greater use of mixed mode non-residential provision.

Two of the eight key priorities of the Nottinghamshire 16-19 Participation & Attainment Plan (2011/12) are to increase post-16 progression options for vulnerable learners[80] and to manage the effective placement of young people in ISPs and colleges within budget in preparation for full commissioning from 2013. These priorities aim to ensure young people with disabilities and SEN have access to appropriate education or training.

---

[80] For the purposes of the Plan, vulnerable is defined as: SEN, English as an Additional Language, Free School Meals and Children Looked After. Outcomes by age 19 for vulnerable learners are disproportionately low. Level 3 is the highest level of study for 37% of the vulnerable group compared to 60% of others.

Training Providers

Learners with mild to moderate LLDD may be signposted to one of the private Foundation Learning providers delivering in Nottinghamshire. Foundation Learning programmes operating predominantly at or below Level 1, offer a combination of vocational, functional and personal/social development modules combined in a programme of study typically lasting six months to a year. There are approximately ten private training providers, funded by the YPLA, operating in Nottingham City and Nottinghamshire delivering Foundation Learning.

Foundation Learning is a programme of study for learners operating predominantly at or below Level 1, including what were previously described as entry or pre-entry levels. Foundation Learning programmes comprise three elements:

- Vocational qualification
- Functional skills
- Personal and social development.

Foundation Learning programmes typically last from six months to a year and operate on a ‘roll on, roll off’ basis. There are flexibilities within the funding guidance to ensure that learners with learning difficulties/disabilities are given sufficient time to achieve their qualifications. A significant percentage of Foundation Learning learners will have some kind of learning or behavioural difficulty, but generally towards the milder end of the spectrum. Nottinghamshire County Council’s Skills for Employment provision deals with more complex/challenging learners and the AAA programme is specifically targeted at learners with learning difficulties and/or disabilities.

The Foundation Learning Education and Employment Training Group continues to lead on coordinated developments, allocating funding, evaluating outcomes and reporting to Partnership Board. The Foundation Learning Progression Working Group is focused on developing a pan-Nottinghamshire progression agreement between colleges and schools to support Foundation Learning learners avoid repeat learning post-16.

Support and Preparation for Employment

For young people with LLDD seeking employment, the apprenticeship route is available for those with the capacity to learn to a minimum of Level 2 standard. The National Apprenticeship Service is currently promoting a number of initiatives to increase the participation of under-represented groups, including LLDD learners, in the apprenticeship programme. No data was available for this needs assessment to identify the proportions of young people accessing apprenticeships who have a disability or SEN.

Jobcentre Plus is the lead agency for supporting adults with LLDD to access employment. Jobcentre Plus has a team of Disability Employment Advisors (DEA), who can signpost to employment support programmes such as Access to Work and Work Choice. Subject to eligibility criteria, DEAs can also refer adults to residential training provision to provide intensive employability support. Portland College in Mansfield is a nationally approved provider for this programme. Nottinghamshire County Council has its own work programme, which supports people with disabilities to find a job and stay in employment.

Gaps in provision

Information from commissioners indicates that there are a range of services and interventions available for young people aged 16+. However, the biggest challenge for many is to find suitable placements for a small number of young people with complex needs, mainly emotional and behavioural or autistic spectrum disorder. Many of these young people have been engaged on alternative provision pre-16, often through one to one support, and therefore struggle to integrate into a college environment, mainstream or specialist, post 16 placement. In 2011/12, a pilot programme has been delivered for four such learners, using on-going support from their alternative pre-16 provider, REAL Education, to support them to transition post-16. Subject to evaluation, this programme may be extended next year and subsequently.

4.8 Early Years and Childcare

Childcare Sufficiency

The Childcare Sufficiency Assessment for Nottinghamshire County Council was completed in April 2011.

It identified that *"Nottinghamshire has an excellent record of providing inclusive childcare provision across the county, and has developed further good practice through the year on year increase in the level of support given to settings by the authority to ensure the needs of individual children can be met, through further staff training, access to specialist equipment etc. Nottinghamshire was a pilot authority for the government's Disabled Children Access to Childcare (DCATCH) project and has developed a model for the delivery of individual childcare packages for those children who, because of their severe and complex needs are unable to access group based care. The model of delivery, with enhanced information to parents and brokerage of the childcare packages has been very successful and the authority has agreed to continue to develop and support this childcare. Feedback gathered from families supported by settings accessing inclusion funding or DCATCH activities across the county has been very positive. This indicator is green across the county[81]."*

The majority of childcare gaps are geographical and by childcare type - i.e. there are some areas in the county where the full range of childcare type is not available. Some rural areas do not have sufficient demand to make group childcare provision viable, so childminder provision is heavily relied upon. In many communities, informal childcare is being provided by extended family and friends, this can be considered as income gaps – anyone caring for a child in these instances should be encouraged to become registered, in order that parents can claim tax credits. Specific needs gaps also occur for disabled children and these are addressed on a case by case basis.

"It would be nice to find some sort of holiday club that is suitable for my child who has Cerebral Palsy. Normal holiday clubs are too difficult for her to deal with"

Local Parent[83]

---

[81] Nottinghamshire County Council (2011) Childcare Sufficiency Assessment 2011 (page 6)

[73] Hamilton & Kakoullis (2010) Nottinghamshire Child Poverty Needs Assessment

[83] Nottinghamshire County Council (2011) Childcare Sufficiency Assessment 2011

Children Centres

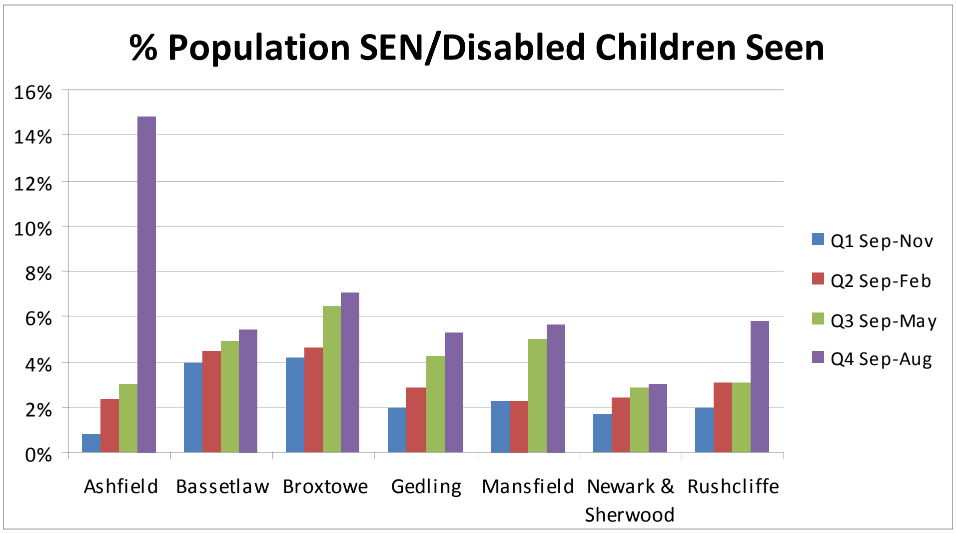
Data from children's centres provides a picture of special educational needs and disability in the under-5 population. Table 4.10 shows the number of disabled children (aged 0-4) as declared by parents on their registration form over the last two years. In most cases, this will not be a registered disability - there are currently only 26 children[84] aged 0-4 with an SEN primary need of physical disability registered in the county[85].

Table 4.10 Disabled children (aged 0-4) seen by children's centres in Nottinghamshire

	Sept 2009 to Aug 2010		Sept 2010 to Aug 2011	
	Disabled children seen	% population disabled children*	Disabled children seen	% population disabled children*
Ashfield	21	2.0%	153	14.8%
Bassetlaw	36	4.6%	42	5.4%
Broxtowe	27	4.1%	46	7.1%
Gedling	20	2.9%	37	5.3%
Mansfield	54	4.3%	71	5.7%
Newark & Sherwood	34	3.6%	29	3.0%
Rushcliffe	24	4.3%	32	5.8%
Nottinghamshire	**216**	**3.6%**	**410**	**7%**

Source: Nottinghamshire County Council, 2011
N.B. These are not confirmed cases of disability, but registration forms completed by parents
*Population disabled children = total number of age 0-4 referrals to the Inclusion Support Service from children's centres over last three years, excluding those who are now aged 5+

Figure 4.11 Percentage of SEN/disabled children aged 0-4 seen in children's centres in Nottinghamshire (September 2010 to August 2011)



Source: Nottinghamshire County Council, 2011
N.B. These are not confirmed cases of disability, but registration forms completed by parents
'Population disabled children' = total number of age 0-4 referrals to the Inclusion Support Service over last three years, excluding those who are now agd 5+

---

[84] Source: Nottinghamshire County Council
[85] Most children are confirmed with a disability in Year 1, not at age 0-4.

The number of referrals by children's centres to the Inclusion Support Service over the last three years also gives an indication of 0-4 SEN and disabled children accessing children's centres across the county (Table 4.12), with the highest numbers of referrals in Ashfield (133) and Mansfield (116), and the lowest in Broxtowe (57).

Table 4.12 Number of under-5's referred by children's centres to the Inclusion Support Service between 2008 and 2011, excluding those who are now age 5+

Ashfield	133
Bassetlaw	86
Broxtowe	57
Gedling	98
Mansfield	116
Newark & Sherwood	87
Rushcliffe	74
Nottinghamshire	**651**

Source: Nottinghamshire County Council, 2011

Data on the numbers of disabled parents accessing children centres was not collected for this needs assessment, even though the centres have targets to reach these groups.

4.9. Disabled Children's Access to Childcare (DCATCH)

Recent national research by KIDS and Mencap[86] has identified that:

- one in ten disabled children were refused a place in childcare provision over the summer of 2011
- one in three parents of disabled children received no childcare over the summer holidays
- one in five families with a disabled child pay more than twice as much as the national average for their childcare
- two in three families found it difficult or very difficult to find appropriate childcare for their disabled child.

The County Council supports the inclusion of disabled children and young people in mainstream childcare settings. Through the Disabled Children's Access to Childcare (DCATCH) programme, providers such as pre-schools, day nurseries, childminders and out of school or holiday clubs can apply for support to help meet the additional needs of children and young people attending their settings (Inclusion Support). This relates to exceptional costs involved in making provision for a child with significant needs.

Under the DCATCH programme, families with disabled children and young people aged 0-19 who are unable to access group childcare receive individual home-based packages. Families supported in this way pay the local rate towards the cost of childcare (£3.50 per hour), with childcare costs over and above this met by the County Council.

---

[86] Are cuts to local authority budgets denying families the right to childcare? – KIDS/Mencap 2011

DCATCH is currently supporting 168 0-19 year olds (as of mid-November 2011). Historic data by district can be seen in Table 4.13 and the current breakdown by age in Table 4.14.

Table 4.13 DCATCH funding for 0 – 19 years by district

	2011-12 (to date*)	2010-11	2009-10
Ashfield	21	34	28
Bassetlaw	29	38	35
Broxtowe	16	16	13
Gedling	32	42	33
Mansfield	11	18	23
Newark & Sherwood	16	32	33
Rushcliffe	43	47	55
Total	168 (to date*)	227	220

Source: Nottinghamshire County Council, 2011
*Number of children will increase as there are still four panels to take place in the 2011/12 financial year

Table 4.14 DCATCH funding by age 2011/12 (as of November 2011)

	0-4	5-9	10-14	15-19
Ashfield	13	2	2	4
Bassetlaw	13	7	5	4
Broxtowe	8	5	2	1
Gedling	21	7	1	3
Mansfield	8	3	0	0
Newark	8	4	1	3
Rushcliffe	25	16	1	1
Total	96	44	12	16

Source: Nottinghamshire County Council, 2011

Parents who use DCATCH were asked to provide their views of what works well with the DCATCH service at an event in 2010/11. The following quotes are from local parents.

- *“DCATCH has really helped me a lot with me going back to college and the supervision with my son’s complex needs. If I had known of this before I would have gone back to college sooner.”*
- *“DCATCH works really well for us. Carer my son likes. I can work flexibly. I can train. New opportunities for better work are now available to me.”*
- *“DCATCH has been supportive and quick at sorting issues, coming out to visit in the home and giving us information about other support available.”*
- *“Speed of response after initial referral.”*
- *“Referral by DCATCH very well handled.”*
- *“The flexibility of arranging the days/hours of our carer on a week by week basis to fit around hospital appointments and work is excellent.”*

- *“I can now look for work and know my daughter will have specialist childcare their ready.”*
- *“I have confidence in the knowledge that the carers are highly regarded and have the necessary skills, knowledge and EXPERIENCE in dealing with SEN and the flexibility of the service.”*
- *“I employed my own worker and trained her. She is able to cater for my son’s needs and mine. Flexible and can look after my son in my home where he feels more comfortable (individual home-based carer).”*

Parents and carers at the same event were asked for feedback regarding Inclusion support for childcare (not just early years) settings and they identified the following:

- *“Early years support was very good and supportive too.”*
- *“Early years support and inclusion support has been amazing with transition into school and brilliant with my needs too.”*
- *“The staff are willing to learn and be trained to support my son.”*
- *“Inclusion support worker educated herself about Reactive Attachment Disorder.”*
- *“Individual support (4 hours) at nursery. Building adaptations → funding through inclusion funding.”*
- *“Where services are accessed these are professionally delivered with child/family in mind (out of school club).”*
- *“Our holiday club recognises the special needs of our son and have done everything to try and help him, including a special place at the club where he can go for time on his own.”*
- *“Support of extra staff at after school club.”*

4.10 Short Breaks Provision

Short breaks provide opportunities for disabled children and young people to spend time away from their primary carers. They provide an essential chance for carers to recharge their batteries and to allow disabled children and young people the experience of new relationships, environments and positive activities. Aiming High for Disabled Children was a central government programme to improve and expand provision for disabled children and young people. Nottinghamshire was a ‘Short Breaks Pathfinder’ from April 2008 to March 2011.

Parents/carers report difficulty in spending leisure time as a family and also the lack of opportunity to spend quality time with non-disabled sons and daughters. Findings from consultation with disabled children and their families in Nottinghamshire reflects the national picture:

- Families want to lead an ‘ordinary’ life
- Children want to have fun and do the same things as other children
- More quality breaks are needed
- More choice of when, where and how short breaks are provided.

The current offer in Nottinghamshire under the Flexible Short Breaks Scheme (FSBS) gives disabled children and young people aged 0-19 up to 100 hours of short break provision per year from a menu of services. These include access to holiday and play activities in mainstream or specialist settings, and sitting and befriending services provided by an approved provider. The hours allocated can be used flexibly throughout the year at regular intervals, or in blocks such as school holidays. Since the FSBS commenced in April 2010 it has provided a service to over 400 disabled children and young people who previously were not accessing any kind of short break. The service is to continue into 2012-2013 with a review of the number of hours that children and young people are receiving.

Short Breaks Case Study

Yesterday I went to the CAF review for Fred - he was referred to an approved Short Breaks provider by the Brokerage Officers in the Families Information Service in October 2010 and was allocated 100 hours of the Aiming High Service.

Fred is a complex young man and it took a while to complete his care plan and risk assessment and then to find the right member of staff to match with him.

In November, I phoned Mum to make an appointment to introduce Fred to a staff member, only to find that circumstances had deteriorated. Mum was very distressed and said that she was exhausted every morning, all the children were ill with coughs and colds, there had been an incident at school and Fred was no longer attending. In fact, Fred was refusing to go out of the house at all. Fred's behaviour had spiralled and become more challenging to the point where he was targeting his parents and siblings. As a result, social services were now making enquires as to if Fred's siblings were at risk and Mum was so afraid of the 'child protection procedure' words that she kept hearing. Mum really didn't know what to do; she felt like a prisoner in her own home and knew that Fred's behaviour was having a huge effect on the other children and on her relationship with her husband. Fred was refusing to engage with anyone this included family and professionals.

The information given to me by Mum made me think that my choice of worker wasn't right and yet again I set about finding an alternative, a male worker who had the experience and patience to work with Fred. At the end of November, I introduced Fred to John and arranged dates of support throughout December.

Because of the flexibility of allocation of the 100 hours of service, initially Simon was able to attend the home for several hours twice or sometimes three times a week. This really helped, because we were able to tailor the service to meet the needs of Fred and his family, which was just as it needed to be.

At first, John spent a great deal of time watching Toy Story on his own, but gradually Fred became inquisitive and eventually sat with Simon to watch the film. After that, a tentative conversation started and the offer of a trip out to get a burger.

At the CAF review in December it was noted that John was the only professional who had been able to engage with Fred and the school staff asked if Simon felt he could introduce Fred to the home tutor. With care, and using a lot of discussion with Fred, John introduced the home tutor to him and Fred gradually accepted this support.

Yesterday I went to another CAF meeting for Fred where it was noted that he had made amazing progress. He now meets with John every fortnight using funding under the FSBS scheme. They go to a range of places like Wollaton Park, Sherwood Forest, bowling, cinema trips, gym etc and Mum described their relationship as 'mates'.

Home tutoring is doing very well with Fred managing support for four days a week now.

The paediatrician described Fred as 'such as success story' and told me that where it had been impossible to work with him in the past, he now merrily came to her surgery, sat, chatted and agreed to her examination.

Social Care closed the case as the concerns are no longer there and the family are once again able to get on with their daily routines.

It isn't often that I come away from a CAF thinking that it's been as good a day as I did yesterday. Without the 100 hours core offer the outcome to this story could have been very different. Mum wishes me to pass on to you her deep thanks. She said to tell you that without this support her whole family could have disintegrated and that she hoped that the service will continue for years to come. She is more than happy for you to contact her if you feel you need more information.

The above is based on information received from one of the approved providers. It illustrates how the FSBS impacts on children and their families. It clearly links the short break into the Pathway to Provision, including the CAF assessment and the multi-agency meetings.

Figure 4.15 Children and young people from Nottinghamshire accessing short breaks

	2007/08	2008/09	2009/10	2010/11
Total No. of disabled CYP received a short break	860	1297	1776	2190
No. of CYP with ASD, challenging behaviour and/or learning disability who received a short break	Not recorded	755	1041	1671
No. of CYP with complex health care needs who received a short break	Not recorded	357	490	410
Other disability	Not recorded	185	245	109

Aiming High funding for short breaks was introduced in April 2008, as can be seen from the table above, numbers of children and young people accessing short breaks has increased since Aiming High was launched. In addition, it can be seen that numbers continue to rise. Annual targets have been achieved since Aiming High was launched.

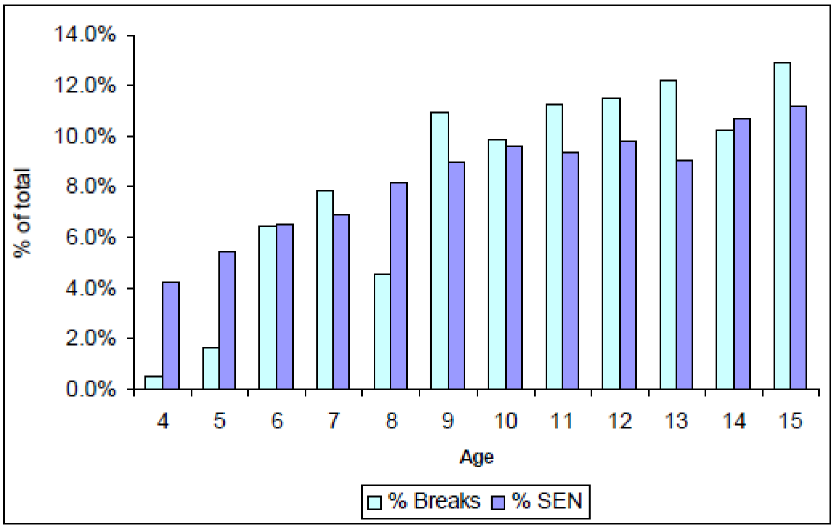
The children who received a short break in 2010 had these types of short breaks:

Individual care sessions short break 2010	**30,270**
Group based activity hours short break 2010	**53,075**
Overnight short breaks 2010	**8,636**

Further analysis has identified possible gaps in provision. Figure 4.16 suggests clear differences in short breaks provision across the county. In S80 (Worksop area), for instance, there was one child accessing short break services for every 40 SEN school pupils. In NG23 (Newark area), on the other hand, there was one child accessing short break services for every seven SEN pupils.

Figure 4.16 shows the distribution of short break services by age. The number of children accessing short break services increases with age. Less than 2% of children accessing short break services, for example, are aged five. 12% of children, however, are aged 15. The number of children with SEN also increases with age, but not as sharply. So, using SEN as a proxy measure for demand for short breaks services, older children appear to be better served by break services than young children, particularly very young children.

Figure 4.16 Percentage of children accessing short break services, and percentage of children with special educational needs (school action plus/statement), by age (2009/10)

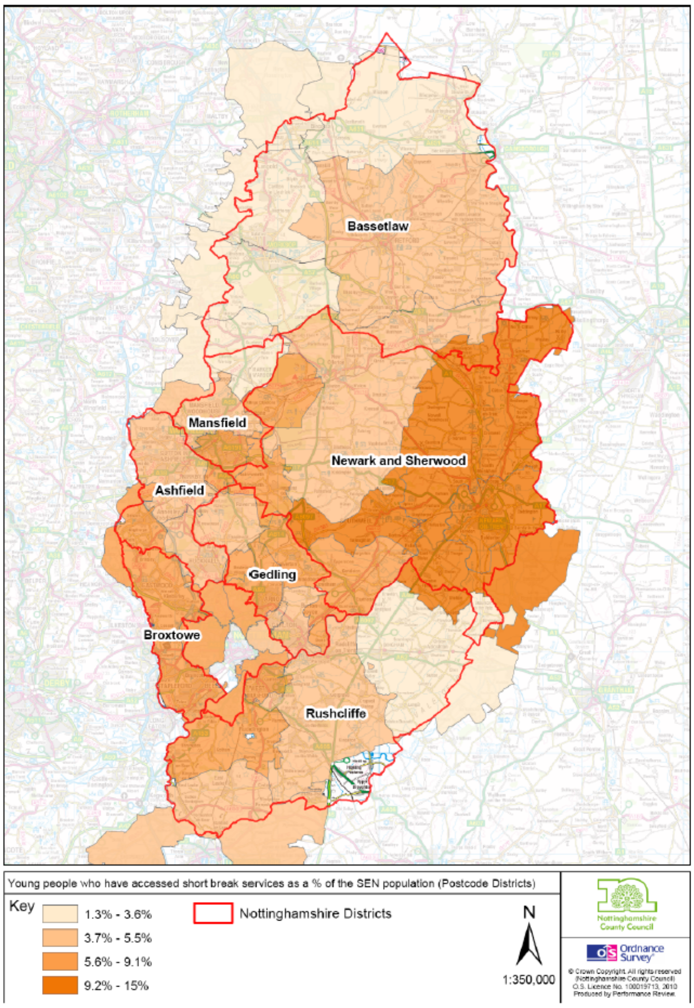


Source: Short Breaks Pathfinder, Nottinghamshire County Council, 2010

Services are being developed to address gaps and increase provision via an approved provider framework. Nottinghamshire aims to offer disabled children and young people aged 0-19 years up to 100 hours of flexible short breaks from a menu of services. The family may select one or more of the following up to 100 hours:

- Sitting and befriending service
- Community based holiday play and activity, including the current Breaks in Partnership scheme.

Figure 4.17 Number of children accessing short break services as a % of children with special educational needs – Nottinghamshire – Quarter 3 2009/10



Source: Short Breaks Pathfinder, Nottinghamshire County Council, 2010

Children and young people with complex health needs often access a number of different services. The map in Figure 4.18 shows the location of providers of residential short breaks accessed by children and young people who live in Nottinghamshire, including those outside of the county. Short breaks provided in the home and community are not shown on this map although children and young people included in this data collection may be accessing these services.

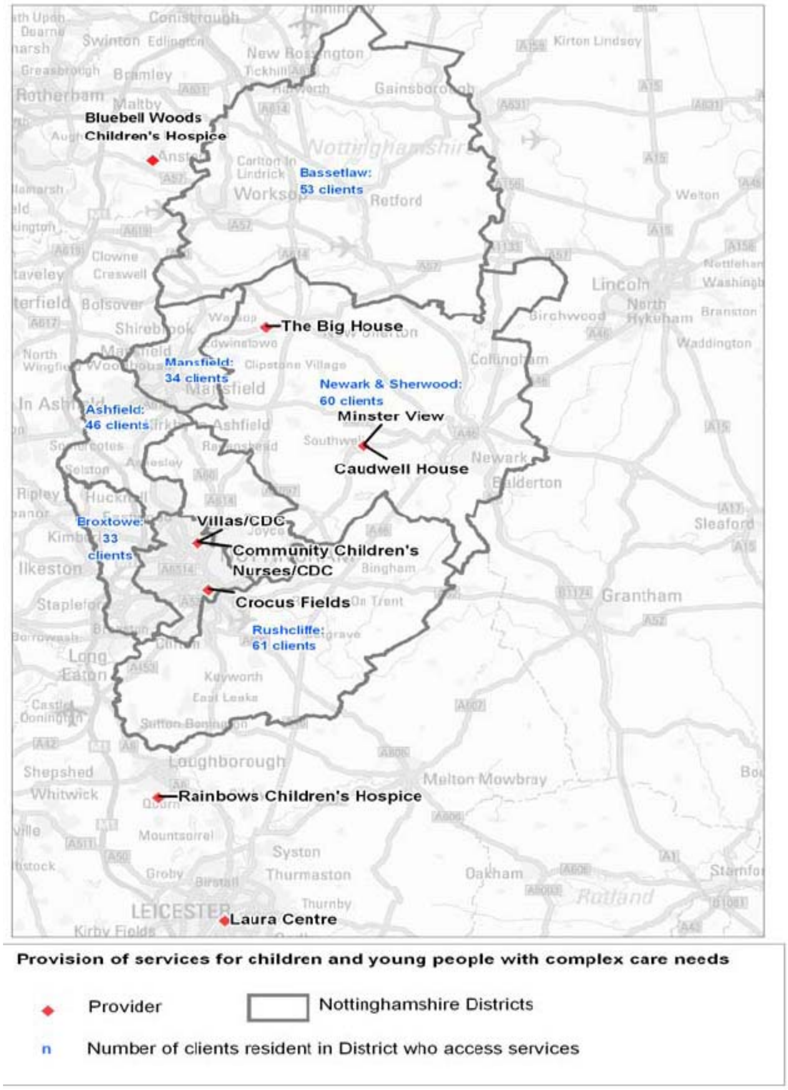
The number of children and young people accessing these services varies by locality and it is unclear whether this relates to parent/carer knowledge of the range of services, geographical location of services or other more complex mechanisms. It is unlikely, however, that the numbers of children and young people accessing services as a percentage of the population relates to the incidence of disability in that locality.

It is possible that those who are the most in need of services are the least likely to access them due to the 'inverse care law'[89] which suggests that those living in areas of deprivation find it more challenging to access services and thus receive fewer services than their more affluent counterparts despite having equivalent needs.

---

[89] Appleby and Deeming (2001) 'Inverse Care Law' Health Service Journal

Figure 4.18 Location of providers of specialist short breaks for patients in Nottinghamshire



Source: Health Needs assessment, NHS Nottinghamshire County 2009/10
[Number of children and young people accessing specialist services by home postcode]

In 2010, capital funding was used to increased access to swimming. As a result of the children, young people and parent consultation, seven centres have been given funding through the Short Breaks project:

- Bircotes Leisure Centre, Bassetlaw
- Bramcote Leisure Centre, Broxtowe
- Cotgrave Leisure Centre, Rushcliffe
- Watermeadows, Mansfield
- Southwell Leisure Centre, Newark and Sherwood.
- Carlton Forum Leisure Centre, Gedling
- Lammas Leisure Centre
- Hucknall Leisure Centre

This funding has enabled some building works to take place and ensured the purchase of a hoist, change bed and pool hoists. All seven centres have accessible changing rooms that can cater for all disabilities. In addition, the key members of the workforce have had disability awareness training. This was delivered by professionals and supported by both the parents and the disabled children.

Increased opportunities in sports and leisure for disabled children and young people:

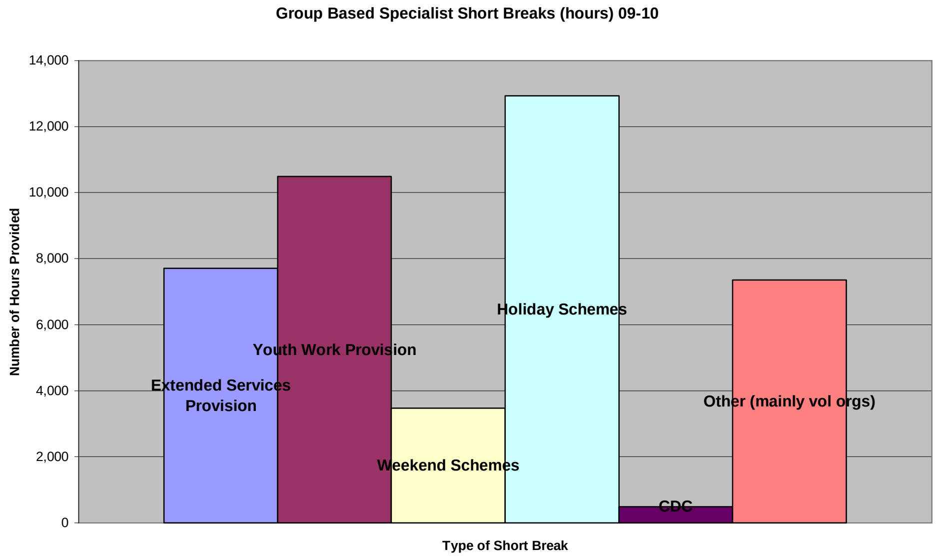
- Lammas Leisure Centre (LC) - Ashfield - Inline Sledge Hockey Club linked to Sledge Hockey. Also GB Fast Track Programme is being run at Lammas with the funding coming from Short Breaks to purchase the equipment.
- Lammas LC and Hucknall LC are setting up Boccia Clubs and Multi Sports Clubs.
- Sherwood Seals - Mansfield - has increased capacity for disabled people to swim.
- Mansfield Maulers have gained extra five wheelchairs enabling more disabled people to play the sport.
- Mansfield District Council - has set up a multi sports club
- Special Olympics Mansfield is increasing opportunities for children and young people with a learning disability.
- Broxtowe has ten new chairs to set up a zone basketball club. They are also running a multi sports club and inclusive swimming sessions
- Newark & Sherwood District Council is running three swimming sessions at the Grove and have set up a trampoline club for autistic children and young people, also running a Boccia club at the same place.
- Young Potentials - Bassetlaw - Regal Theatre has set up a project to run art, music and drama sessions for disabled children and young people, linked to the Olympics.
- Gedling is running a multi sports club through positive moves.
- Parkwood LC – Rushcliffe is running multi sports sessions for all disabilities, also soft play session linked to Ashlea School in Cotgrave.
- Parkwood LC is also working with the Nottinghamshire County Cricket Club to set up cricket sessions for disabled children and young people.
- The re-build of the **Robin Hood Activity Centre,** which has links to the Mill Adventure base, this ensures access to camping and adventure activities.

Nottinghamshire County Council's Sports Development Service also exists to ensure equality of opportunity and fair access to culture and sport, and increase participation in sport and culture opportunities. The Service works with sports clubs, coach and volunteers with training and expert advice on where monies should be best placed to increase opportunities.

"We continue to deliver educational training to raise awareness of disability and how to include disabled people in sport, we are also working with national organisations in developing further training.

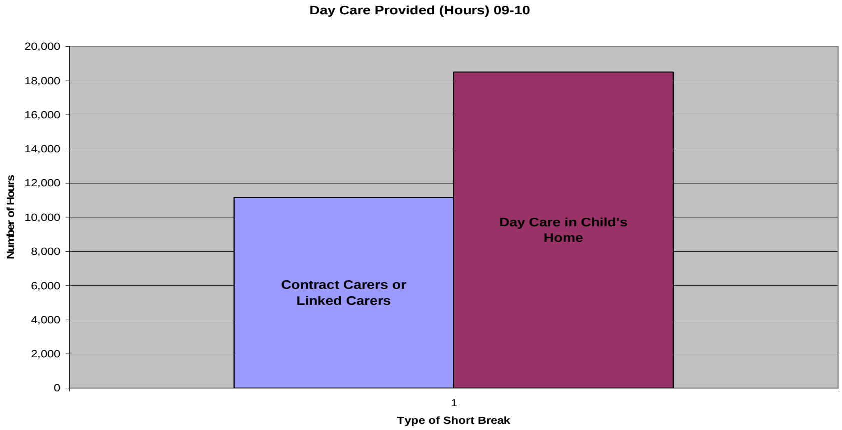
We work with the Short Breaks Project Team to maximise the funding available to allow more facilities to become accessible and increase the opportunities for young disabled people to access sport, including eight swimming centres in Nottinghamshire that now have fully accessible changing facilities."

Figure 4.19 Group Based Specialist Short Breaks (hours 2009-2010)



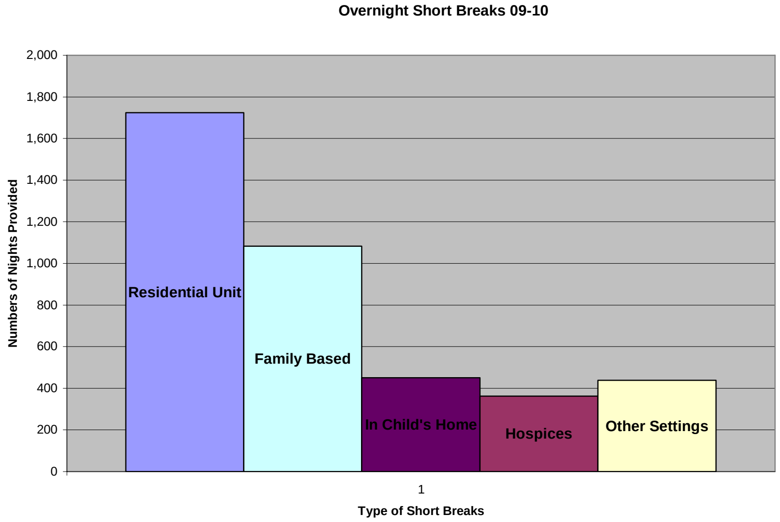
Source: LAIMP, April, 2010

Figure 4.20 Day Care Provided (Hours) 2009-2010



Source: LAIMP, April, 2010

Figure 4.21 Overnight Short Breaks Provision and Use (2009-2010)



Source: LAIMP, April, 2010

Some examples of Short Break providers commissioned through the Short Breaks Project:

Children's Development Centre, County Health Partnerships (CHP) – short breaks

The Children's Development Centre (CDC) is a fully funded health short breaks unit. It provides overnight provision and day care to children and young people with complex health care needs, physical disabilities and learning disabilities. It is situated on the City Hospital campus, but it is a separate organisation from the hospital, being provided by County Health Partnership (CHP). The service targets children and families in the South of Nottinghamshire. As well as short breaks, it provides a range of services including community children's nursing, support to a number of community paediatric clinics, a range of therapy provision and the Early Support Programme

Nottinghamshire Performing Arts is a universal training programme for young people aged 7 – 19 (Year 3 and above) interested in the performing arts. Students can attend a Saturday Performing Arts Centre and/or a music/dance/theatre company. Saturday Centres offer a range of music, drama and dance activities for all abilities where students choose three or four activities during a Saturday morning, culminating in a performance to parents at the end of term and achievement of Bronze Arts Award. Companies offer a higher level single focus e.g. concert band, advanced music ensemble, choir, Red Hot Band, training band, string group, dance and theatre company and perform in external locations, working with professional organisations to reach a wider audience. The training programme is also delivered in special schools across the county (current centres are Ashlea, Derrymount and due to commence at St Giles). In 2010-2011 over 180 disabled children and young people accessed either a Nottinghamshire Performing Arts session at a mainstream or special school.

Short Breaks Service Case Study – Child H

Child H and their family felt they did not receive adequate support when they initially left hospital. The family had support from CDC groups and the paediatricians at CDC, but no practical advice or information. The exit from hospital was very scary for the parents. They felt that some training in basic life support would have been useful.

A referral was made for respite through the CDC community nurse. The family also have the number of a nurse at CDC to contact if any problems arise. The family now feel well supported. They receive a service from C.A.R.I.N 4 families and access the School for Parents at Rutland House School.

Mum feels that ward based nurses don't really understand the implications of caring for a child with additional needs and therefore would not leave their child alone, unless either a parent or carer was with her.

The family feel they have had to dig deep to find any relevant information on benefits and services. They feel that it is going to be difficult again when their daughter starts the transition into school.

Short Breaks Service Case Study – Case Study Child M

M initially went home from hospital with no concerns. At six weeks the health visitor referred to hospital as her head was not growing and she had increased vomiting.

The family were on the ward for over six weeks. On discharge they had very little support. A Children's Community Nurse came to the home and passed an NGT and told the family there were no additional services that could help them.

The family moved in with grandparents for additional support. Mum researched support services and referred herself to Sure Start. Mum feels that additional training for children with CCHN needs to be given to health visitors and ward based staff so that appropriate referrals can be made for families to support them. There was no information available on disability and carers allowances on the wards. Parents feel there was a general lack of coordination and information.

They feel more training for junior doctors and ward rounds by community staff may be useful. When staying in hospital the family were unaware there was a sensory room in the hospital. Mum feels a pack with all the above information would be useful.

No resuscitation training was given prior to leaving hospital. Parents feel that although now competent to care for their daughter, a lot of it is self taught and they would like refresher training annually. They were 'terrified' when they went home. They do feel, however, they have learnt a lot from C.A.R.I.N 4 Families nursing staff.

Parents paid for private physiotherapy due to the delay in the referral process to CDC and had to wait three months for an appointment with the relevant consultant and self-referred to social care.

The family feel that they still are not receiving the support they need to care for their daughter but the C4F support was exceptional.

4.11 Play for Disabled Children

The short break project has developed seven new Saturday and holiday clubs for severely disabled children that run in each district. There have been fun days and taster activity events during school holidays and weekends. Also play forums and 70 private, voluntary and independent providers have been supported to enable access for disabled children. A bank of highly skilled play workers has been developed to support play activities for disabled children where required.

A local parent's view of Play Services

X accesses Saturday and holiday clubs at his school (name of school given). I understand these are due to cease once he reaches the age of 14. Unfortunately, he is unable to access any other form of leisure activities without considerable support. He is a challenging child (family describe severe disabilities). X will need at least one to one, if not two to one, care especially when he is out in the community. Your form (the children's development review form) doesn't allow for an understanding of challenging behaviour or that resources are needed to keep him safe in the community, and for others in the community to be protected from his aggressive behaviour.

The Short Break Project Team has already acknowledged the issue highlighted in the parent's comment above. They have recently commissioned Saturday clubs to extend their age group up to 18 years, which will commence in 2012. This new activity will be evaluated prior to any roll out to other play services.

4.12 Disability Youth Support Services

The Disability Youth Support Team has more activities across all the districts, including:

- specialist link clubs on a weekly basis
- residential trips both in this country and abroad.

Two adapted mini buses, linked with a volunteer group with charitable status, to support the maintenance and access of these buses. The buses can be accessed through the Disabled Youth Support Team for groups of children and young people with disabilities. Sailing boats and other adapted boats are accessible at the adventure bases, and are suitable for children with a wide range of needs.

4.13 Special School Nursing

The Special School Nursing Team leads on health service provision in special schools. The service includes the universal delivery of the healthy child programme, and care of children with complex care needs in special schools to enable them to access education.

The Health Needs Assessment of pupils in special schools (Appendix Two) identified that there are varying levels of need across special schools, Fountaindale School has highest percentage of pupils with the most complex/highest level needs in Nottinghamshire; Beech Hill and Redgate have a greater proportion of pupils with moderate/low need. It would therefore be expected that variable levels of provision of special school nursing would be delivered. However, there is currently some inequity in how special school nursing is delivered across Nottinghamshire and further work would be required to ensure the service is equitable and based on need.

Currently in Bassetlaw the special School, St Giles is supported by Universal Services. There is a team of Health Care Support Workers who deliver the care in the school supported by a Senior School Nurse. The school has expanded recently and the level of need of the pupils that attend has also increased. The service provision for the school is currently under review to identify what additional resources are needed.

4.14 Paediatric Speech and Language Therapy (SALT)

South Team (Principia, Nottingham North and East, Nottingham West)

- Children with severe/significant disabilities, including learning difficulties, physical difficulties and hearing impairment with associated speech, language and

communication needs/associated eating and drinking difficulties who are 0-11 in mainstream schools and 0-16 in special schools.
- Children with specific language disorders aged 0-11 years
- Assessment for diagnosis and care packages for children with social interaction difficulties/ASD – aged 0-6 years.
- Input into the complex communication clinic once a month (for all ages).
- Service for communication aid users aged 0-16, and 16-19 if in full time education.
- Acquired brain injury 5-16 year olds, but up to 19 years if in full time education.
- Generalist stammering service for children aged 0-11 years and a specialist service for 7-19 years.
- Specialist stammering service for adults countywide (including North, South and Nottingham City).

North Team (High Point, Newark and Sherwood)

- Children with severe/significant disabilities, including learning difficulties, physical difficulties and hearing impairment with associated speech, language and communication needs/ associated eating and drinking difficulties who are 0-11 in mainstream schools and 0-16 in Special Schools.
- Children with specific language disorders aged 0-11 years
- Assessment for diagnosis and care packages for children with social interaction difficulties/ASD – aged 0-6 years.
- Service for communication aid users aged 0-16, and 16-19 if in full time education.
- Generalist stammering service for children aged 0-19 if in mainstream education.
- Service for communication aid users aged 0-16, and 16-19 if in full time education.

Open access referral is in place for both of these teams. However, from the 1st April 2010 to 30th September 2010, 1,153 referrals were made to the service (excluding Nottingham City) - but 50% were discharged after one appointment because they did not have a SALT need. This implies that large numbers of inappropriate referrals were made to the service during this six month period.

The service works with young people staying in full time education post 16. However, there is no provision for young people not in education training or employment aged 16-19. This potentially is a gap in provision as there may be unmet need for this group.

4.15 Paediatric Physiotherapy

Paediatric physiotherapy is offered to children and young people with learning disabilities, physical disabilities and complex care needs.

Referral criteria

Children with physical disabilities including complex health care needs. This includes orthopaedic conditions, neurological conditions, neuromuscular conditions, syndromes, developmental co-ordination disorders. The North team also accepts referrals for rheumatologic conditions and respiratory conditions.

Referral sources are through doctors. Re-referral is open access as long as a newly identified functional issue is identified; referrals are made through two single points of access. South Referrals go to the Children's Development Centre (CDC) at NUH and in the North referrals go to CDC at Sherwood Forest Hospital Trust.

In the North Team between 1st April 2010 and 30th September 2010, there were 120 referrals with an average wait of 11.3 weeks. In the South Team between 1st April 2010 and 30th September 2010, there were 48 referrals with an average wait of 4.3 week wait (this includes the City). The target is to be seen within 13 weeks of referral.

A rapid response respiratory physiotherapy (RRP) service for children and young people with severe disability, and life limiting/life threatening conditions is in place in the south of the county. The service focuses on children and young people who have spent prolonged periods in hospital with chest infections.

The aims of the pilot service included:

- Rapid response chest physiotherapy assessment & treatment to children in community setting
- Training to parents, carers, professionals and other staff from a range of agencies
- Improved quality of life & seamless service
- Prevent acute respiratory admissions & facilitate early discharge
- Empower parents/carers with their child's treatment
- Increase choice of place of death
- Identify how an equitable service can be provided across Nottinghamshire.

This pilot offers support to children in the south of the county including Nottingham City. There is currently no service like this in the north of the county. It was agreed in December 2011 that the physio service would be expanded from April 2012 to cover Nottinghamshire (except Bassetlaw) and Nottingham City.

Data was examined by NHS number for each child who has accessed the RRP service. What is important to acknowledge is the complexities of this relatively small group of children and young people (CYP) and their overall high costs in secondary care. All these CYP have degenerative conditions which require increasing levels of health care as their condition progresses (therefore likely increased admissions) and are unlikely to live past 20 years old. Overall costs in secondary care to the 42 CYP who have accessed the RRP service is £1.7 million between April 2008 – October 2011. Between April 08 – June 10 overall there were 181 spells respiratory related into secondary care total cost £360,277.15 (data reflects City & County). Since the service commenced an 89% reduction in admissions to secondary care was achieved. Improving outcomes for children and young people enabling them to stay at home and cost savings for the NHS.

It is estimated that 88 admissions have been prevented[90], with associated savings and improved outcomes and quality of life for children and young people and their families. Savings are calculated based on the tariff for *unplanned paediatric respiratory medicine* of £2,431 per spell.

---

[90] Assessed by Consultant Community Paediatrician (Neurodisability) and physiotherapist

Table 4.22 Pilot service costs of admission pre & post service & number of admission pre & post service

	No. Spells pre RRP	Cost in admissions pre RRP	No. Spells post RRP	Cost in admission post RRP	% reduction in no. of admissions	% reduction in cost of admission
City	136	£259,630.60	26	£45,146.35	81%	73%
Total County	45	£100,646.55	5	£7,867.31	89%	92%
NW	6	£15,648.08	0	0	100%	100%
NNE	13	£36,033.37	2	£4,790.60	85%	87%
Principia	12	£21,876.04	3	£3,076.71	75%	86%
N&S	14	£27089.06	0	0	100%	100%
Total	181	£360,277.15	31	£53,013.66	83%	85%

It has been identified that there are approximately 80-100 children and young people across Nottinghamshire (excluding Bassetlaw) who could benefit from the service[91]. Therefore, it is being proposed that the service is expanded to cover the county (excluding Bassetlaw), ensuring an equitable service is provided to all children and young people with severe disability, and life limiting/life threatening conditions who would benefit from rapid response respiratory physiotherapy in the community. Table B shows the estimated costs and savings associated with rolling out the service across the county in 2012-13.

Table 4.23 Estimated costs and savings associated with full roll out of service

2012-2013	Cost of Rapid Response Physio Service	Avoided admission (Spells/Costs)	Net Savings
Nottingham city (40%)	£44,000	Between 68/£130,016 and 68/£162,860	Between £86,016 and £118,860
Nottinghamshire County (60%)	£66,000	Between 102/£195,024 and £244,290	Between £129,024 and £178,290
Total	£110,000	Between £325,040 and £407150	Between £215,040 and £297,150

Notes

- *The estimated cost savings for the expanded service are based on average tariff cost of £1912, although most respiratory spells cost £2395 (from SUS data):*
- *Estimated patients to access service in 2012-2013 = 85 equating to = 170 saved spells*
- *Projections 2012-2013*
- *These figures are calculated based on doubling the current service from 1.0 whole time equivalent (WTE) Band 7 Physiotherapist to 2.0 WTE.*

Feedback from parents and carers:

- *"We just wanted to thank you for the fabulous work you've been doing with E, which has kept him out of hospital twice now since you have been doing the community work and this has limited the negative impact on our lives. Thanks again."*
- *"This service is excellent and I hope it will be made into a permanent service."*
- *"I will be ringing you all the time! I definitely think it will be made permanent because there are lots of children that need you."*

---

[91] Data supplied by General and Community Paediatricians, NUH, SFH

- *"This is a fantastic service and gives me peace of mind and you are really quick to respond to any of my concerns."*

4.16 Paediatric Occupational Therapy Service

This service provides packages of care which enhance the functional potential of children's everyday tasks and activities, at home (e.g. dressing and self care skills), in school (e.g. access to the curriculum, handwriting etc), and with leisure pursuits. They work in partnership with parents/carers and other professionals and agencies to reduce the impact of the children's disability, to ensure the best outcome for the child and family.

There are north and south teams, as well as a therapeutic support team, which includes learning disabilities, physical disabilities and complex care needs. The service follows three broad strands and pathways:

a) Children with physical disabilities
b) Children with learning disabilities
c) Children with functional and co-ordination disabilities.

Referrals are accepted from community and hospital paediatricians, paediatric physiotherapists and speech and language therapists. Referrals in the North Team also are accepted from special educational needs coordinators (SENCO).

All children are seen within 13 weeks of referral to the service. However, there are long waits for treatment because demand exceeds capacity. Between April 2010 and September 2010, the service received 105 referrals from Nottinghamshire (excluding Bassetlaw) and 62 referrals from the City.

The team also visit Fountaindale and Yeoman Park Special Schools (Monday to Friday), Orchard School (Monday to Thursday), Ashlea School (every Tuesday), Carlton Digby (Mondays and Fridays), Glenbrook Primary (twice a term for ½ a day), and Oakfield School in the City (Mondays to Friday). The team visit other schools and children centres as required. The service also runs from the Children's Development Centre (CDC) at NUH daily. During school holidays, staff work with children in home or venues such as schools, if premises are open.

The Joint Public Health and Social Care AHDC OT Pilot was established in response to the concern that children with additional needs could come into contact with up to five different children's occupational therapists throughout their development. It was acknowledged that each OT did have a specific and specialist role, but that there was indeed some duplication of skills in respect of equipment provision and delivery, and specifically surrounding 'seating'.

In April 2009, the Social Care OT service and Public Health agreed a small pilot to encourage more collaborative working between health and social care and to develop a common knowledge base. The pilot was evaluated in March 2011.

The pilot offered three strands:

1. Joint training – delivery of specialist training in postural care and sensory modulation
2. Short term loan equipment scheme – provision of equipment to support access to community activities and holidays

3. Occupational therapist post – for a period of six months to facilitate timely intervention on health referrals.

The evaluation found that the OT post offered some excellent joint working and assessments. Collaborative working has in reality resulted in an increased referral rate to social care from health colleagues.

Outcomes and improvements were identified through the pilot and these included:

- Service users have benefited from a more timely response to referral requests
- Service users have had a more consistent message re the use of equipment and have a better understanding of the OT respective roles
- Earlier intervention has eliminated the need for ongoing support in some cases
- Improved communication and better working relationships between OT health based and social care based colleagues
- Enabled nine children/young people to access wider community activities or holidays through the use of short term loan equipment
- Supported the discharge rate in terms of the social care waiting list for assessment
- Collaborative working has supported a more seamless transfer of cases between health based and social care based OT.

There were also clear cost benefits to the approach used in the pilot. It is envisaged that the financial savings of a more collaborative service will be realised in the long term i.e. a more timely and consistent approach regarding postural care and its importance will reduce the need for more complex and costly intervention later in a child’s life. In addition, working collaboratively reduces the likelihood of duplication on assessments and is therefore more cost effective. The cost benefits of this will be seen in the short term.

The pilot made the following recommendations:

Joint Training

- Development of joint Health and Social Care postural care assessments, so that parents receive a consistent message in respect of positioning and its importance with a view to developing a joint assessment tool
- Development of a common Seating Care Plan to be used by both Health and Social Care for the benefit of parents and home care staff
- Further training to develop the Norfolk ‘train the trainer’ model, educating and empowering parents to manage postural care.
- Development of a ‘buddy system’ between Health and Social Care to gain increased knowledge of respective roles
- Development of protocol /process in respect of fast tracking provision of specialist equipment
- Development of staff induction programme to incorporate aspects of both Health and Social Care settings.

Short Term Loan Scheme

- Further promotion of the service
- Widening access to the service in terms of hospital discharge and short break services.

Occupational Therapist Post

- Development of a joint OT commissioning strategy with clear pathway to provision.

Bassetlaw Paediatric Occupational Therapy

This is a small highly specialist community service working closely with Community Children's Nursing team and the Community Children's Learning Disability Nursing team to provide assessment and treatment for children and young people who have a functional disability which affects their ability to participate in activities of daily living. The service is offered to children and young people who are aged 0-19 years who are registered with a Bassetlaw GP.

Triage Clinic
The team offers assessment within a maximum of 12 weeks. This has been achieved by the introduction of the new triage system where all new referrals are offered an initial appointment at the Triage Clinic. At this clinic all children and young people are assessed and either sign posted onto another service or allocated to a therapist for treatment. The clinicians offer advice and information at this clinic in order to ensure that all parents and carers are aware and agree with

Fine Motor Groups
The team offers summer fine motor groups which are based on three 90 minute treatment sessions for children and young people who have been identified through assessment as having fine motor skill deficits.

Sensory Pilot
The paediatric occupational therapists have explored a sensory clinic and treatment package as a pilot over the summer which has evaluated very well from both therapist and family perspectives. The results will be presented to the senior management team and children's commissioning officer as an example of innovative practice which meets the Early Intervention agenda for children.

PDSS
The team offers assessment, advice and recommend specialist equipment for children with functional/postural difficulties to access the curriculum in main stream schools.

Short term loan wheelchairs
The team have agreed a new pathway with the physiotherapists at Bassetlaw Hospital to provide short term loan wheelchairs to ensure that children are discharged in a timely manner for the children's ward.

Specialist seating clinic with Sheffield M&SRC
A collaboration with the specialist wheelchair technician has been arranged at St Giles special school in Retford with the paediatric occupational therapists. This service offers a local seating service for Bassetlaw children.

Special school treatment packages
The paediatric occupational therapists provide handwriting advice packages to mainstream schools.

4.17 Continuing Care

There are no clear definitions of continuing care needs but it is generally recognised that they include multiple health needs where care pathways require co-ordination because of the complexity of service provision and input from local authority children's and young people's services.

This National Framework for Children and Young People's Continuing Care sets out an equitable, transparent and timely process for assessing, deciding and agreeing bespoke packages of continuing care for those children and young people under the age of 18 who have continuing care needs that cannot be met by existing universal and specialist services alone.

It describes how local organisations, including PCTs and local authorities, should work together to assess need and put in place packages of continuing care. It should be read by all those with responsibility for commissioning and providing continuing care to children and young people.

It is clear from the framework that continuing care should be a multi-agency approach. Which locally it is predominately a health led decision. It is recommended that a Multi-agency decision-making forum is the best place to make decisions regarding children's continuing care. The multi-agency decision-making forum should comprise of professionals from different disciplines, i.e. from both PCTs and local authorities. The forum will take into consideration the recommendations and proposed options for packages of continuing care. If a continuing care need is identified, it is for the PCT and the local authority to decide what services each will commission and fund. There need to be a stronger multi-agency approach locally.

Summary of the continuing care pathway[92]

Phases of the continuing care process	Stage of care pathway	Summary of key actions	Timescales	Cumulative timescales
Assessment phase	1) Identify	Child or young person with possible continuing care needs identified through effective referral. Fast-track if necessary.	1 working day	1 working day
	2) Assess	Nominated children's and young people's health assessor completes four areas of assessment.		
Decision-making phase	3) Recommend	Nominated children's and young people's health assessor prepares recommendations and costed options.	8 working days	9 working days
	4) Decide	Multi-agency forum considers recommendations and costed options and decides on package of continuing care for child or young person where continuing care need is identified.	14 working days	23 working days
Arrangement of provision phase	5) Inform	Child or young person and family, referrer and relevant organisations informed of decision.	5 working days	28 working days
	6) Deliver	Identify provider(s) for package of continuing care/commissioning and implementation of package of continuing care/ongoing training, support and monitoring.	Dependent on complexity, commissioning, Disabled Facilities Grant Funding processes and/or national exemplars	
	7) Review	Re-assessment of child or young person's continuing care needs and appropriateness of package of continuing care should occur three months after initial assessment, then annually as a minimum or sooner as appropriate.	3 months/annually/ as appropriate	

There are a number of services in Nottinghamshire (including Bassetlaw) that offer continuing care for children and young people including **C.A.R.I.N. 4 Families**, which is a nursing care service to children and young people aged 0-18 who have complex

---

[92] DH (2010) National Framework for children and young people's continuing care

health care needs that require ongoing nursing support. Nursing care is delivered in the child's home or other settings for prolonged periods of time (e.g. overnight care).

Continuing Healthcare in Nottinghamshire (excluding Bassetlaw) currently has 30 patients aged between 0 and 25 who receive fully funded Continuing Healthcare. Decisions are made regarding how healthcare needs will be met. There are occasions where the day to day patient's care is not fully funded, but they may decide to fund the entire costs of a piece of equipment that may be required.

Within NHS Bassetlaw, there are usually 10 – 15 children in receipt of continuing healthcare packages. These may be fully funded through the NHS or jointly funded packages with social care. The decision support tool for children differs from that used for adults, but the fundamental principles of joint decision making with social care is the same.

4.18 Equipment

There are up to 6,000 children living at home in the UK who are dependent on assistive technology[93].

Historically in Nottinghamshire, children's OT's in social care have assessed for and made provision of equipment within the home setting (including seating, bathing, toileting equipment, as well as bed provision and equipment for moving and handling), whilst OT's in health have assessed for and made provision for seating and toileting equipment in educational settings. When, however, both social care and health OT's have been involved with the same child at the same time, this has caused confusion for the family as to who is responsible for equipment provision. Furthermore, with ICES (Integrated Community Equipment Services) allowing health OT's to provide the first seat within the home environment, the confusion surrounding roles and responsibilities in respect of seating has become even more confusing for both family and therapists. These issues were addressed in the Joint Public Health and Social Care AHDC OT Pilot mentioned above.

There is a national initiative to re-engineer children's equipment services as outlined in the Children's Equipment Report 'Models and Options for Children's Equipment and Related Services'[94] as described below.

The Department of Health commissioned an independent consultant to review the commissioning and provision of children's equipment. "*Current delivery arrangements are fragmented and lack strategic thinking. There is little consistency in delivery arrangements and eligibility. Budgets are fragmented and inadequate. Little account is taken of geography and the interaction of public bodies within an area when planning services. This exacerbates the so called 'postcode lottery'. Waste in the administration of the process is endemic. Decision-making is difficult and accountability avoided. Professionals are disillusioned and parents have given up waiting for public services to deliver and are turning in ever-increasing numbers to the charities*[95]*".*

The report goes on to analyse the various factors underlying poor service provision, concluding that mainstreaming transformation of children's community equipment services would require change in four major areas: governance, pathways, sourcing strategies and management of equipment once bought (equipment stores).

---

[93] National Service Framework for Children, Standard Eight, page 7

[94] DH (2010) Models and Options for Children's Equipment and Related Services

[95] DH (2010) Models and Options for Children's Equipment and Related Services

The report identifies that we need to work towards the following outputs:

- Holistic arrangements for equipment and related services for disabled children.
- Reduced administration and therefore opportunities for significant cost reduction.
- Coherent sourcing strategies, which should create additional opportunities for significant cost reduction, particularly through lower supplier 'cost of sale'.
- Simplified pathways, providing better service from the point of view of disabled children and their families, as well as creating the opportunity to improve data gathering and performance reporting. These in turn should help commissioners and providers improve services still further.
- Single point of contact for parents and carers.
- Reduced number of commercial relationships, leading to a reduction in the opportunities for error and an increase in accountability.
- Single budgeting and banking arrangements that will facilitate straightforward purchase-to-pay pathways and the provision of coherent financial and management information.

Integrated Community Equipment Stores

In Nottinghamshire there is an Integrated Community Equipment Store (ICES) that covers the south of the county including Nottingham City (South ICES), and an equipment store that covers the North of the County (North ICES). They both operate using different models: the leaseback model (North) and the ownership model (South).

Both teams perform well, though there have been plans to establish a single joint ICES for Nottingham City and Nottinghamshire County. The ICES Project Board was established in March 2010 to oversee the development of a single service across Nottingham, Nottinghamshire and Bassetlaw, whilst maintaining value for money with continued choice and control for service users.

ICES work with disabled people of all ages. *"Both North and South ICES are impacted on by high levels of disabled students attending Portland Training College that then take up permanent residence in the areas*[96]*".* Both also provide equipment to children attending special school as well as home. "*Growth in service demand has increased by 36% over the period 2004-2008 (South ICES). Future growth in demand for equipment is expected to accelerate considering the demographic impact of a growing older population and increasing numbers of children with disabilities*." [97]

There are extensive eligibility criteria for equipment provision based on individual partners own commissioning and assessment policies.

No performance data was available for this needs assessment and no further updates have been provided regarding any changes in the commissioning and delivery of ICES.

Short Term Loan Scheme

This short term loan of equipment scheme was established in May 2010 as part of the Joint Public Health and Social Care AHDC OT Pilot mentioned above. With the secured Aiming High funds, certain items of equipment were purchased, including

---

[96] Pitcher J (2010) 'Integrated Community Equipment Service (ICES) Project 2010-11 – Nottingham City and Nottinghamshire County ICES: Service Model Option Appraisal"

[97] Pitcher J (2010) 'Integrated Community Equipment Service (ICES) Project 2010-11 – Nottingham City and Nottinghamshire County ICES: Service Model Option Appraisal"

fold away mobile hoists, small paediatric special supportive seats, buggies, transfer slings and portable padded beds. The purpose of this equipment has been to allow family's the opportunity to request the loan of equipment to support them in taking their disabled child on a holiday, a weekend away to relatives participating in social events in the wider community. This equipment has also been used to promote some emergency respite overnight or day care.

The scheme continues to be publicised to all open cases held by the countywide OT team, and both health and social work colleagues have also been informed of the new service provision.

During 2010/11, Continuing Healthcare fully funded 27 items of equipment for patients aged 0-25 and from April 2011 to September 2011 they funded 17 items of equipment for patients aged 0-25.

The following case studies identify how the Specialist Equipment Panel assesses cases based on needs and criteria for support.

NHS Nottinghamshire County Case Study 1

Tom (not real name), a nine year old boy, is quadriplegic. He has developed a leg length discrepancy and this is likely to increase as Tom grows.

Specialist seating was requested to aid Tom's postural management and help prevent long term deformities and consequential higher level of dependency.

This request was taken to the Specialist Children's Equipment Panel at NHS Nottinghamshire County; this panel consists of a commissioning manager from NHS Nottinghamshire County and a senior occupational therapist from Nottinghamshire County Council.

At this panel, the referral form was discussed. This included the needs assessment which had been completed by an occupational therapist. The panel discussed the needs assessment and from this agreed that while there were clearly health needs, there were also social needs, e.g. seating allowing Tom to socialise and make it easier for carers to carry out aspects of Tom's personal care. Joint funding was agreed.

<u>The positive aspects of this case</u>
The health assessment was clear in its rationale, namely:
- *Why this equipment was needed*
- *What it was needed for*
- *The health and social needs for equipment*
- *The viability and costs of alternatives*
- *The life span of the product*
- *Assurances that this equipment is not available in ICES.*

The assessment was completed in May 2011 and taken to the July 2011 panel, because the product had been costed and sourced, so was able to be ordered immediately after the panel and delivered without delay.

NHS Nottinghamshire County Case Study 2

Fred (not real name) is a two year old boy, who is ventilated; he has a large package *of care, which is delivered in the family home. Fred lives with his parents and older brother and sister. They live in a three bed roomed house. The brother and sister have been sharing a room but now want separate rooms. A request came to the Specialist Children's Equipment Panel at NHS Nottinghamshire County to joint fund an extension to the house for a fourth bedroom to accommodate the growing family.*

This was rejected by specialist children's equipment panel at NHS Nottinghamshire County. The responsibility for this extension fell outside of the Health remit and by inappropriately submitting the request delayed any future applications to appropriate authorities.

4.19 Community Paediatric Service

Community paediatric services are commissioned from Nottingham University Hospital Trust, Sherwood Forest Hospital Trust and Doncaster and Bassetlaw Hospital Trust. They are commissioned to provide children and young people aged 0 -19 years with a range of interventions and assessments, delivered in a range of community settings. They tend to offer general community paediatric clinics, neurodisability clinics, life shortening conditions service, medical support to schools (including special schools), children in care services and child protection services.
There are clear statutory requirements in relation to medical support to schools (including special schools), children in care service and child protection services.

The Community Paediatric Service is integral to the delivery of a multi-agency approach to early intervention and prevention. The National Service Framework for Children, Young People and Maternity Services (DH 2004) core standard 1 focuses on early intervention, based on timely and comprehensive assessment of a child and their family's needs. It states that the health and well-being of all children and young people is to be promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS in partnership with local authorities.

A review by PCT commissioners of the Community Paediatric Service from NUH was completed in 2011. The review identified that "*one of the core strengths of the Community Paediatric Service is the expertise in, and contribution to, dealing with both overt and less overt safeguarding concerns. If children are to be protected from harm and their welfare promoted, effective joint working between agencies and professionals with different roles and expertise, is required. As commissioners we need to ensure that the services we commission ensure early identification of safeguarding issues*[98]*".*

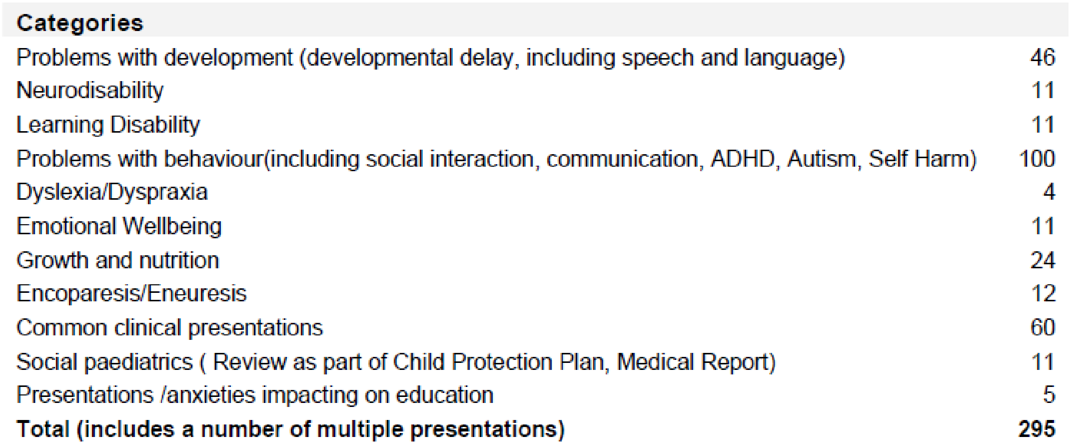
Community paediatric services are required, as a statutory partner, to work with local authorities (Nottingham City Council and Nottinghamshire County Council). This includes direct work with early support services, contributing to multi-agency assessments and diagnosis (for example in relation to communication disorders such as autism and ADHD), the provision of health assessments and reports to support children who have SEN, Statements, tribunals, police and court reports. Each local authority has an Early Intervention Strategy, supported by multi-agency pathways to provision, with a multi-agency commitment to apply the Common Assessment Framework where indicated.

---

[98] Handley S & Hooton D (2011) A Review of Community Paediatric Services delivered by Nottingham University Hospitals, May 2011, NHS Nottinghamshire County and NHS Nottingham City

The reasons for referrals to the NUH led Community Paediatric Service as indicated in Table 4.24, identify that children with disabilities and/or SEN are most likely to be referred to the service.

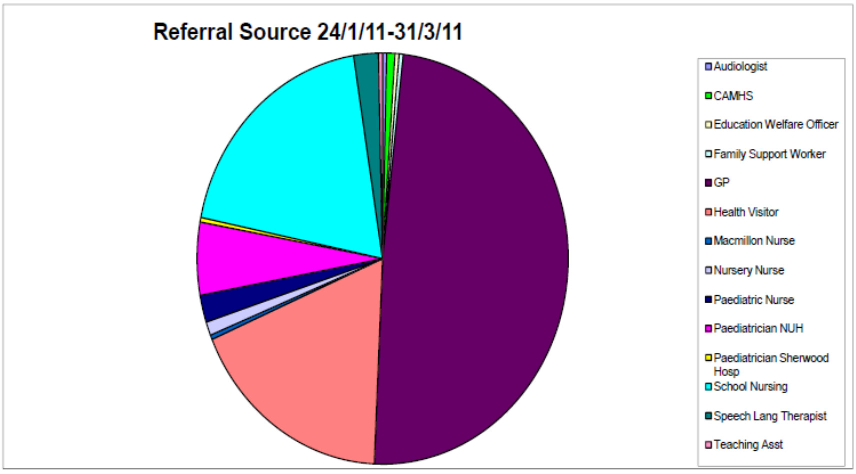
Table 4.24 Reasons for referrals audit of 200 consultations during 2010 -11[99]



Categories	
Problems with development (developmental delay, including speech and language)	46
Neurodisability	11
Learning Disability	11
Problems with behaviour(including social interaction, communication, ADHD, Autism, Self Harm)	100
Dyslexia/Dyspraxia	4
Emotional Wellbeing	11
Growth and nutrition	24
Encoparesis/Eneuresis	12
Common clinical presentations	60
Social paediatrics (Review as part of Child Protection Plan, Medical Report)	11
Presentations /anxieties impacting on education	5
Total (includes a number of multiple presentations)	**295**

Referrals highlight general practitioners as they account for 50% of the referrals into the NUH service, followed by referrals from a range of primary care professionals including health visitors and school nurses. This picture is likely to be reflected in other community paediatric services in Nottinghamshire.

Figure 4.25 Snapshot of referral sources to Community Paediatric Service at NUH in 2011[100]



---

[99] Handley S & Hooton D (2011) A Review of Community Paediatric Services delivered by Nottingham University Hospitals, May 2011, NHS Nottinghamshire County and NHS Nottingham City

[100] Handley S & Hooton D (2011) A Review of Community Paediatric Services delivered by Nottingham University Hospitals, May 2011, NHS Nottinghamshire County and NHS Nottingham City

4.20 Coordinated Training Service

A coordinated training service delivered by NUH, that provides a range of clinical competency based training and assessment to parents/ carers and any worker who providers care/service to a child with an additional health need.

Activity to date:

- Quarter 1: 16 training courses; 116 individuals attended; 10 competency packages complete
- Quarter 2: 27 training courses; 196 individuals attended;48 competency packages on target to complete
- The service has been extended until March 2013.
- Evaluation has shown that the service is meeting needs and demand is high. There may be potential for roll out of this pilot
- There is potential to integrate with all relevant training services post March 2013, work is taking place to examine this.

4.21 Children's Palliative Care

There are a number of local providers who give palliative care to children and young people as part of their core activity. These include community children's nurses and community paediatricians, as well as additional services which are dedicated to meeting the palliative needs of children and young people, e.g. the Butterfly Project.

The Barnados and NUH '**Butterfly' project** – this covers Nottingham City and the South of Nottinghamshire for children and young people aged 0-19 years.

It provides a bereavement and support service, volunteers, sibling groups, and supports with educational issues. The Butterfly Project can also offer consultations with a BME worker and, where possible, they offer funding for therapeutic activities for the immediate families.

Mentors also offer children and young people who have siblings with life limiting conditions opportunities to access activities in the community, pursue their hobbies or interest or the chance to go out and have some fun.

In April 2011, the Integrated Community Children's Nursing pilot led by Children's Community Matron, commenced providing 24/7 end of life nursing care at home to enable families to have the supported choice in Nottinghamshire of where their child can die. Between April and September 2011, five children have been supported to die at home, who previously would have died in hospital.. A gap remains in nursing support for families who have children who have complex health care needs who die suddenly at home in the night.

Palliative care gaps and issues were highlighted in a scoping report[101] for children and young people with complex care needs. Most of the gaps highlighted in 2009 have now been addressed by commissioning a range of appropriate interventions, such as 24/7 end of life nursing care and a children's community nursing service based at Sherwood Forest Hospitals NHS Trust, providing a primary care service in

---

[101] Wilcock S & Atkin J (2009) Scoping Report for Children and Young People with Complex Health Care Needs, NHS Nottinghamshire County

High Point and Newark & Sherwood. However, the following gaps and issues remain:

- Provision of therapy services is inconsistent
- Prompt referrals to community based services vary due to a lack of awareness of services available and lack of provision
- Limited availability of specialist family support and key working.

Furthermore the scoping report highlighted a number of recommendations, the only outstanding suggested action is to develop flexible provision with a multi-skilled workforce that is county-wide, offering a range of services, including 24 hour on call, seven days a week support with the capability for home visiting for short breaks at end of life if required by families. Further work is taking place examining what specialist community service for children should be in the future. The aim is to move towards an integrated service.

Nottinghamshire has developed a palliative care pathway, however it requires a review and refresh to accommodate changing service delivery and links to other pathways.

4.22 Social Care Children's Disability Service (CDS)

The **Children's Disability Service (CDS)** provides a social care service for those children who have a permanent and substantial disability and who require both the services of a specialist social worker and specialist services. These children/young people are those with:

- Autism
- Complex health needs
- Severe physical disabilities
- Severe learning difficulties
- Deaf children and hearing children of deaf parents, who need specialist communication skills, i.e. British Sign Language (BSL), or Sign Supported English (SSE) will be assessed initially by CDS, with a worker who can meet those needs. The Ashfield and Mansfield Team cover the whole of the county for this area of service
- Visually impaired children/young people**.**

Children and young people who have ADD, ADHD, conduct disorders, emotional/behaviour difficulties, mild/moderate learning difficulties or high functioning autistic spectrum disorder (including Aspergers syndrome) and who meet the criteria for a social care service, will be worked within the reception and assessment teams/ child care fieldwork teams and signposted where appropriate onto other service providers/agencies. The CDS will provide advice/guidance where appropriate. In some cases, it may be appropriate for another agency to take the lead role.

It is not possible for the CDS to provide a service for all children who have additional needs and who meet the criteria for a social care service. The team includes 2.5 qualified social workers who are specialist workers and work with deaf families who need specialised communication skills. CDS has a number of establishments to carry out their work. These include:

Minster View

Minster View is a residential and short term breaks community home for young people situated near Southwell.

It provides residential accommodation for eight young people; with a further four short term break beds available (plus one emergency bed). The building is split into two distinct living areas. To the right hand side of the entrance lobby and car park is the residential accommodation for eight young people and to the left the short term breaks unit.

Minster View offers 52 week residential provision for eight children and young people between the ages of 7 and 18 and short term breaks provision for another four aged between 4 and 18.

Criteria for providing accommodation:

- All requests for residential and short term breaks will be considered by the Inter-Agency Panel, in line with Nottinghamshire County Council children and young people's operational guidelines.
- All children and young people will have a core assessment and their placements on both the residential and short term breaks units will be planned and considered as a positive choice for the young person and their family. Parents and carers and the child or young person will work in partnership with staff to participate in the planning of all residential and short term breaks. Parents/carers will be asked to provide full information regarding the health and medication needs of the child/young person.
- A child or young person placed at Minster View either on a residential basis or for short term breaks will have a severe learning disability combined with challenging and difficult behaviours.
- Challenging behaviour can be defined as "children with a learning disability who have behaviour which is of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed at serious jeopardy, and which is likely to seriously limit or deny access to and use of ordinary community services[102]".

The building was built in 1926 as part of the Greet House Workhouse complex as the 'New Infirmary'. Both units have a full range of facilities including soft play areas, outside climbing/play facilities, en-suite facilities, sensory rooms, separate kitchen facilities for independence work and areas for private study etc. All young people have single bedrooms. For extra safety and security they have 'door pads' which indicate to night awake staff when a child has left their room, and a 'listening device' in bedrooms to enable checks on any noises within a bedroom without physically disturbing the child by entering the room.

The establishment is regularly inspected by Nottinghamshire County Council and Ofsted to ensure that good working practice is maintained and that standards in all areas are at or above the required level.

---

[102] Emerson, E. (1998). Working with people with challenging behaviour. In E. Emerson, C. Hatton, J. Bromley & A. Caine (eds) Clinical Psychology and People With Intellectual Disabilities. Chichester: Wiley.

Caudwell House

Caudwell House is a sixteen bedded children's establishment run by Nottinghamshire County Council. It provides residential care and a range of support services including short breaks to children and young people with physical disabilities and associated learning difficulties.

The establishment is regularly inspected by Nottinghamshire County Council and Ofsted to ensure that good working practice is maintained and that standards in all areas are at or above the required level. Copies of inspection reports by Ofsted are displayed in the reception area and copies are available on request.

Caudwell House takes a 'children first' approach. They aim to treat each young person as an individual with specific needs. The overriding principle at Caudwell House is that the young people should have an experience that is as familiar and enjoyable as possible, in a safe, healthy and relaxed environment.

The unit is well equipped for play and leisure activities, having its own sensory rooms, art and craft room, ball pools, play room and hydrotherapy pool along with a vast range of games and activities. There is a range of accessible outdoor play equipment and a play safety surface for all weather outdoor play. A nursing support service is provided by CHP into Caudwell House to support Children and Young people's health needs.

The Big House

The Big House is situated in the village of Edwinstowe, eight miles from Mansfield. It is a large country house and Grade Two listed building.

The house is well-decorated and comfortable with a large range of indoor activities and games for use by the children and young people. Outside, the grounds are extensive and incorporate a large, totally safe play area for the young people. There are plenty of trees, shrubs, flower beds, swings, cycles (and track) and equipment designed to challenge and to improve dexterity and mobility. There is also a small pool for the children and young people to use in the summer and laser beam alarms to allow the night staff to safely monitor all the young people.

Eligibility criteria:
Any child looking to be placed at the Big House will have a severe learning disability, currently functioning around half the level of expected developmental age, combined with manifestations of challenging and complex behaviours. This will be determined by an assessment by a psychologist, core assessment and via a statement of special educational needs.

- The child or young person should be of school age, between 4 and 18 years.
- The child or young person will attend their own school.
- Parents/carers and the child/young person should fully participate in the planning of all short breaks.
- The child/young person must reside in the areas of Mansfield, Ashfield, Bassetlaw or Newark, Nottinghamshire.

The establishment is regularly inspected by Nottinghamshire County Council and Ofsted to ensure that good working practice is maintained and that standards in all areas are at or above the required level.

Table 4.26 Referrals to the Social Care Children's Disability Service and average numbers of referrals received per month

	Social Work			Occupational Therapy			Both needs			Total			% Increase monthly	
	2009	**2010**	**2011**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**	**2009/10**	**2010/11**
January	10	15	20	5	14	11	2	3	1	17	32	32	88.24%	0.00%
February	13	16	18	9	10	7	0	4	1	22	30	26	36.36%	-13.33%
March	13	21	23	12	12	7	0	3	1	25	36	31	44.00%	-13.89%
April	12	16	21	6	5	8	1	0	0	19	21	29	10.53%	38.10%
May	11	17	22	5	8	9	0	1	0	16	26	31	62.50%	19.23%
June	12	14	19	13	15	9	0	0	0	25	29	28	16.00%	-3.45%
July	12	17	0	7	11	0	0	1	0	19	29	0	52.63%	-100.00%
August	13	14	0	10	4	0	3	1	0	26	19	0	-26.92%	-100.00%
September	11	22	0	17	7	0	0	2	0	28	31	0	10.71%	-100.00%
October	17	16	0	13	5	0	0	1	0	30	22	0	-26.67%	-100.00%
November	18	20	0	11	10	0	1	1	0	30	31	0	3.33%	-100.00%
December	10	16	0	11	3	0	1	0	0	22	19	0	-13.64%	-100.00%
Total	**152**	**204**	**123**	**119**	**104**	**51**	**8**	**17**	**3**	**279**	**325**	**177**	**16.49%**	**-45.54%**

Source: Nottinghamshire County Council, 2011
[Numbers below five have not been suppressed, as they are based on averages]

In October 2011 Ofsted identified the following assessment of safeguarding:
"Following learning from a serious case review, the Children with Disability Service has recently restructured to provide increased management support, including a duty manager, to ensure safe and consistent decision making for all referrals, with a focus on the impact of long term neglect on children with disabilities. As a result of this, all cases were reviewed and there are increased numbers of children now appropriately safeguarded by child protection plans.

There is a greater emphasis on safeguarding children alongside providing services to support children and families through short breaks and direct payments. Staff across the partnership are aware of the learning from serious case reviews and have amended practice and policy accordingly. Within the health service changes brought about by learning from serious case reviews include the development of an escalation process, focused recording logs, improved sharing of health information and co-location of specialist nurses in the referral and assessment teams and children with disabilities teams. This work is effectively led by the NSCB. Action plans have been implemented and findings are integrated into the training provided by the NSCB. Recent evaluation has been undertaken to explore the impact of this learning on practice."[103]

---

[103] Ofsted (2011) Nottinghamshire Safeguarding Inspection Report http://www.ofsted.gov.uk/local-authorities/nottinghamshire

Case Study - Child H

On initial discharge from hospital mum acted as the key worker. Mum does not feel comfortable with social care being involved. She also does not like the fact that some professionals expect her to discuss personal things in a meeting forum.

The family received support from Health until H went to school. However when her health needs deteriorated, Children's Social Care (who were already involved) failed to refer for some additional support.

The family feels that there are some limitations to the flexibility of services they receive and would like two carers at each visit. Mum feels that the CCN service is responsive to H's needs.

There is a lack of information about services and feels a parent's directory may be useful. Mum also feel there is a gap with children with complex care health needs not being referred to appropriate services.

4.23 Children's Social Care

Placements
Anecdotally it is known that out of authority placements for children and young people with disabilities and/or SEN are costly, and most children would prefer to be closer to home. No data was made available for this needs assessment to help review out of authority placements.

Further work would be required to understand who uses out of authority placements, why this placement was used rather than a more local service provision, feedback from children and young people, as well as cost implications.

4.24 Early Intervention

In Nottinghamshire, using an early intervention approach is critical to prevent poor outcomes worsening for children, young people and families. The Nottinghamshire Early Intervention and Prevention Strategy sets out Nottinghamshire Children's Trust's ambition for the development of early intervention and prevention services. The Strategy has been developed in response to the national policy context and the local needs of children and young people in Nottinghamshire and applies across the Nottinghamshire Children's Trust and its constituent services.

Nottinghamshire's ambition for early intervention and prevention services is that children, young people and their families will receive the most appropriate support to meet their needs at the earliest opportunity, in order to ensure better outcomes and the cost effective delivery of services.

The Early Intervention Strategy defines the five key strands of early intervention and prevention work in Nottinghamshire and for each of the five strands there is a detailed implementation plan.

The five key strands are:

i) The provision of services to ensure the best start in life
ii) The development of language for life

iii) The engagement and support of parents and carers
iv) The development of effective structures and processes
v) The use and provision of management information.

Pathway to Provision

The Pathway to Provision is a two part resource which includes a multi-agency thresholds guidance document and an online resource available through the Families Information Service Directory.

The Pathway to Provision multi-agency threshold guidance has four sections which include: Nottinghamshire's ‘Continuum of Children and Young People’s Needs’; definitions and indicators for practitioners to assist in the identification of levels of need for children and young people; Pathway to Provision at the four levels identified; and a number of appendices including the ‘Step Up and Step Down’ process for when referrals are made into Children's Social Care, and when support from Children's Social Care is coming to an end. The lists of services available in 4.1 are set out in line with the Pathway to Provision for consistency.

Common Assessment Framework

The Common Assessment Framework (CAF) is a holistic assessment used to identify the strengths and needs of children and young people from pre-birth to age 19. The CAF assessment is used at the early intervention stage to ensure a thorough assessment is completed at the earliest opportunity, allowing practitioners to work together to formulate an effective package of support. This is a consent based process.

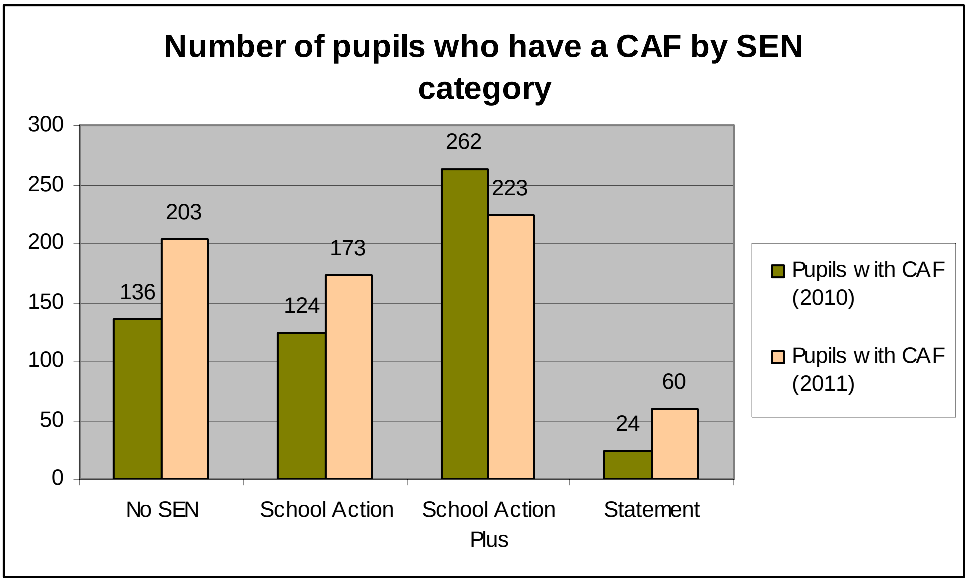
By matching young people who have a CAF against their corresponding SEN status from the January school census of each year, it is possible to map the correlation between SEN and CAF assessments. Table 4.27 and Figure 4.28 indicate that pupils who are in the School Action Plus category are on average (over the last two years) around 25 times more likely to have a CAF than non-SEN pupils.

Table 4.27 Nottinghamshire pupils who have a CAF by SEN category

	Pupils with CAF (2010)	% of cohort (2010)	Pupils with CAF (2011)	% of cohort (2011)
No SEN	136	0.15%	203	0.22%
School Action	124	0.73%	173	1.05%
School Action Plus	262	5.12%	223	4.54%
Statement	24	1.98%	60	4.76%

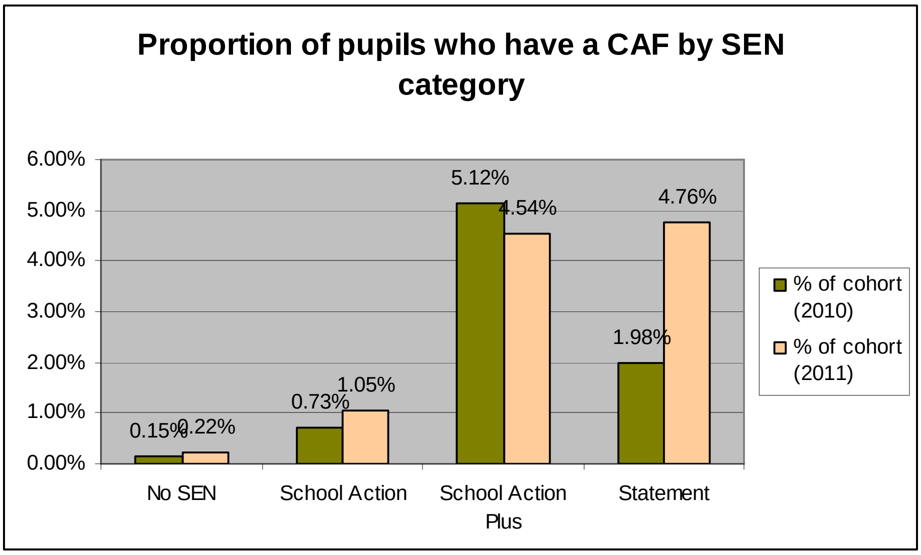
Source: Nottinghamshire County Council, 2011

Figure 4.28



Source: Nottinghamshire County Council, 2011

Figure 4.29



Source: Nottinghamshire County Council, 2011

Joint Access Teams

Joint Access Teams (JATs) are recognised as the key mechanism for early intervention in Nottinghamshire. There are 42 JATs across the county, meeting on a monthly basis to discuss children and young people with early intervention or targeted needs. JATs have a 0-19 focus, supporting professionals to identify who is most appropriate to work with families as well as generating good local information about where families, can access advice about emerging difficulties.

Unfortunately information regarding which groups of children and young people have been referred to a JAT is currently very patchy, as the detail lacks clarity around diagnosed disability.

JAT Case Study - David

David is a nine year old boy who attends primary school. The family had recognised that he was different to his five siblings from an early age. Initially the funny comments he made, literal interpretation of information and trusting nature was endearing, but as time progressed the family felt that this may become a problem and affect the way others would view him. School were also aware of his need for support around communication. The family discussed this with their GP and the child was diagnosed with Childhood Autism.

The parents have a good relationship with the school and feel able to approach the head teacher if they have any concerns about their child. On this occasion both parents spoke to the head teacher about minor incidences that had happened in school and expressed their concerns that they were finding it increasingly difficult to identify avenues of support for their child's autism. They also confided that they were feeling anxious about the transition to secondary school in two years time as their child considers the primary school to be 'his school' and doesn't understand the need for transition.

Prior to the referral to the JAT, school had put in place a routine to help with communication and understanding, which included an opportunity at the end of each day for the whole class to reflect to ensure that issues and incidences are resolved before the children leave the classroom. David showed a keen interest in reading, and while he was already doing well, additional sessions were arranged to help him to progress further with his reading. The family where also seeing a consultant about their child's autism on a six monthly basis.

Prior to the discussion at the JAT, parents had attempted to seek support around autism, which included phoning social care. The children's disability team informed school that they wouldn't be able to provide any services at that time. The family felt that they didn't know where to turn to find the support they were looking for.

After listening to the parent's concerns, the head teacher explained the JAT process to mum and dad. Although at this stage she wasn't sure if this would be an appropriate referral to the JAT, she did feel that the family were in need of advice and information and felt that the JAT was an appropriate forum for practitioners to share their collective knowledge about autism with the family. The head teacher also felt that it would be beneficial for the family to speak to staff at the secondary school, giving them an opportunity to discuss their concerns about their child's transition. Again, she knew that a representative from the secondary school (the SENCO) would be in attendance.

Once the family had agreed to their child's needs being discussed at the JAT, the head teacher asked if either or both of the parents would like to attend the meeting to talk about their child. Dad said that although he had work commitments, he would be willing to take time off to attend the meeting as he felt that it would be helpful to discuss his child's needs in person. The head teacher explained that there would be a range of services in attendance and confirmed with dad that he would feel comfortable speaking in this situation. The head teacher then sat with both parents to complete the first two pages of the CAF in order to submit to JAT members prior to the meeting.

There was a broad range of services in attendance at the JAT meeting who were able to give dad some useful information about support services relating to autism. He was told about Norsaca and APTCOO, and was given information about appropriate after school clubs. Dad was willing and able to approach these services when he was given their contact information. Dad was also able to talk about his concerns relating to his son's transition to secondary school. During the meeting he *met the SENCO from the secondary school who reassured him that along with the primary school they would put a robust transition plan in place which would start earlier than usual and would include additional visits to the secondary school for his child. Dad was relieved that they had an awareness of his son's needs and felt reassured that this process would be managed effectively. It was only necessary to discuss this child at three JAT meetings before the discussion was closed. All involved felt that needs were identified and a plan would be put in place to meet them.*

The SENCOs at both the primary and secondary school worked together to plan the successful transition to secondary school.

Dad explained that he did contact the services that were suggested at the JAT meeting. There are activities for his son to attend if they decide they would like to take them up. They recently received a phone call from a service inviting them to a group on Saturday mornings but were unable to attend as mum does not have access to the car on Saturday mornings. They are also aware of a club for older children with autism but at this stage have decided not to take their son to this as they would like to keep things as normal as possible and do not want him to feel that he is different. They are pleased that they have these options and may feel that it is appropriate to attend in the future.

The family explained that they felt it was incredibly beneficial to have all the services together in one room at the JAT who were willing to listen to and help the family.

JAT Case Study - Jordon

Jordon is 14 years old and has a diagnosis of autism, ADHD and has a statement of special educational needs.

Jordon is happy in school and when the school brought the case to JAT, they were confident that his needs are met there.

At the time of referral, Jordon's mum was working as housekeeper at a large property and their home was tied into the job. Due to complications arising from the employers' marital situation, the house became the focus of a legal dispute between the owners. One of the couple was happy for Jordon and his mum to remain in the house, whilst the other was keen to sell the property; they were even showing people round the property without any notification and this became a great anxiety to Jordon and his mum. To make matters worse, the property had become infested with vermin. Jordon was not sleeping and stopped taking his medication.

Jordon's mum had become depressed and was on medication, although she had been to the housing office to find new accommodation, she had been told that she would have to be homeless before they would offer her accommodation. The situation was making mum's depression much worse and she felt unable to cope.

Jordon's mum had a good relationship with the school SENCO, she spoke to her about all of the difficulties the family were experiencing; she felt these difficulties were impacting on Jordon's well being. Mum also disclosed that she was in debt and could not afford heating for the house or basics such as new shoes for Jordon.

The school SENCO explained to Jordon's mum about the JAT and asked if she would be happy for the case to be discussed there. Jordon's mum said she had never asked for help before and described herself as "having to admit defeat", as things were so bad that she was desperate for any support. The first two pages of the

CAF were initiated as the referral tool.

The JAT discussed the family's case without Jordon or his mum present, as she did not feel able to attend and trusted the school SENCO to talk about their difficulties. The very close relationship between the school SENCO and the family enabled good communication about what the JAT had discussed and recommended.

The JAT membership formed a team around the family approach:

- *The Community Health Nurse contacted the Mental Health Team to put in place support for mum*
- *The educational psychologist offered support to school around how they might best support Jordon at this difficult time, in terms of his autism*
- *Police staff offered advice to mum around how to deal with the legalities of the situation*
- *The JAT housing rep was updated on the current housing situation*
- *School put in place provision for Jordon, to settle him into his school day and they offered his mum a hot drink and breakfast every morning, if she needed it*
- *Housing Team contacted environmental health about the vermin in the property, which led to an inspection of the property and due to the hazards, were awarded a new property*
- *The local youth worker advised of times/days when Jordon could access the youth club, if he wanted to.*

Following the meeting, the Community Health Nurse continued to make regular calls to the family home and helped mum to contact a solicitor to prevent the owner of the house coming into the house and showing people round. This practitioner had had some past involvement with the family and had a close working relationship with Jordon and his mum. By the next JAT meeting, the family were to be re-housed in a village not too far away and the JAT decided to close the case.

However, by the following meeting, it became clear that Jordon was unable to cope with using public transport for the journey to school and his mum could not afford to transport him. The JAT continued to offer school advice about the case, it was thought that home to school transport from the local authority would help and this would mean Jordon could stay at his present school, an important issue for a young person with his needs.

By the following month's JAT meeting, the community health nurse was able to report that Jordon's mum had been referred to the mental health crisis team, as her condition had worsened. She was engaging with a mental health worker. Due to Jordon's mums financial and other issues, she had been referred to social care as a vulnerable adult. Jordon's mum had been successful in an application for home school transport and so Jordon was able to stay at his school.

By the time of the next JAT meeting, transport to and from school was in place for Jordon and so he could remain at his school. Adult social care services had supported mum to apply for benefits and she was receiving advice re debts. The local youth worker reported that Jordon had started to come to the youth club.

As the family were receiving appropriate support, the case was closed to the JAT.

4.25 Transport

Transport provision is provided on a statutory basis for children with disabilities in order for them to access school. The following table details the transport provision available in Nottinghamshire in 2011/12.

Table 4.30 Transport Provision in Nottinghamshire

Provision	Transport Offered?	Assessment of Needs
Early Years	Based on need	Provided for children with a statement of SEN.
Mainstream School	Nottinghamshire County Council (NCC) Home to school Transport Policy	NCC assessment (based on distance, free school meals (FSM) eligibility /working tax credit, medical evidence & age). SEN pupils have assessment by SEN Team and Transport & Travel Services (TTS) arrange provision (use of bus pass or specialist transport) preferred school provision policy also considered.
Special School	NCC Home to school Transport Policy	NCC assessment (based on distance, FSM eligibility /working tax credit, medical evidence & age). SEN pupils have assessment by SEN Team and TTS arrange provision (use of bus pass or specialist transport) preferred school provision policy also considered. However for residential schools NCC provide if parents do not have transport access.
Short Breaks (SB)	**Residential SB** - universal. **Sitting & Befriending** - universal. **Home from Home** - volunteer expenses. **Contract Carers** - travel expenses.	**Flexible SB** - SW assessment (based on distance and need)
Children's Social Care	Based on need	Social worker assessment of need
Alternative Provision	NCC Home to school Transport Policy	For statemented full-time students only. Schools provide if they made referral, parents provide if their choice.
FE College	NCC Post 16 Transport Policy	TTS assessment for full time students based on medical evidence, distance and age 16-21 (or 25yrs in exceptional cases)
Adult Social Care	Transport Policy	Provided if identified in an individual support plan
Extended Services	None	In rare cases parents negotiate for all using the same home to school transport to arrive to school early or leave later to enable access. Some CYP on individual transport packages may be able to access.
LA Youth Provision	Minibuses are available for trips only. CYP make their own arrangements to access provision.	Not applicable

Children and young people with disabilities may travel long distances to access their mainstream or special school. Table 4.31 highlights where children live in comparison to the location of their school. This includes children and young people who live in other local authority areas. A detailed map showing the distances that children and young people travel to access a special school is available on request.

Figure 4.31 Number of special school pupils by district of residence and designated school (2011)

	Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**		**Newark and Sherwood**	**Rushcliffe**		**Total by District / Local Authority**
Home Address	Bracken Hill Special	Fountaindale Special	St. Giles Special	Foxwood Special Foundation	Derrymount Special	Digby Special	Beech Hill Special	Redgate Special	Yeoman Park Special	Orchard Special	Ash Lea Special	
Ashfield District	52+	7+	1+	5+	4+	1+	6+	3+	17+	-	-	**143**
Bassetlaw District	-	4+	102+	-	-	-	-	1+	-	1+	-	**131**
Broxtowe District	2+	4+	-	31+	3+	1+	-	-	-	-	2+	**72**
Gedling District	1+	4+	-	3+	10+	22+	-	-	1+	2+	7+	**86**
Mansfield District	4+	9+	-	-	2+	-	16+	6+	16+	1+	-	**89**
Newark And Sherwood District	-	9+	4+	-	-	2+	11+	6+	7+	58+	4+	**147**
Rushcliffe District	-	3+	-	5+	4+	1+	-	-	-	4+	26+	**61**
Notts	**86**	**50**	**134**	**74**	**39**	**43**	**56**	**21**	**85**	**80**	**61**	**729**
Out of County	1+	8+	-	17+	9+	16	-	-	2+	2+	3+	**74**
Total by Notts Special School	**87+**	**58+**	**134**	**91+**	**48+**	**59**	**56**	**21**	**87+**	**82+**	**64+**	**803**

Sources: School Census & Capita ONE

Notes:

1. Initial data for Nottinghamshire Special School pupils was taken from the School Census (October 2009), with additional data from Capita ONE (eg. home address) and GIS software (District / Ward identification)
2. Includes pupils who are sole or dual main registrations
3. Excludes pupils with a confidential address
4. Numbers from 1 to 5 inclusive have been suppressed and replaced in the table by a cross (x)

County Council provision for home to school transport for pupils attending special schools and other specialist provision accounted for around £5.7m in 2011/12, up from £4.7m in 2005/06 (Table 4.32).

Table 4.32 Home to school transport costs for children and young people with SEN and learning difficulties or disabilities

2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012*
£4.74m	£4.56m	£4.53m	£5.77m	£5.47m	£5.73m	£5.71m

Source: Nottinghamshire County Council [* Projected annual spend as at period 7]

In Nottinghamshire transport is also provided to enable children and young people to access short breaks. Budgets, however, are very tight and continuously over spend. In addition, because disabled children increasingly have a range of equipment needed to accompany them to a short break, transport provision is often unable to transport the child with their equipment.

Transport Case Study

Child G was due to access a short breaks service directly from school. Local authority transport, however, could only accommodate the pupil with one reasonably sized bag on the transport available. If the child is a wheelchair user then this will is fixed to the vehicle as normally is the case on the home to school transport provision. However, the vehicle cannot accommodate a walker or other large equipment. His family were advised that they would need to deliver this larger equipment to the short breaks provider themselves if the equipment was not available at the service.

Luggage on short breaks transport from schools has been an issue over the past couple of years and an agreement was reached between Transport and Social Care regarding the amount of luggage children could take from school to their short break.

Parent Partnership Case Study

A Yr 10 girl (T) has been out of school for ten months following extensive bullying, mainly on the school bus (this took place in another county). The family experienced domestic violence and T moved with her mother into Nottinghamshire. T had serious emotional health issues and is still under CAMHS as a result.

Mum applied for a school place once it was felt that T could access education again, but failed to gain a place at a school local enough to meet her needs (i.e. so there would be no bus travel required).

Mum is supported by the Parent Partnership Service Choice Adviser to consider schools and make the necessary applications and appeals, but to date T is still out of school as the only school place that has been offered would involve a bus journey. CAMHS professionals provided evidence to indicate that this was not an appropriate offer but their advice has not yet been acted upon. T did have some home tuition provided but only a few hours per week. Her emotional health and wellbeing have not benefited from her lengthy time out of school. [T’s case has now been taken up at a higher level.]

4.26 Transition Support

'*The legal transitions between child and adult services, however, occur between ages 16 and 19. For example, young people usually move from child to adult health services at 16; from child to adult social services at 18; and from school-based education to further or higher education at* 19[105].'

Most data and studies about children/young people who have finished post-compulsory schooling refer to the 16-25 age range. Transition is a high priority following the County Council's SEN Review, and a multi-agency Transition Protocol[106] is now in place. As the number of statements in Nottinghamshire is low, the target groups for transition in Nottinghamshire include children and young people who:

- are on the roll of the Nottinghamshire Learning Centre
- have a statement of SEN
- are on the roll of a special school
- are in receipt of the local authority's High Level Needs funding allocation
- are a looked after child
- attend an independent non-local authority education/care setting.

All Year 9 pupils with Statements of SEN are offered a transition review, but in 2009, only 61% of young people attended their review. It is not clear why some young people are not attending or whether this is a recording issue. Feedback from the Parent Partnership Service indicates that the level of support varies, with a tendency towards less support for young people without statements, but that this depends on the school. Two schools in the county have, however, been identified as Beacon Schools for Person Centred Reviews (Foxwood Special School & Brackenhill).

All young people are entitled to a transition support worker and a Connexions personal advisor.

The **children's social worker** has a responsibility to think beyond the 18th birthday. Disabled young people should be supported to have more independence as they become adults. The family of the disabled young people may also need support to allow the young person to make more decisions for themselves as they move through the teenage years.

The Mental Capacity Act has an impact on how we work with young people of 16 and 17 about decisions that affect them. They should be treated as young adults in terms of being part of any decision making that affects their future.

Particular responsibilities of the children's social worker include:

- Liaising with the transitions co-ordinator and the Connexions personal advisor (PA) once the young person reaches 14.
- Ensuring that, between the ages of 14 and 16, the young person and their parents have an appropriate level of contact with the transitions co-ordinator

---

[105] Wellard S & Wheatley B (2010) 'What if we said No?' Grandparents Plus http://www.grandparentsplus.org.uk/wpcontent/uploads/2011/03/Findings2010_ONLINE_NEW.pdf

[106] Nottinghamshire County Council and Partners (2010) Nottinghamshire's Multi-Agency Transition Protocol – supporting young people with SEN and Disabilities from aged 14 (year 9) into adulthood

or Connexions PA, so that they can start to prepare for the changes that transition to adult services will bring.
- Attendance at the transitions co-ordination meetings.
- Highlighting to adult services at an early stage (i.e. from age 14), those young people who are likely to need complex or costly care packages in adulthood.

When does children's social care responsibility end? Young people become adults on their 18th birthday and in most cases children's social care services cease to have any responsibility for young people as soon as they reach 18. This means that the social work role ends and all funding and services end. There are two exceptions to this general rule:

- Young people eligible for aftercare (i.e. those who are looked after) - generally speaking, young people who are eligible for adult social care services would not have a separate after care worker, but they may be eligible for some elements of after care support.
- Young people who are living in, or who have a short break in, a unit for disabled children - legally (under the 1989 Children Act), a young person up to the age of 21 can be "accommodated" in a children's "community home" if this would "promote his welfare". This is the legal basis for short breaks, and residential accommodation continuing beyond 18 in children's residential units.

Good transitions planning should mean that most young people are able to move to adult services provision in a planned way some time between their 18th and 19th birthdays. If the young person is at school, they may continue to receive the children's service until their 19th birthday, as long as this continues to meet their needs. In these instances, the social work role and all other services and responsibilities transfer to adult services at the 18th birthday.

Responsibility under the SEN Code of Practice - SEN Strategic Services will notify the countywide transitions co-ordinator of:

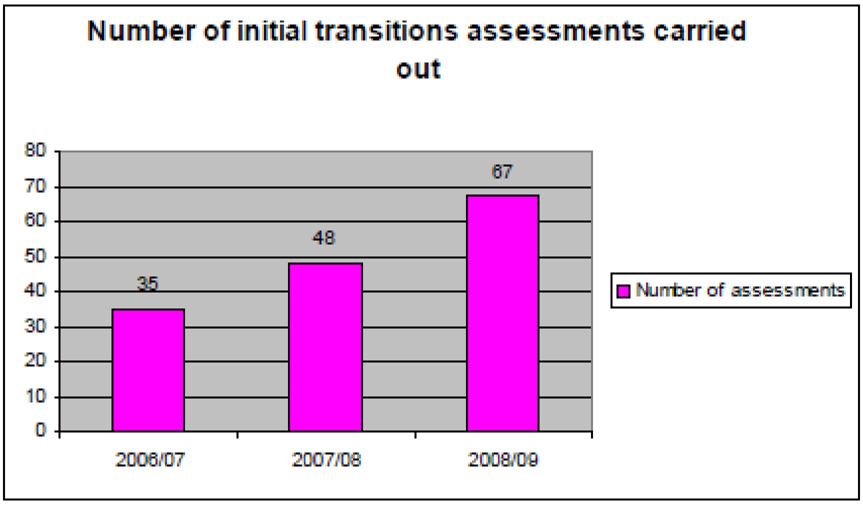
- All year 8 children with a Statement of SEN who will have a Transitional Plan Review in the following year, and children who are at School Action Plus stage of the Code of Practice 2002.
- Young people between the end of Year 11 and Year 14 who are eligible to leave school in the Summer Term, and who have a Statement of Educational Needs, or who are at School Action Plus stage of the Code of Practice 2002.

A list of all young people so identified, with information about the nature of their impairment, will be made available to the countywide transitions co-ordinator each May by the data management officer of SEN Strategic Services. Special educational needs coordinators (SENCO) are responsible for identifying any additional young people not on these lists, who may need transitions planning, and passing their details to the local transitions co-ordinator.

The **transition co-ordinator** has a specialist role to identify the most disabled young people who will be moving into Adult Services, to assess their needs and to develop care plans and funding streams to meet them. They are based within Community Learning Disability and Physical Disability teams. They are line managed by the team manager but receive additional specialist support from the countywide transition co-ordinator.

Exact numbers of young people are difficult to quote exactly, as some move out of the county during the transition period. However, rough numbers can be gleaned from the volume of initial transition assessments which take place (Figure 4.8.1 and Tables 4.33 to 4.34). The numbers of initial transition assessments undertaken are on the increase in each borough/district (except for Newark & Sherwood), and have almost doubled in three years across the county (35 in 2006/07 to 67 in 2008/09). Although category titles have changed over time, the largest increases have been in disability (+94% in three years) and learning disability (+93% in three years). There has been an increase in BME children involved in transition from zero in 2006/07 to nine in 2008/09.

Figure 4.33 Initial transition assessments 2006/07-2008/09



Source: Adult Social Care & Health Department, Nottinghamshire County Council, 2010

Table 4.34 Transition assessments undertaken 2006/07

	Abuse or Neglect (Child)	Asperger's	Disability (Child)	Learning Disability	Mental Health	Physical Disability	**Grand Total**
Grand Total	*	*	16	14	*	*	**35**

Source: Nottinghamshire County Council, 2010
[*Number below five and suppressed]

Table 4.35 Transition assessments undertaken 2007/08

	Abuse or Neglect (Child)	Asperger's	Cases Other Than Children In Need (Child)	Disability (Child)	Family In Acute Stress (Child)	Learning Disability	Vulnerable Adults	**Grand Total**
Grand Total	*	*	*	23	*	20	*	**48**

Source: Nottinghamshire County Council, 2010
[*Number below five and suppressed]

Table 4.36 Transition assessments undertaken 2008/09

	Abuse or Neglect (Child)	Asperger's	Disability (Child)	Family Dysfunction (Child)	Learning Disability	Low Income (Child)	Physical Disability	**Grand Total**
Grand Total	*	*	31	*	27	*	*	**67**

Source: Nottinghamshire County Council, 2010
[*Number below five and suppressed]

Transition planning requires the consideration of a number of services and entitlements, such as benefits, further education, higher education, employment, health service transition, transport, housing, leisure opportunities, social care services, direct payment and individualised budgets. The collection and analysis of key services and entitlements gathered during transition assessments would have been useful for this needs assessment and particularly for commissioners and planners.

Further work is required to:

- breakdown the cohort into categories of disability including primary and secondary disabilities
- assess a range of issues for children and young people during transition stages using data from transition assessments
- assess needs by locality to assess gaps in provision, collective issues and issues linked to child poverty levels,

A local parent's view of transition support through Respite Services and Continuity of Care

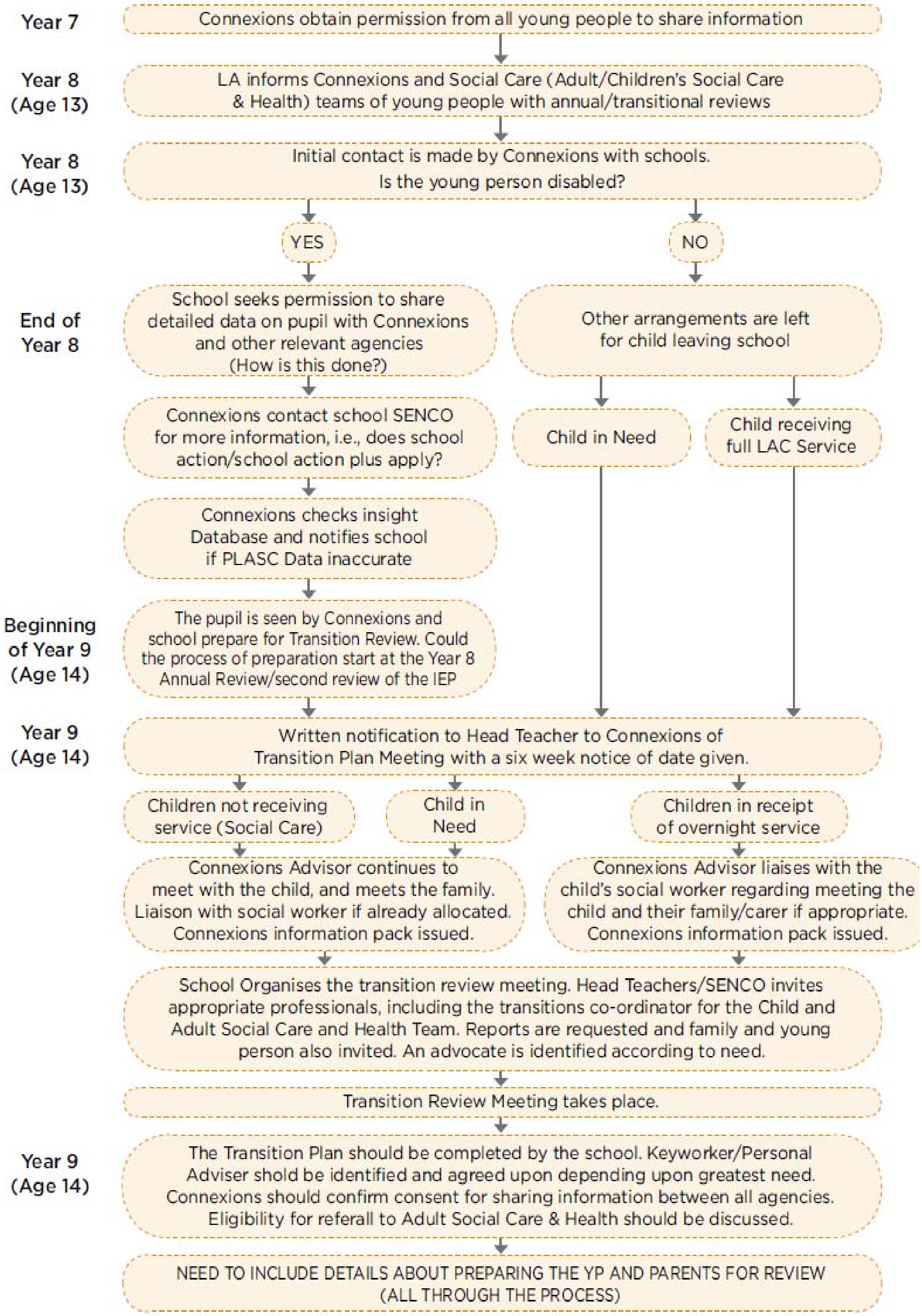
I hope the project will consider the age profile of our young special needs people. Once my son reaches the magic age of 18, the Respite Foster Carer who has been looking after him since he was six years old will no longer support him. As almost a surrogate second 'mum', my son will no longer see or have access to her which will be very sad for him.

A transition protocol was developed in 2010[108] and includes a multi-agency pathway described below. A strategic transition partnership group is in place, which is responsible for ensuring the transition protocol is implemented and reviewed.

---

[108] Nottinghamshire County Council and Partners (2010) Nottinghamshire's Multi-Agency Transition Protocol – supporting young people with SEN and Disabilities from aged 14 (year 9) into adulthood

Nottinghamshire Multi-Agency Transition Pathway



Year 7

Connexions obtain permission from all young people to share information

Year 8 (Age 13)

LA informs Connexions and Social Care (Adult/Children's Social Care & Health) teams of young people with annual/transitional reviews

Year 8 (Age 13)

Initial contact is made by Connexions with schools. Is the young person disabled?

YES

NO

End of Year 8

School seeks permission to share detailed data on pupil with Connexions and other relevant agencies (How is this done?)

Other arrangements are left for child leaving school

Connexions contact school SENCO for more information, i.e., does school action/school action plus apply?

Child in Need

Child receiving full LAC Service

Connexions checks insight Database and notifies school if PLASC Data inaccurate

Beginning of Year 9 (Age 14)

The pupil is seen by Connexions and school prepare for Transition Review. Could the process of preparation start at the Year 8 Annual Review/second review of the IEP

Year 9 (Age 14)

Written notification to Head Teacher to Connexions of Transition Plan Meeting with a six week notice of date given.

Children not receiving service (Social Care)

Child in Need

Children in receipt of overnight service

Connexions Advisor continues to meet with the child, and meets the family. Liaison with social worker if already allocated. Connexions information pack issued.

Connexions Advisor liaises with the child's social worker regarding meeting the child and their family/carer if appropriate. Connexions information pack issued.

School Organises the transition review meeting. Head Teachers/SENCO invites appropriate professionals, including the transitions co-ordinator for the Child and Adult Social Care and Health Team. Reports are requested and family and young person also invited. An advocate is identified according to need.

Transition Review Meeting takes place.

Year 9 (Age 14)

The Transition Plan should be completed by the school. Keyworker/Personal Adviser shold be identified and agreed upon depending upon greatest need. Connexions should confirm consent for sharing information between all agencies. Eligibility for referall to Adult Social Care & Health should be discussed.

NEED TO INCLUDE DETAILS ABOUT PREPARING THE YP AND PARENTS FOR REVIEW (ALL THROUGH THE PROCESS)

4.27 Personalised Budgets and Direct Payments

Direct Payments are paid to parents of disabled children and disabled young people aged (16-17) to arrange their own care and support. They are not taxable and do not affect social security benefits. They aim to provide flexibility and choice to children and families to ensure they receive support that meets their particular needs and circumstances. They also aim to provide the young person or parent to have more control over when, how and who provides support.

Direct Payments can be used to pay towards support and equipment that the local authority or NHS have agreed is needed following an assessment, e.g. home care, befriender or short breaks services.

Parents and young people in receipt of direct payments are responsible for:

- arranging the support they need
- sorting out any problems with the support and who provides it
- evidencing how they use the money
- agreement to spend the money only in ways that keep the child safe and well.

Parents and young people can use the money to employ their own staff. If they choose to employ staff, they have additional responsibilities as the legal responsibilities of an employer and the staff they employ report directly to the parents/young people. Recipients of Direct Payments are signposted to a range of organisations that can offer independent advice and help with direct payments.

Social workers in Nottinghamshire maintain regular contact with parents/young people to ensure that the Direct Payments are working well and still meeting needs, with annual reviews also in place. SEN Green Paper Pathfinder in Nottinghamshire (the One Project) aims to promote the use of personal budgets and will evaluate its use and impact. The Joint Commissioning Group should ensure clear oversight of this activity to inform future planning.

Local Uptake of Direct Payments

The take up of direct payments has been improving in the county, giving them more choice and control. Payments have been well-received by BME young people, to enable them to recruit from their own communities. However, some parents' views have also highlighted challenges, as identified by the local parent below.

Table 4.37 local update of Direct Payments

	07/08	08/09	09/10	10/11
No. of Disabled CYP accessing Direct Payments	95	205	258	260

Source: LAIMP, April, 2011

A Local Parent's View of the option of Direct Payments

I do receive direct payments but, as my son's respite carer is employed directly by social services as a contract carer, she is unable to do any other form of paid work expressly as part of her employment contract. I learnt this to my cost when I needed someone in as a matter of urgency to look after X whilst I attended my other child's school at short notice.

My disabled son is unable to be looked after by people who are not familiar with him or to him. He needs a high level of personal care….. (Description given). His aggressive behaviour does not lend himself to be looked after readily by people not highly trained and specifically with him. Since receiving direct payments, I have managed to retain the services of Y who used to work with my son as a young pre-school child whilst I worked. However, Y has since had a lot of absence (family explain the legitimate reasons for this). Needless to say, I no longer can work, as I cannot get anyone to look after him during the long school holidays and finding term-time, school hours only work is extremely difficult.

Direct payments only work if there are people willing to be employed and paid on a taxed/PAYE basis. Many of the people who may have cared for X were willing to do the work provided that they could be paid in cash. These are generally low-paid individuals who are at or just marginally above the minimum wage and who get tax credits etc., and would therefore not want to have 2nd jobs which were taxed at source. However, since my disabled son is very difficult and challenging behaviourally, there are, of course, not that many volunteers coming forward to look after him in any event.

Further work is required to have a greater understanding of:

- Why some families and young people do not take up Direct Payments.
- Views and experiences of parents and young people in receipt of Direct Payments.
- How to collect information from social workers and recipients of Direct Payments.
- Market development work required, what is already in place, what is successful for children and families.
- Which groups are most likely to access Direct Payments e.g. by age, disability etc
- Support for 16/17 year olds managing their own Direct Payments

Disability Nottinghamshire organised an event for individuals living in the county who are receiving some form of social care (paid or voluntary) or in receipt of a personal budget to meet face-to-face with providers of services. This is promoted as an opportunity for organisations to promote their services and for individuals to see what is on offer to them.

The event was targeted at:

- providers of services to disabled people, their carers, family, friends and neighbours, individuals living in Nottinghamshire who are currently in receipt of a personal budget, or those who are considering a personal budget in the future
- Carers, family members, friends or neighbours of someone they know who is receiving social care or needs some care in the future
- Social workers, commissioning officers, brokers, direct payment support services, micro providers, care workers and personal assistants
- District and county councillors, voluntary, community and charitable organisations
- Health care practitioners, hospital trusts, clinical commissioning groups and infrastructure organizations.

The event took place on the 22nd November 2011. It would be useful to see how useful and well attended this event was. Commissioners may have a role to encourage providers to attend.

Disability Nottinghamshire identified the following quote from one of their service users regarding self direct support:

"Social workers giving out wrong information and challenging account management needs."

This quote relates to the consistency of the message that social workers are giving users around what they can/cannot do with a personal budget. This service user would like to see more training and support for social workers to make sure they are informing users correctly of their rights and responsibilities.

4.28 Nottinghamshire's SEN/Disability Green Paper Pathfinder

Nottinghamshire has been selected, as one of 20 pathfinders across England, to develop and test out an integrated approach to improving life outcomes for children and young people with SEN and disabilities. This will be done through the development of a statutory single assessment process and plan, covering health, education and social care, which will replace the current education-focussed statementing system. In developing this process, we are also being asked to test out a range of options, including the development of personalised budgets.

It will build on existing good practice developed through the Early Support model, the Achievement for All Project, person-centred planning approaches and our long history of partnership working across Nottinghamshire. It will draw on the principles of the CAF and the Family Partnership model and will require cultural change within health, social care and education to provide a single assessment, process and plan. It involves working very closely with parents, carers, children and young people and the voluntary sector.

The SEN Green Paper Pathfinder in Nottinghamshire (the One Project) aims to test out the viable delivery and impact of an integrated response to meeting the needs of children and young people with a disability and/or special educational need:

- ONE single point of access
- ONE assessment
- ONE care plan
- ONE review
- ONE outcome.

The Pathfinder will work with key partners, including children, young people, their families and the agencies that provide services and support for them in order to:

- establish structures, systems and pathways which facilitate integrated provision and support for children and young people with additional needs and their families
- reduce duplication of assessment, planning and resources resulting a single assessment and person-centred support plan
- develop coordinated, comprehensive and timely multi-agency assessments of children/young people with additional needs and their families
- ensure that these assessments lead to joint support plans and prompt, high

quality interventions which maximise the children's and young people's potential, enhance their future prospects, keep them safe and enable them to participate in family and community activities

- provide the information, support and advice that children and young people and their families need
- enable children/young people with additional needs and their families to be actively involved in decisions that affect them, including the planning and delivery of services
- engage with the voluntary and community sector to explore their role in advocacy and key working for children/young people and their families
- build on the national evaluation and local initiatives in respect of personal budgets to develop and pilot a range of options.

A three phased approach will be adopted, beginning with the identification of a cohort of children/young people with complex needs. Phase 2 will extend the demographic of the group and include looked after children. Phase 3 would focus specifically on excluded pupils with complex needs attending the county's pupil referral units. Each phase will be staggered over intervals during the pilot.

Published guidance on thresholds for intervention and funding bands will add transparency and manage expectations; where there is unresolved disagreement, VCS mediation services will be utilised, signposted by the key worker. Nottinghamshire is basing its approach on existing good practice within Adult Social Care's "Putting People First" initiative, to develop and test a framework for offering and providing personal budgets to the target group.

The following table highlights the expected outcomes for the SEN/Disability Pathfinder and the supporting success criteria which will help Nottinghamshire understand the impact of the pathfinder activity.

Outcome	Success Criteria
A reduction in the number of meetings and assessments	Children/young people, parents & professionals attend fewer meetings
There is greater flexibility about where meetings are held according to the needs and desires of the family	Parents meet in settings of their choice.
Information is shared effectively between all parties, as appropriate	Information is available to inform the assessment process and the implementation of the One Plan
The role of the key worker is developed	All families within the pathfinder have an identified key worker, who has defined and consistent role in co-ordinating services for families
Interventions are appropriate and timely	Children/young people, parents & professionals report that the interventions that are implemented are both timely and appropriate.
Joined up working across services and agencies is common practice for the children and young people within the pathfinder	Each child in the project has a 'team around the child'.

Outcome	Success Criteria
Individual service budgets will not be a barrier to the implementation of the single assessment plan	The Joint Strategic Commissioning Group will ensure that resources are aligned to facilitate the delivery of the single assessment plan
Parents and carers have more personal choice and greater control over resources	All families within the project are offered access to personalised budgets with 30% take up
There is a reduction in duplication of services for children/young people with additional needs and their families	Each child in the project has a single assessment and a single plan.
The VCS are an integrated part of the single assessment process and parents feel that the assessment process is fair, transparent and independent from the Local Authority.	Parental survey of families in the project show high levels of confidence.

It will be important for the Joint Commissioning Group for Children with Disabilities and/or SEN to have a clear overview of the activity of the pathfinder.

A local voluntary sector organisation, APTCOO, has been awarded the contract for the mediation aspects of the SEN/Disability Pathfinder. Further information about APTCOO is available below.

A Place to Call Our Own (APCTOO)

APCTOO provides one to one support to families who are at crisis point. By having one to one support and speaking to someone who understands, it empowers the family to make the right choice and to cope with their child's disability. APCTOO also provides ongoing support as long as the family needs it. They hold group sessions for parents and carers to get together, which encourage them to support one another and provides a network of advice and friendship to each other.

APTCOO also provides group sessions for children to attend so that they can mix with their peers. Often children with a disability feel left out of social circles. APTCOO groups provide them with a sense of inclusion and belonging. One of the play sessions is for both parent and child, so that they can engage with each other in relaxed surroundings.

APTCOO Case Study 1

Parent R came in for crisis support at the request of her social worker. Parent R has been deaf since birth and has two children, one with Asperger's Syndrome and one who is undergoing a diagnosis for ADHD and Autism. Parent R had recently moved to the area from Worksop and had no support network in the area. The children have previously spent time in foster care, as Parent R was hospitalised due to her mental health issues.

When Parent R came into the centre, which was her first point of contact, the duty worker took the initial contact and sign posted mum to the deaf and signing club. The duty worker took all the initial information down and passed it on to the family play worker. We could only contact Parent R by text because of her disability.

When the family play worker picked up the initial contact, she firstly texted Parent R and introduced herself and told her to contact us when the best time would be for a

1:1. Parent R then text back and we arranged a day.

Parent R came for the 1:1 which we fill in an initial contact form. We filled this in together and I gave mum some information on the youth club which her son could attend. Parent R also rented some fibre optic lights for her daughter to help her sleep at night, as the recent move and changes has affected her sleep pattern.

Her son now regularly attends the APTCOO Youth Club and the fibre optics are working for her daughter. Parent R will use us as a support network as and when she requires it.

APTCOO Case Study 2

Family in crisis presented themselves with no warning at the front desk. Mum and gran were in tears about 14 year old boy S being in trouble at school and at risk of exclusion. S has ADHD. The family felt like they had exhausted every avenue available to them in terms of support, guidance, help and advice.

APTCOO were able to deal with the immediate crisis by means of a one to one session where the family could be heard. This in turn led to a good rapport being built so that an effective assessment of needs could be undertaken with the family.

An opening has been established through this intervention so that the family can have the opportunity receive support in terms of advocacy, partnership services, confidence training for mum, and the building of a successful support network locally with other parents of children with ADHD.

APTCOO Case Study 3

L first became known to APTCOO through his parent seeking support and advice to help cope with his disabilities which were diagnosed as Autism and Tourettes.

APTCOO were invited to a school review. At the review L's behaviour was stated as being abusive and aggressive, particularly towards his parents and sibling. Triggers for this behaviour could be when changes happen at the school or within the home, cooking smells or not wanting something enjoyable to end. Parents felt that the best way of dealing with this behaviour was to give him time out from others in order to calm down. They had also tried restraint techniques but this only escalated his behaviour. At the review meeting it was agreed that APTCOO would offer L a place at the APTCOO youth club, although L's mother felt he would refuse to attend.

Following an introduction to the youth club lead, he attended APTCOO for the first time accompanied by his mother. On the first visit, L approached another young person and introduced himself. His mother was very surprised to see him attempt to socialise with others and that generally his behaviour was good whilst at youth club.

Subsequently, L attended youth club on his own and has engaged in discussion about club rules, boundaries and behaviour expected by all members whilst at the club. He has begun to make early attempts at socialising, which is something he has historically been unable to do very well. He is already forming good relationships with staff and volunteers. He has engaged well with APTCOO's Healthy Lifestyles programme and thoroughly enjoys the cooking and kitchen element of the programme.

Whilst L still expresses occasional reluctance to attend youth club he always changes his mind. His current progress is remarkable. He is able to recognise rules/ boundaries and therefore able to engage with activities that interest him.

As part of L’s plan, he will continue to take part in the Healthy Lifestyles programme but also be encouraged to get involved with other activities which will help develop his social skills and self esteem.

4.29 Information, Advice and Guidance

“*Parents report a ‘constant battle’ to find out about what services are available and the roles of different agencies and to get professionals to understand their needs.*”[109]

Research highlights the needs of parents for information and services, about their child’s condition, and about how they can support their child’s development. Children also speak of the need for information about their condition, treatment, about how to live with the condition and how to overcome disabling barriers.

Evidence suggests that care co-ordination should ensure that families’ needs for information, advice and help are identified and addressed. Particular areas covered should include financial support e.g. help with claiming benefits, aids and equipment, housing adaptations, behaviour problems and support for all family members’ needs.

A national exercise[110] carried out with parents identified a three dimensional model of good practice:

- Short directories of local services and support networks, which are regularly updated
- More in depth and informative booklets covering local and national services.
- Support for locally based facilitators or key workers to guide parents through information.

Nottinghamshire offers a range of information, advice and guidance services for parents/carers and children/young people, some of which are listed below:

The Family Information Service (FIS) offers free, impartial guidance and information for families with children & young people aged 0-20. The FIS maintains a comprehensive Family Services Directory and provides a free phone information helpline and a brokerage service providing advice and guidance on choosing childcare.

The 2011 Nottinghamshire Childcare Sufficiency Assessment[111] assessed calls to the FIS. It highlighted that 75% of families aware of the FIS, equalling the target sufficiency rate. There are on average over 10,000 calls to the FIS freephone helpline over the year, along with 59,000 hits on the FIS website. The website (www.nottinghamshire.gov.uk/fis) also feeds information about services for families in Nottinghamshire to www.direct.gov.uk. Information is also delivered face to face via the FIS team, at community venues, such as children’s centres.

Despite no external advertising for FIS in the last financial year (2010/11), targets have been achieved, although call numbers have fallen. However the calls are longer, with more complex queries to be answered, such as brokerage of childcare for families of disabled children, access to short breaks, safeguarding issues etc.

---

[109] Sloper T (2004) ‘Meeting the needs of Disabled Children’ Quality Protects Research Briefings (no 6) Research in Practice

[110] Sloper T (2004) ‘Meeting the needs of Disabled Children’ Quality Protects Research Briefings (no 6) Research in Practice

[111] Nottinghamshire County Council (2011) Childcare Sufficiency Assessment 2011 (page 6)

This coincides with the launch of the Family Services Directory, the on-line resource to support Pathways to Provision, leading to an increase in the number of people using the County Council's website to find information.

Parents and Carers who have disabled children provided the following feedback of the Nottinghamshire FIS in 2010/11

"FIS staff know their stuff"

"Families Information Service advocated on our behalf when we were struggling to access a setting. This was really helpful. They helped with transition from 0-3 → 3-5 care"

IRIS - is an Information service (website and quarterly newsletter) for parents of children and young people with disabilities living in Nottingham City and Nottinghamshire County. The IRIS Project is a one-stop shop offering information, advice and support to parents and carers of children and young people with disabilities based in Nottingham and Nottinghamshire. The project is provided by Family Action and commissioned by Nottinghamshire County Council and Nottingham City Council until March 2012.

The IRIS Project has four elements:

1. The Ask IRIS website that can be accessed by all and contains relevant, up to date information and signposting for families of children with disabilities.
2. A quarterly magazine to all families of children with disabilities.
3. To support the co-ordination of a database of disabled children across Nottinghamshire and Nottingham (information given voluntarily by families).
4. To empower families of children with disabilities to have a voice in order to change and shape future services in the county and Nottingham City.

Children's Development Centre Library, Nottingham University Hospital Trust – offers an on site staffed library for professionals, parents and service users at the City Hospital site. It provides a range of information, advice and guidance on children's disability issues, services and conditions. It is available for those living in the City and southern boroughs of Nottinghamshire.

Parent Partnership - provides impartial advice, information and support about educational issues to parents and carers of children with special educational needs and disabilities.

Every local authority has to provide funding for a parent partnership service, to give impartial advice, information and support about education issues to parents and carers of children with SEN and/or disabilities living in the area. This is a statutory requirement, set out in the 1996 Education Act.

Nottingham and Nottinghamshire Parent Partnership Service supports parents and carers of children with SEN and/or disabilities living in the two local authority areas of Nottingham City and Nottinghamshire County.

Disability Nottinghamshire - provides a free, confidential and independent advice service relating to any aspect of disability to disabled people, their family, friends, carers, professionals and students. The service is offered by people who have personal experience of disability either by being disabled themselves or by having direct experience of caring. From a quick query about how to get a Blue Badge or Radar Key, to a two hour session filling in a Disability Living Allowance (DLA) or Attendance Allowance form – there is an experienced team on hand to help which is free to all residents of Nottinghamshire.

Quotes from service users from Disability Nottinghamshire:

"I just do not know where else I could have gone to get anything that even resembles the services, advice and physical help Disability Nottinghamshire gave to me personally"

"Other services are very few and far between, often with long waiting lists. There are very few specialist disability organisations, like you, many other places work on the medical model."

"I have trusted Disability Nottinghamshire to help me in a way that no other service could. I would not know where to start looking for any other services."

Finding Your Way - is a directory for parents/carers of services for children with physical, learning or emotional disabilities in Nottingham and Nottinghamshire. It is produced by the Information Service at the Children's Development Centre, which is part of Nottinghamshire Healthcare NHS Trust. The next edition is due out in 2012 and is being funded by Aiming High for Disabled Children, Nottinghamshire County Council. A pdf version of *Finding Your Way* can be downloaded from the IRIS website.

Parentzone – a County Council run website that provides information and opportunities to get involved in the community, things to do and for parents to have their say

Youthzone – a website designed by young people for young people aged 11-19, parents, carers, teachers and youth workers to find out about things to do for young people in Nottinghamshire.

Sort it online – led by Nottinghamshire Futures, this website offers comprehensive information to support option and transition choices. Key features include:

- Planning changes - your transition plan
- Your choices
- Foundation Learning
- Money matters
- Help with travelling
- Also includes FETCH, website signposting

The Parent Point - a website (www.theparentpoint.com) developed by Connexions Nottinghamshire which includes a section specifically for parents whose children need additional support. The website explains the key phases in the transitions journey, the role of Connexions and other intermediaries and outlines the main post-16 progression options. The website contains a link to the Nottinghamshire Parent Partnership Service website.

Disability Nottinghamshire identified the following quotes from members in relation to information, advice and guidance:

"In my opinion, the Nottinghamshire County Child Poverty Strategy appears vague as

to who should deliver welfare benefits advice, information and support (including appeals and tribunals) services. Why can't this be Disability Nottinghamshire?"
"The Children's Trust needs to include welfare benefits advice & appeals as part of the overall strategy and fund long-term support for families in Notts."

4.30 How Integrated Are Our Services?

National evidence[112] states that disabled children have high levels of unmet needs. A reason for unmet need is a lack of co-ordination between different agencies and professionals providing services for disabled children, so that no holistic view of the child and family is obtained.

There is no assessment outside of the Ofsted regime to assess how well services work together in Nottinghamshire. Ofsted identified in 2011 that "*Partnership working is improving, with children subject to child protection plans having a full range of relevant professionals engaged in reducing risk. Children spend less time subject to child protection plans and the number of re-referrals is reducing. While there are some good examples of early intervention and preventative multi-agency work, the common assessment framework (CAF) is under used as a tool to support children and their families.*

There is some effective interagency working, evidencing good partnerships with Police, health and education partners. This includes the significant improvement in the arrangements to identify and find children that are missing from home, school and care by all agencies. The work of the Joint Action Teams (JATs) is welcomed by professionals across agencies and provides an effective forum for multi-agency cooperation and planning for early intervention. Staff from the children's social care area duty teams attend these meetings to support and advise professionals on risk and thresholds. However there remains variable evidence of the impact of the range of early interventions and the local authority are mindful of the need to analyse further links between practice and improved outcomes[113]."

Integrating Occupational Therapy Functions

During the pilot for the Joint Public Health and Social Care AHDC Occupational Therapy Pilot it became *"…evident that the skill set for both social care and health OT's was extremely specialist and that to work towards one OT one child, could create a therapist with skills that spanned so wide that they would be in danger of becoming 'jack of all trades, but master of none'.[114]"*

Following a presentation with lead commissioners from the Local Authority and Health, which explained the possible future roles and responsibilities of children's OT's in both Social Care and Health, and how integration could be progressed whilst acknowledging that the specialist skills of OT's in both establishments, it was acknowledged that the skill set for both health and social care OT's was very specific and different, but that the area of equipment did overlap and that it was this area that possible integration could progress.

---

[112] Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice, available from http://www.uea.ac.uk/menu/acad_depts/swk/MRC_web/public_html/files/qpb6.pdf

[113] Ofsted (2011) Nottinghamshire Safeguarding Inspection Report http://www.ofsted.gov.uk/local-authorities/nottinghamshire

[114] Marsden K (2011) 'Aiming High Pilot Project Report' Nottinghamshire County Council

Information Sharing

Nottinghamshire County Council currently (2011/12) commissions a local voluntary sector provider to maintain a register of all children in Nottinghamshire with a disability. This register is a statutory duty for all local authorities to have and maintain.

Anecdotally the register in Nottinghamshire is not as comprehensive as it should be, due to a lack of information sharing and consent to share information. A register that is utilised by all key staff would reduce the need for children and families to repeat their story and support young people at key transition points as highlighted below by a local parent.

Local Parent

I would have thought that having a register would only be of any use if planners and budget holders made use of the data in the register to plan for services to be provided where they are needed most. I hear of so many parents of disabled children who have such high levels of anxiety and stress when it comes to their children reaching the age of 18 and having to leave full-time education and finding there are no suitable day-care or residential centres with appropriately compassionate, caring and well-trained staff to cope with some of our highly challenging young people.

I am very grateful for the respite and play services my son receives and would feel far less anxious if I could be assured that planners were assessing needs for the growing population of severely learning disabled children coming through the system and that provision, recruitment and training of staff should be happening now to meet their needs once they reach adulthood.

The SEN/Disability Green Paper Pathfinder will also help to strengthen integrated working practices working towards one assessment of needs, one care plan, one single point of access, one review.

5. What do children and their families tell us?

Parents say[115] that the system is bureaucratic, bewildering and adversarial and that it does not sufficiently reflect the needs of their child and their family life. This is certainly evidenced by parents and carers in Nottinghamshire also.

Consultation carried out by the County Council, NHS Nottinghamshire County and IBK initiatives 2009 in 2009 with disabled children with complex health needs and their families indicated that:

- Finding support workers is sometimes difficult
- Services on offer do not always help with the complex 'juggling act' of looking after a family with a disabled child
- It is difficult to find out what services are available
- Some families were happy with the services they received, but most felt that things could be much better
- Transport and school holidays are a particular challenge.

Further local consultation conducted by **Parentline Plus** between October 2009 and March 2010 of 300 parents across the county identified that parents and carers struggle to find information about local support networks for children with additional needs and describe a feeling of being 'lost in the system'.

An example of a local voluntary organisation which deals with disability, **A Place to Call Our Own (APTCOO),** reports many different effects that parents and carers experience, having and caring for a child with a disability. Some are positive, such as strengthening the family unit, but most often feedback to APTCOO includes feelings of isolation and the stresses and strains on relationships.

There are also many physical effects reported to APTCOO, such as being constantly tired and having back problems from lifting and carrying all the time. Parents sometimes do not look after their own health, usually because of lack of time or support and they may turn to alcohol or smoking to help them cope, or have problems with over-eating or not eating enough. Most parents report feeling depressed to APTCOO and high blood pressure and mental health problems are common. In addition, there may be a higher proportion in domestic violence in relationships, as there are generally not the facilities available in refuges for women with disabled children.

APTCOO finds that siblings also report feeling pushed out, may be jealous of all the attention their disabled sibling demands and are often carers themselves. They may under-achieve at school through having no time to do homework or being tired. Some self-harm, suffer from tiredness and/or depression, and may lose friends due to lack of understanding, or be bullied. In addition, there can quite often be physical violence and harm to siblings from the disabled child's challenging behaviour.

Former National Indicator 54 (services for disabled children) gauged parental satisfaction with services for disabled children. Nottinghamshire scored 64 (out of 100) in 2009/10 for both local authority and PCT areas, against a national score of 61

---

[115] Department of Education 'Support and aspiration: A new approach to special educational needs and disability – a consultation'
http://www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208027

(Tables 5.1 & 5.2). This placed the county equal 2nd in relation to its statistical neighbours, equal 7th out of 145 local authorities and also equal 7th out of 150 PCTs. In line with national figures, the lowest area of satisfaction in Nottinghamshire was with accessible feedback and complaints procedures.

Table 5.1 National Indicator 54 - Services for disabled children: national sub-indicator performance (2009/10): England

England	**Overall score: 61**		**Number of respondents: 31,466**
	Health	**Education**	**Care and Family Support**
Information Number of respondents	69 29,340	70 28,526	69 29,503
Assessment Number of respondents	76 13,238	77 13,135	67 3,700
Transparency Number of respondents	96 13,720	92 13,424	89 3,809
Participation Number of respondents	61 13,698	48 13,435	53 3,808
Feedback Number of respondents	12 29,321	20 29,933	12 13,773

Table 5.2 National Indicator 54 - Services for disabled children: local sub-indicator performance (2009/10): Nottinghamshire

Nottinghamshire	Overall score: 64		Number of respondents: 441
	Health	**Education**	**Care and Family Support**
Information Number of respondents	**72** 419	**69** 401	**72** 421
Assessment Number of respondents	**79** 189	**78** 166	**79** 62
Transparency Number of respondents	**96** 197	**95** 169	**93** 64
Participation Number of respondents	**67** 196	**51** 170	**62** 64
Feedback Number of respondents	**12** 422	**17** 416	**15** 185

The **County Council Review of Special Educational Needs and Inclusion** found that parents reported access to social and leisure opportunities for children and young people with SEN was uncoordinated and frequently unavailable. Parents felt that the very few opportunities available were founded and supported by them.

The **Aiming High for Disabled Children Short Breaks Project** asked children, young people parents and carers for information regarding their needs.

Parents/carers said:

- They want an ordinary life
- They want to have breaks so that they can continue to care for their children close to home
- They want to be able to do things as a whole family, but also with their non disabled children
- They want a simpler system to access services.

Children and young people said:

- They want to have fun
- They want to do things with their friends and with their brothers and sisters
- They want access to a wide variety of activities in their local community (Swimming as an activity came top of the list when we asked 450 children in special schools what they wanted to do more of outside of school).

Nationally **C4EO** have also gathered views of parents through existing research evidence, parents value services that:

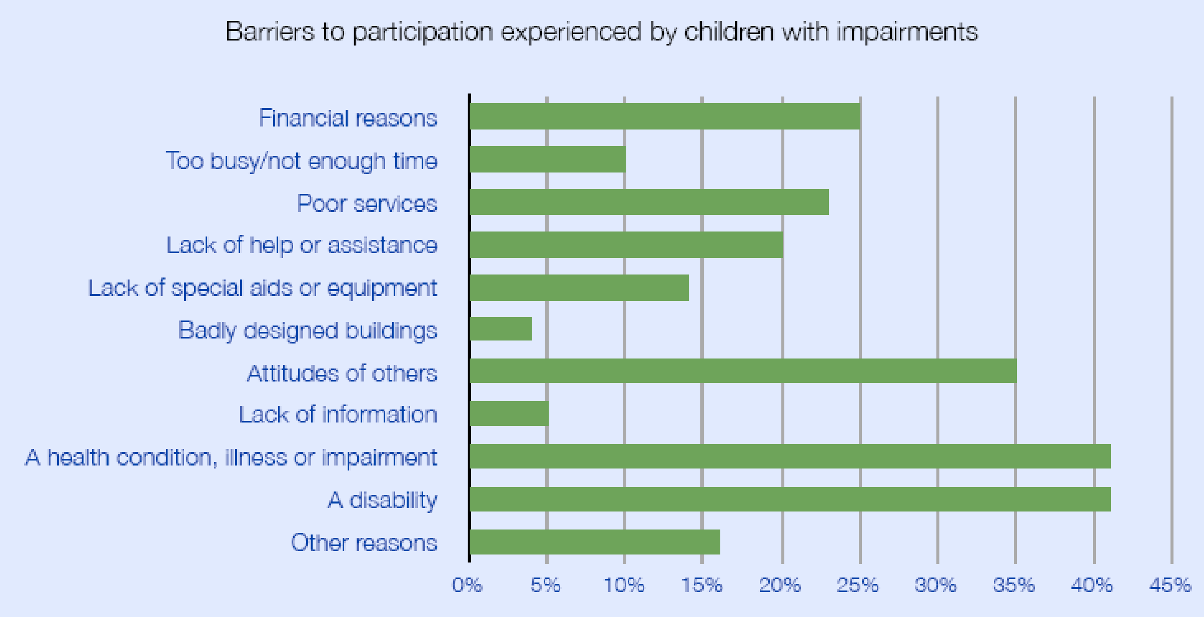
- provide support at the time of diagnosis
- provide access to information and advice
- make assessments which consider and meet whole-family needs
- set targets and identify developmental milestones
- provide evidence of achievements
- offer ideas and suggestions for activities
- develop parents' skills
- ensure rapid and easy access to services that are joined-up and coordinated
- provide information to help parents make informed decisions about treatment options
- enable parents, especially mothers, to enter or return to work
- reduce the time for the 'statementing' process.

The national Life Opportunities Survey conducted by the Office for National Statistics in December 2010 interviewed disabled adults aged 16+ and gathered data on 11-15 year old disabled children via their parents. The results show that:

- 49% of disabled children were reported to experience a restriction in at least one of their key life areas (compared with 13% of other children)
- leisure or play activities were the areas of participation restriction experienced most frequently by disabled children, with 37% of their parents reporting a restriction in this area
- parents also reported higher levels of restriction constraining disabled children's participation in education (30%), personal relationships (22%) and transport (21%).

Barriers to participation experienced by children with impairments are summarised in Figure 5.3.

Figure 5.3



Source: Association of Young People's Health, 2011

The **Parent Partnership Service (PPS)** in Nottinghamshire which aims to advocate for parents and carers provided the following current case studies that reinforce the findings listed above.

A 17 year old (A) with a statement of SEN and at a Notts special school has been without any full-time educational input since Easter 2011. A has very significant speech and language delay and learning needs. The school said he was not able to access the Post-16 activities they offered as he was not safe to take off-site (he tends to lie down in the road etc but is not violent/aggressive).

At the end of the summer term the head teacher strongly suggested that it would not be appropriate for A to return in September but had pressure put on him to agree to a continuation of the half-time attendance for another half term.

Mum had been supported by PPS previously but our involvement was stepped up at this point. There was no input from Social Care at the time. Mum was advised to look at other special schools and did so, but by the end of the half term no other school was able to offer a place; in fact all said they could not meet A's needs. A's case was taken to a JSF at that point and additional funding has now been made available for the original school to employ an additional teaching assistant to work with A until the end of this school year so that he can have a full-time education.

Social Care are now involved, but it is not clear what will be the next step for A after July 2012 (he is currently in Year 12 so would be entitled to another year in education – the issue up to now has been that what was on offer at school was not appropriate, but that may no longer be arguable).

I have to say that I do not believe this case would have had even the shakily good outcome that has emerged had the PPS caseworker not harried, chased, ensured that those who needed to know did, and generally put pressure on professionals who could make things happen e.g. the funding for the teaching assistant to be made available.

A 5 year old (S) with complex needs, mainly around ASD but including some physical needs and still wearing nappies/pull-ups, has recently transferred from one school to another following the failure of the first to identify/acknowledge her level of need. The major issue seemed to be around toileting, with school initially refusing to change her and demanding that mum was on hand to do that; later S was put on a toileting programme and school was willing to change but not clean her up. The first school refused to attribute S's behaviours/difficulties to ASD because there was no formal diagnosis, despite professionals being involved and advising that S showed needs consistent with ASD.

A secondary school, now an Academy, which recently permanently excluded a pupil, said that he could not be considered to be disabled (i.e. for the purpose of the exclusion) until they had received a written diagnosis, despite having been told verbally that he had Asperger's.

A yr 10 boy (D) who is also a young carer for his disabled mum was dropping into a cycle of not attending school, and of not engaging when he was there. Parents were concerned about several areas of his academic and social life, to the point that they requested a statutory assessment of D's needs. This was turned down, but a series of fairly strong recommendations were made as it was felt that the school were not meeting this lad's needs.

After much pressure a CAF was initiated, as recommended. The first meeting was not attended by anyone from the school staff who could throw any light on D's learning difficulties, or on school's response to recommendations following the refusal to assess; the school nurse attended, and a member of staff whose role is around safeguarding.

5.1 What do children, young people and parents tell us about schools?

We have little qualitative intelligence on how pupils with special educational needs in mainstream schools are getting on – do they feel supported, are they being bullied, do they have friends and so on. These factors will necessarily impact on their emotional well-being and ability to achieve at school. Parents consulted for the Joint Strategic Needs Assessment expressed some concern about the awareness and understanding of SEN in schools (and other agencies) and the support that is offered.

The County Council's SEN Review_highlighted that some parents want special school placements for their children while others prefer mainstream school placements. Some want mainstream schools that offer a more "specialist" approach or curriculum. Others said they would like to see a more flexible offer, with increased opportunity to have access to aspects of special school provision whilst retaining their child's placement in a mainstream school. Parents want choice and participation in decision making, particularly in relation to types of provision. They expressed the view that this was not always possible or offered.

The Review also reported on how children and young people feel about school, namely that they:

- are not sufficiently engaged in decision making processes that affect them, particularly those around their own support needs
- have different learning styles and that the level of personalised learning in schools does not always match the diversity of needs as expressed by the young people themselves
- Are not having their social and emotional needs met at school. Some young people do not have the social skills for developing healthy networks and friendship groups and are often the victims of bullying.

Countywide forums are in place for young people with specific needs to influence decisions. The award winning ‘Nottinghamshire Pioneers’ is a forum for disabled young people who are extremely active in improving service provision and have done considerable work around hate crime and the holocaust.

6. Evidence Based Practice

Increasing the quality and range of early years interventions[123]

While there is substantial evidence that early years interventions improve outcomes for children and families, it is still uncertain as to how long the gains last, whether the gains are a direct or indirect result of the intervention, and whether simpler interventions could deliver as much or even more benefit.

Research has also not yet identified which interventions work best for which groups of families. Evidence is strongest in identifying the services that parents most value, but professionals do not always share the same views as to which service outcomes are most important. However, research does show that the most effective interventions are tailored to the child and are family centred; take place in natural homely surroundings and take the family's environment and resources into account; are structured and are the right intensity and duration; and aim to develop parent-child relationships, as well as support child development.

Research also shows that:

- **key workers improve the quality of life for families with disabled children** by ensuring quicker access to benefits and support, and reducing levels of parental stress. Effective key workers have good counselling and communication skills, are able to work in partnership with parents and children and also respect their expertise. They also have specialist knowledge of different conditions. Key workers therefore should have regular training, as well as high quality supervision and support.

- **web based information** offers parents instant, 24 hour support, that can be usefully focused on specific issues or problems.

- **high quality pre-school centres** improve children's cognitive development and reduce the need for special education at primary school, especially for the most disadvantaged groups of children.

- **neonatal interventions for low birth weight babies are only effective in the short-term** because other associated factors, such as poverty and social exclusion may have a far greater impact than any disability or impairment.

- **Early years interventions are not meeting the needs of the most disadvantaged.** The greatest benefits are experienced by families with the highest levels of social capital, education and income. Therefore, services need to compensate for social disadvantage.

Successful approaches to service development integrate the improvement of early years interventions into a strategy for improving children's services as a whole; consider philosophy and principles, rather than just eligibility; and aim for simplicity in service design and partnership arrangements.

---

[123] From: C4EO Progress Map Summary (No. 4), June 2009

Improving access to positive and inclusive activities[124]

Participating in positive activities is associated with improved outcomes for disabled children's health and well-being. Not all services are genuinely and actively inclusive, and there are different interpretations of what inclusion means. Disabled children and their families want inclusive services where disabled children and non-disabled children meet, as well as some 'segregated' services exclusively for disabled children.

Research cannot yet identify the play and leisure preferences of different types of disabled children, or the different types of support they need. Indeed, there are very few studies in this area and it is difficult to draw any firm conclusions about best practice. However, implications from research for local service improvement include the following:

- **all staff need to be skilful in facilitating inclusive play and activities** between disabled and non-disabled children.
- **a range of specialist and inclusive activities** should be offered to give more choice.
- **disabled children, young people and their families needs support** to help them engage, particularly if they are from a disadvantaged background.
- **limited exposure to non-disabled children's activities interferes with disabled children's social development**, particularly in terms of their understanding of peer culture.
- there should be a cross-agency strategy to **ensure all disabled children and their families receive information** about local play activities.
- **taster sessions help** to encourage children to try out a new activity.
- **local authorities should undertake 'access audits'** of play and leisure services, and make changes to ensure all aspects of the service are inclusive.
- **disabled children and their families should be involved** in the evaluation, redesign and development of services. Local authorities should also monitor the numbers of disabled children participating in positive activities and evaluate the outcomes.

There is also evidence about the barriers to access and participation. These barriers to the inclusion of disabled children in play and leisure activities are multiple and complex and relate to:

- **the child and their individual preferences**, their confidence and belief in their abilities, shyness or lack of social skills and previous experience of inclusive play.
- **the family's tendency to participate** – e.g. socially disadvantaged families with lower levels of income and access to support, or families who have less belief in their child's ability and lower levels of trust, may not readily access services.

---

[124] From: C4EO Progress Map Summary (No. 5), June 2009

- **the service**, particularly the attitude and awareness of staff, their knowledge, skills and understanding.

- **lack of detailed, proactive, up-to-date and accessible information** about the service on offer

- **the environment**, in terms of physical access to buildings, amenities and equipment, public transport and its cost, access to childcare facilities and the attitudes of other members of the public.

Sufficient differentiation of services to meet diverse needs[125]

Research in this area is very limited and there are virtually no studies of interventions and their outcomes. In terms of providing services to meet the needs of different groups of disabled children, the evidence suggests that many disabled children and their families have similar needs, but meeting those needs requires different approaches depending on individual circumstances; and that achieving positive outcomes for disabled children requires an assessment and response to the whole family and consideration of all the social and environmental factors likely to have an impact.

Staff working with specific groups may require specialist skills and knowledge, but being able to respond flexibly to meet the needs of every disabled child should be a feature of all mainstream services. In addition, while sensitivity to culture specific needs is required, care should be taken not to assume that all members of a particular group have the same needs.

There are a number of group specific findings:

- **BME disabled children**
  - The most pressing problems affecting some disabled children from BME backgrounds are poverty and social disadvantage – these factors appear to have a greater influence on the prevalence and impact of disability than ethnicity.
  - The needs of most families are basically the same. Differences lie in the capacity and willingness of services to respond. BME groups experience more difficulties in referral and access to services, as well as racism, bullying and poor staff attitudes.
  - BME families are less aware and make less use of specialist disability services.

The factors specifically associated with positive outcomes for this group include collaborative relationships between families and services, which recognise any cultural differences as a source of strength; language and culturally specific information to help families make choices and be involved in decision making; and a diverse workforce and provision of interpreting and translation services.

---

[125] From: C4EO Progress Map Summary (No. 6), June 2009

- **Disabled children in asylum seeking families**
    - Asylum seeking families may not report their child’s impairments for fear this may affect their immigration status.
    - Many of these families have unmet care needs and struggle to cope with unsuitable housing, being isolated and communication problems.
    - Evidence suggests greater attention should be given to their current disadvantage, rather than to any past trauma.

- **Disabled children with complex needs**

Children who require support from multiple agencies need an effective key worker, effective case coordination and more effective transition planning between children’s and adults’ services. In addition, many parents believe that earlier intervention would have prevented the need for an away-from-home placement.

7. Headlines

Demography

- The national picture indicates that more disabled children and young people are living longer and surviving into adulthood.
- There are between 7,000 and 12,000 children and young people (0-19) experiencing some form of disability in Nottinghamshire. Indications are that this is slightly more prevalent among boys than girls.
- Nottinghamshire's overall 0-19 population is forecast to rise by 8.7% between 2011 and 2033, with the largest increase being in the 10-14 age group (20.2%).
- 20-24 year olds represent the highest proportion of young people with limiting long term illness (6.5%) in Nottinghamshire, followed by the 15-19 age group (5%). The lowest proportion is the 0-4 age group (2.7%).
- The highest number of young people (0-24) claiming Disability Living Allowance (DLA) live in Ashfield (1,380), followed by Mansfield and Newark & Sherwood (both 1,170 each). The lowest number live in Rushcliffe (640).
- There has been a 60% rise in young claimants (0-24) of DLA in Nottinghamshire over the last decade.
- One in five Nottinghamshire school pupils has some kind of special educational need (SEN). The highest rates are in Mansfield (24.1%), Ashfield (21.4%) and Bassetlaw (21.3%).
- Over the last five years, the percentage of SEN pupils in Nottinghamshire primary schools has decreased from 16.6% to 16.0%. However, in the county's secondary schools, the percentage has increased from 15.9% to 22.8%.
- Around 1,550 pupils in Nottinghamshire have been assessed as School Action Plus or Statemented, so have a primary need of behavioural, emotional or social difficulties (BESD) by schools, and 1,880 have some form of learning difficulty.
- National evidence indicates that black and minority ethnic families are less aware of, and make less use of, specialist disability services; and that asylum seeking families may not report their child's impairments for fear it might affect their immigration status.

Themes

Poverty

- National research shows that disabled children are more likely to live in poverty – the average income of families with disabled children is nearly a quarter less than the mean UK income.
- In Nottinghamshire, the rates for severe disability are greatest amongst children from 'semi-skilled manual' family backgrounds, with the lowest rates in the 'professional' and 'managerial' categories.
- A recent health needs assessment of Nottinghamshire (city & county) special schools also identified a strong relationship between level of need and deprivation. It is not certain if this is a reflection of actual prevalence of need,

or ability to meet need due to resources available within the family.

- 13% of Nottinghamshire school pupils are eligible for free school meals. This figure more than doubles for pupils who are at School Action Plus or have a statement (28%).
- National evidence suggests that families with a disabled child are 50% more likely than other families to live in overcrowded accommodation, to rate their home as being in a poor state of repair and to report problems with wiring, draughts and damp in the child's bedroom.
- It is possible that those who are most in need of services are the least likely to access them due to the 'inverse care law', which suggests that those living in areas of deprivation find it more challenging to access services than their more affluent counterparts.
- National evidence suggests a lack of 'door to door' transport, either through school transport services or public transport, is a key barrier to participation in out of school opportunities and activities for many disabled children and young people.

Social Care

- There are just under 100 school pupils in the county who are both the subject of a child protection plan and have an SEN category. Just under half of these (47%) have BESD.
- There are on average 75 looked after children (LAC) in Nottinghamshire who have a disability, with the highest numbers in Mansfield and Ashfield.
- The number of children (aged 5-15) who have been looked after continuously for at least 12 months and who have an SEN category totals 180 (or 74.5% of that cohort). As there are approximately 20% of Nottinghamshire pupils overall with SEN, this means LAC are three and a half times more likely to have SEN compared to all pupils.
- So far in 2011 there have been 177 referrals to the County Council's Disabled Children's Team (up to November), compared to 325 in all of 2010 and 279 in all of 2009.
- In 2010/11, 260 disabled children and young people in Nottinghamshire accessed direct payments, up from 95 in 2007/08.
- Nottinghamshire pupils who are in the School Action Plus category are around 25 times more likely to have a Common Assessment Framework than non-SEN pupils.
- National data indicates that children with SEN and/or disabilities are disproportionately at risk of bullying. However, the number of disability hate crime incidents reported in Nottinghamshire is low.

Early Years and Childcare

- The Disabled Children's Access to Childcare programme is currently supporting 168 children and young people (0-19). 96 of these are in the 0-4 age range.
- Children's centres in Nottinghamshire saw 410 disabled children (aged 0-4) between September 2010 and August 2011, compared to 216 in the previous twelve months.

School Education

- The achievement gap at Key Stage 2 between SEN and non-SEN pupils in Nottinghamshire has narrowed over the last four years, but is slightly worse than statistical neighbours and the national average.
- At Key Stage 4, the gap in Nottinghamshire is better than statistical neighbours and the national average, but is widening as non-SEN pupils improve at a faster rate than SEN pupils.
- Children with SEN in Nottinghamshire have higher than average absences from school and are four times more likely than the rest of the school population to be persistent absentees. This is broadly in line with other local authorities.
- SEN pupils in the county are ten times more likely than the rest of the school population to receive a fixed period exclusion from school and nearly 15 times more likely to be permanently excluded.
- Over a quarter (27%) of children who are electively home educated in Nottinghamshire have special educational needs.
- There are 11 special schools in the county, which currently accommodate 847 pupils. 84 pupils who live in the county attend special schools in other local authorities and 103 pupils who live outside the county attend Nottinghamshire special schools. Placements in independent or non-maintained special schools have increased from 58 in 2005/06 to 132 in 2011/12.
- The most common high level needs in Nottinghamshire (city & county) special schools are personal care, physiotherapy, continence, communication, occupational therapy, wheelchair and moving/handling.
- County Council provision for home to school transport for pupils attending special schools and other school provision will account for around £5.7m in 2011/12, up from £4.7m in 2005/06.
- Children and young people with SEN in Nottinghamshire schools consulted in 2009 said they did not feel sufficiently engaged in decision making processes that affect them; that they are often the victims of bullying; and that the level of personalised learning in schools does not always match the diversity of their needs.

Post-16 Education

- The biggest challenge commissioners face is to find suitable placements for a small number of young people with complex needs (mainly emotional/behavioural or Autistic Spectrum Disorder (ASD)), who have been engaged on alternative provision pre-16 (often one to one support) and therefore struggle to integrate into a mainstream or specialist post-16 placement.
- Young people in Nottinghamshire with learning difficulties and/or disabilities (LDD) are over-represented in NEET (not in education, employment or training), especially School Action Plus pupils.
- The proportion of Nottinghamshire residents aged 16-19 with LDD in further education and sixth form colleges is 22%, which is slightly above the regional average (19%).
- In the county in 2010/11, there were 49 residents aged 16-24 with placements in Independent Specialist Providers (ISPs), up from 38 in 2009/10.

Nottinghamshire is one of six local authorities in the East Midlands with 50% or more of their residents in ISPs placed in residential rather than day provision.

- Between 2001/02 and 2010/11 there was a 72% increase in the number of accepted disabled UCAS applicants in Nottinghamshire (403 accepted in 2010/11), compared to a 16% increase in the non-disabled population.

Caring Responsibilities

- Parents with disabled children are at increased risk of stress compared to other parents, and stress levels are strongly linked to child behaviour and sleeping problems.
- The numbers of children and young people accessing short breaks has increased from 860 in 2007/08 to 2,190 in 2010/11.
- Siblings can feel pushed out, may be jealous of the attention their disabled sibling receives and are often carers themselves - which can in turn affect their achievement at school, their general well-being and their own friendships.
- A national study of families with children with profound and multiple difficulties found that 60% of parents spend more than 10 hours per day on basic physical care. These demands can deter parents and carers from accessing employment.
- A different national survey identified that over nine out of ten family and friends carers who responded were grandparents.
- Local intelligence from the voluntary sector indicates that parents/carers sometimes do not know what support is available to them to help with transitions and how to access it. All parents consulted found transition planning a very difficult process and commented about the uncertainty they felt.
- Consultation with local families in 2009 indicated that services on offer do not always help with the complex ‘juggling act’ of looking after a family with a disabled child and that it is also difficult to find out what services are available.
- Other consultation locally undertaken in 2009 found that parents reported access to social and leisure opportunities for children and young people with SEN to be uncoordinated and frequently unavailable.

Health

- It is difficult to identify the numbers of disabled children attending hospital due to the lack of a systematic way of recording status. However, one issue that has been identified is disabled children who spend prolonged periods in hospital with chest infections. A rapid response physiotherapy service is currently being piloted in the south of the county to treat this issue in the community – it is estimated that there are approximately 80-100 children and young people in the county (excluding Bassetlaw) who could benefit from the service.
- National data shows that children who have a limiting illness are more likely to be overweight or obese, particularly if they also have a learning disability. There is no local data on obesity and disability, as children unable to stand on scales are excluded from the National Child Measurement Programme.

- Children with physical or learning disabilities are identified nationally as at risk of not being fully immunised. There is, however, no local data on this.
- There are an estimated 1,800 children and young people (0-19) with ASD in the county. Diagnoses of ASD and demand on services are on the increase.
- NHS Continuing Healthcare in Nottinghamshire (excluding Bassetlaw) currently has 30 patients (aged 0-25) who receive fully funded continuing healthcare. In addition, during 2010/11, 27 items of equipment for patients (aged 0-25) were funded, with 17 items in the first six months of 2011/12.
- Future growth in demand for specialist equipment is expected to accelerate given the increasing numbers of children with disabilities.
- An audit of 200 referrals to the Community Paediatric Service during 2010/11 identified that the highest proportion (50%) were as a result of problems with behaviour, such as ASD, ADHD and social interaction.
- The Paediatric Occupational Therapy Service received 105 referrals from the county (excluding Bassetlaw) and 62 from the City between April 2010 and September 2010.

8. Conclusions

Improving the lives of disabled children and young people is a key priority for Nottinghamshire's Children's Trust. Representing a diverse group, disabled children often have highly complex needs requiring multi-agency support across health, social care and education services. Disabled children often require a vast and complex array of services, so they stand to benefit from joined up approaches to joint commissioning and planning.

The prevalence of severe disability is increasing because of higher survival rates of children and babies with some complex problems. Even if disability prevalence remains constant, the number of children with disabilities will continue to increase as the population of children and young people is forecast to grow. This needs assessment begins to identify some issues and encourages further work to forecast for increasing demands on services.

"Parents of children with disabilities experience vast variation in the kinds and levels of support they receive from a range of services, which appear to have little bearing on need."[127] This is reflected in the case studies and quotes included within this needs assessment where parents and carers are confused about what services their children are entitled to, what services are available; and what to do when support needs (real or perceived) are not met and the reasons for this. We have identified that there is some unmet need, however without having access to all data and performance information it is a challenge to identify exactly where unmet need is.

Substantial inequalities persist between disabled children and young people and their peers. This is an issue nationally and locally reflected within this needs assessment e.g. education outcomes.

There is a lack of current local information on the numbers of children and young people with disabilities and long-term conditions and the needs of this group; this has been compounded by challenges around data and information sharing across organisations. This has also made it a challenge to assess full levels of unmet need for disabled children and their families.

Data is not always available but where it is we are not routinely sharing or analysing data for the benefit of service users. This results in children and families having to repeat their story too often and continued siloed working practices.

There are a substantial number of services which offer support and interventions to children and young people with varying levels of disabilities and/or SEN. There seems however often to be a lack of coordination of these services and interventions for families as services and teams often work very separately from each other.

This needs assessment is the tip of the iceberg as far more work is required to understand this subject appropriately to be able to influence service provision and working practices.

---

[127] Department for Education and Skills (2006) 'Health and Well-being: Physical Health' Research and Practice Briefings: Children and Young People

9. Key Recommendations for Planners and Commissioners

9.1 Top Six Priority Recommendations for members of the Joint Commissioning Group

1. The availability of relevant data would enable commissioners to more effectively commission services to meet the needs of this local population. Further work is required to further assess needs; in particular where data has not been made available for this needs assessment (further information is provided in later).
2. Ensure co-ordinated planning at all levels, with roles and responsibilities of different agencies clarified and understood by frontline staff working with young people.
3. Increase opportunities to integrate key services to ensure that there is a consistent approach, reduced duplication, improved efficiencies and clearer pathways for children, young people and families.
4. Increase joint commissioning opportunities to reduce silo working across agencies working with the same children and families.
5. Demand on services exceeds availability so budgets are tight, commissioners and services need to plan more together to be efficient and ensure needs led services and interventions developed and delivered jointly.
6. Use evidence based practice to shape local services and interventions, and help build the evidence base and invest time and resource into evaluation of interventions and processes.

9.2 Additional Recommendations

Data/Information Sharing and Evidence related Recommendations

- **Information sharing** - Removing barriers that prevent the sharing of data will enable joint commissioning whilst minimising duplication for children and young people, families and service providers. Without more effective data-sharing, delivering integrated services will remain challenging.
- There should be more cross referencing of data sets to combine and explore data held by Nottinghamshire County Council, PCTs and NHS providers, Nottinghamshire Futures etc.

- **Improved data collection –** during the development of this needs assessment it has become apparent that organisations do not collect data that commissioners and planners would find useful, in particular measuring the impact of interventions on outcomes for children and young people with Disabilities and/or SEN. In addition mainstream services lacked data regarding disability e.g. apprenticeship schemes, and specialist services do not routinely collect data for service users including ethnic origin.
- Commissioners should be explicit about what data is collected and shared within contracts for all commissioned services working with these groups.
- Services and commissioners should look to develop improved monitoring which captures categories of disability need rather than just looking at primary or secondary needs in most cases. The Health Needs Assessment carried out in Special Schools provides a useful categorisation system.

- Data should be used to systematically plan and resource for evaluating the impact of what has been commissioned

- **Forecasting** – this needs assessment has identified there will be higher demand on services in the future. Commissioners and planners will need to ensure that forecasts are planned and resources available to meet increasing demand. In light of budget restrictions, planners may be required to review thresholds for some service provision to ensure those with greatest need are prioritised e.g. transport.

- **Improve the Nottinghamshire register of children and young people with a disability or SEN –** The register of all disabled children should be maintained by the Local Authority as they hold comprehensive education and social care information, improved information sharing with health partners is also critical. A comprehensive, up to date, and well used register is central to ensure a safe and responsive transition through key stages including early years to school, school to FE College, children's to adult services. It will also allow permission for data sharing across partners.
- Consistent requests for consent to share data should be a routine element of all initial contacts with families. Promoting the use of the register among a range of practitioners including healthcare who have early contact with target groups is fundamental to ensure children and young people's needs are identified and addressed in order to improve their outcomes. Data collected and analysed through the register should be shared with front line practitioners so they understand the rationale for data collection.

- **Use evidence based practice** – this needs assessment identified evidence based practice to help improve outcomes for children with disabilities and/or SEN. A number of key areas have been included within these recommendations.
- It is also important however to help build the evidence base and invest time and resource into evaluation of interventions and processes.

- **Identification of Pre School disabled children -** Numbers of children aged 0-4 with a disability or SEN are often not known by services such as Children Centres. Health partners will hold more data on this population and it would be advisable if information could be routinely shared using the register of disabled children so that services can be targeted appropriately.

- **Increasing Numbers of SEN Young People** – explore why there are increasing numbers of young people assessed as having SEN in secondary schools in Nottinghamshire, and not in primary schools.

- **Assessing levels of unmet need** - A recent health needs assessment of special schools identified a strong relationship between level of need and deprivation. It is not certain however if this is a reflection of actual prevalence of need, or ability to meet need due to resources available within the family. It is important to remember that those living in areas of deprivation find it more challenging to access services than their more affluent counterparts. It would be useful therefore to carry out some qualitative work with families from different socio-economic groups to fully assess levels of need and unmet need.

Intervention Approaches

- **Targeted interventions** – the needs assessment has identified that further work is required to ensure those with the greatest needs are targeted. It is important therefore to target children and families from the poorest socio-economic groups and key BME communities who we know are less likely to engage with some services.

- **Early intervention and prevention** - Understanding the causes of disability is critical for all Children's Trust partners, so the wider partnership can invest time and resource to support early intervention and prevention approaches e.g. maternal health (smoking, alcohol and substance use, folic acid) and prevention of infectious diseases during infancy and childhood.

- **Lead Professionals** - Establish lead link/co-ordination roles for families requiring a range of interventions from a range of services. Children and young people who undergo a CAF will have a lead professional; however it is advisable for a lead professional role to support a whole family where there is a disabled child/young person, in particular those with complex needs. Improved partnership working is a necessity.

- **Participation of Service Users** - Listening to parents/carers and children/young people to help improve and plan services is critical to ensure those services meet identified needs. Evaluation practices must also routinely engage service users and target groups.

- **Early Years interventions –** evidence suggests that high quality pre-school centres improve children's cognitive development and reduce the need for special education in primary care. It would be useful to therefore assess the quality of early year's provision for children with disabilities or additional needs.

- **Direct Payments** - Analysis of feedback of parents and young people in receipt of direct payments should be sought and used routinely to understand any concerns, anxieties, barriers and support needs e.g. support as employers of their own staff.

- **Service/Care Pathways** - A number of service pathways are available for specific disabilities including ADHD, ASD, and Palliative Care. It is advisable that the joint commissioning group review these collectively to ensure pathways are clear and there are clear interrelations with a range of services across Nottinghamshire.

<u>Information and Communication</u>

- **Information, Advice and Guidance –** ensure clear non biased information, advice and guidance for parents and carers to help them to understand their rights, their entitlements, local services and how to access services for their children as well as support for themselves.
- Evidence suggests that web based information is the most effective in dealing with specific issues or problems.

- **Improved communication** – this needs assessment identified that in some cases parents and carers have higher expectations for services above and beyond what they can offer. Services need to be explicit about what they offer and to whom and when, this should be included on service materials as well as Nottinghamshire wide websites that target parents, carers and young people. It is also important for all professional groups to understand any recent changes to services including thresholds.

- In addition some parents and some professional groups do not understand why there are layers of bureaucracy before being granted approval for some services and interventions. A greater understanding of the procedures surrounding the access to some services e.g. why a school may require written proof of a diagnosis, the processes and thresholds is urgently required.
- It is also important to ensure that parents, carers, children and young people understand why processes take time to complete by explaining to them what is involved, this is important at the start of processes but also throughout any process of assessment. Nevertheless if assessment processes are taking too long as identified by some parents in this needs assessment, then this should be remedied as soon as possible.

Focusing on Outcomes

- **Measuring Outcomes** – many services have traditionally collected data on the numbers of service users seen and have not fully adopted service evaluation which captures the impact on the outcomes for children and young people. The forthcoming joint commissioning strategy should focus on improving outcomes and encourage improved evaluation and performance activity.

- **SEND Pathfinder -** It will be important for the Joint Commissioning group for children with disabilities and/or SEN to have a clear overview of the activity of the pathfinder to ensure learning influences practice e.g. the use of one assessment and one care plan shared by a range of organisations and professionals. This will also provide an opportunity to inform the evidence base of what works**.**

Education Outcomes

- **Educational attainment** - further work is required to improve the attainment of children and young people who have a SEN statement and therefore close the gap between SEN children and young people and their peers at all key stages in particular Key Stage 4.
- Ensure that children and young people with disabilities and/or SEN are a key target group within the imminent 'Closing the Gap' strategy, in order to narrow the attainment gap.

- **Pupil Premium –** schools are due to receive the Pupil Premium which should help them to improve the attainment of the schools most disadvantaged pupils. It would be useful to ensure schools have access to evidence based practice on how best to use the resource for children and young people who are eligible for free school meals and have a disability or SEN.

- **Post 16 Educational Placements –** Information indicates that there are a range of services and interventions available for young people aged 16+ however the biggest challenge for many is to find suitable placements for a small number of young people with very specific complex needs. Many of these young people struggle to integrate into a college environment, mainstream or specialist post 16 placement. It is important to further develop the market to ensure placements are available for these specific needs, as well as a review of the 2011/12 pilot programme which is using on-going support from the alternative pre-16 provider for four young people to support them to transition post-16.

Health Outcomes

- **Occupational Therapy** – following on from the Joint Public Health and Social Care AHDC Occupational Therapy Pilot, there is still a need to develop a joint Occupational Therapy commissioning strategy with a clear pathway to provision in respect of equipment and other shared roles to ensure collaborative working and reduced confusion for families and therapists.

- **Improving access to specialist equipment -** Further discussions with health colleagues are required to agree a way forward to develop a fast track procedure/protocol for equipment (taking account of ICES criteria for provision).
- There need to be clear simple pathways for service users and professionals to help them understand roles and responsibilities for Occupational Therapy, Equipment Panels, ICES etc, this will also help ensure children and families know what to expect and who to contact.

- **Palliative care and Complex Health Needs** – a recent scoping report identified a number of recommendations that have yet to be implemented. These included the need for consistent provision of therapy services for this group of children and young people; the need for prompt referrals to community based services and increasing the availability of specialist family support and key working.
- There is also a requirement to develop flexible provision with a multi-skilled workforce that is county-wide, offering a range of services, including 24 hour on call, seven days a week support with the capability for home visiting for short breaks at end of life if required by families.
- A review and refresh of the palliative care pathway would be a positive step forward to ensure children and families are effectively supported.

Approaches to Joint Commissioning

- **Costs and benefits** – to enable improved joint commissioning and agreement of shared priorities, it would be useful to look at the costs of all key services and interventions. Commissioners should look to share this data so that cost benefit analysis work can be achieved, and decisions for commissioning priorities should explore value for money.
- An investment based model of joint commissioning should be adopted so that commissioners can assess value for money and cost benefit analysis.

External Placements

- **Cross border working** – as has been identified in this needs assessment, Nottinghamshire pupils attend Special Schools outside of the Nottinghamshire County borders as other children attend Nottinghamshire schools from neighbouring areas. It would be worthwhile to assess how packages of support are agreed and funded for children and young people.

- **Out of Authority Placements -** Further work is required to understand who uses out of authority placements, why this placement was used rather than a more local service provision, why there are larger numbers being placed in these placements, feedback from children and young people, as well as cost implications. It would be useful to look at out of authority placements for children and young people using social care placements, special school placements and those in post 16 placements jointly.

Transition processes

- **Transition support** - It would be useful to widen the scope of research into support on transitions for all children and young people with SEN, for example children with dyslexia or young people moving into further education, training or employment. However it would be useful to gather specific qualitative information from children and families about transition.
- Transition services require greater collaboration across all key agencies to meet the priorities of young disabled people with complex needs as they move into adulthood.

Equitable Access to Services and Interventions

- **Transport** – an urgent review of transport availability and use is required to ensure that those who need it most are able to access flexible transport, this however may mean that some universal transport provision will move to a needs assessed allocation in order to spread out already very thin resources.

- **Special School Nursing -** there seems to be currently some inequity in how Special School Nursing is delivered across Nottinghamshire Special Schools, further work would be required to ensure the service is equitable and based on need.

- **Short Breaks** – activity for children and young people to access short breaks seems to be responsive to need and the team is active in collecting and analysing information from service users. Work should continue to ensure those children and families most in need are prioritised for interventions.

- **Inclusive universal services** - All universal services need to be inclusive for children and young people with disabilities; this encourages children and young people to participate in activities with their peers and siblings and helps their understanding of peer culture. There should not be sole reliance on specialist activities. The use of access audits will help assess if services are inclusive.

- **Children Centres –** it is unclear if outreach targets for Children Centres in reaching disabled children are being met. It is known however that numbers seen at Children Centres are increasing; the interventions that took place in 2010/11 have had a positive impact on numbers seen by the centres. Further work should be implemented to ensure there is a continual increase in the numbers of disabled children accessing Children Centres. It would also be useful to identify the impact of Children Centre interventions on the outcomes of disabled children.

9.3 Further Needs Assessment Activity

Ethnicity	Further work is required to ensure ethnicity data is collected by services as well as the register of disabled children, so that services can be prepared to meet a range of varying needs linked to ethnicity. We know for example that asylum seeker families are less likely to request support so organisations may be required to implement outreach activities to engage them.

Gender	This needs assessment identified that more boys than girls are being assessed as having a disability. Additional work is required to explore this further and to understand gender differences e.g. are more boys than girls being identified as having challenging behaviour which has impacted on the data or is this linked to increasing diagnoses of ASD?
Locality of residence	This needs assessment struggled to identify the geographical location of where disabled children and young people reside. Those in special schools however are known and data is available in Appendix Three, however further work is required to identify needs based on locality. This data may be available through better implementation of the register of disabled children and young people.
Social care data	This data was not fully made available for this needs assessment so we lack information about how well social care support disabled children and their families in Nottinghamshire.
Out of authority placements data	No data was provided for use in this needs assessment. It would be worthwhile to explore the numbers of children and young people in a range of out of authority placements, why they are there, how their needs are being met, and performance of these placements as well as cost. It is recommended that a further needs assessment is developed to look at this issue and include qualitative data from service users and their families.
Transition assessments	Analysis of a range of data collected during core transition assessments would be useful for those responsible providing and commissioning services for children and families. Further work would be beneficial to collect, analyse and share this data with the joint commissioning group to enable them to have a greater understanding of issues for children and young people during key transition stages.
Qualitative feedback from children and young people	Although pre existing qualitative data was requested for this needs assessment, more information seemed to be available from parents and carers rather than the children and young people themselves. Any further needs assessment work must make every effort to engage children and young people with disabilities and/or SEN to gather their views of services and the issues facing them which impact on a range of outcomes.
Uptake of direct payments/ use of personal budgets	Full data regarding the use of direct payments by parents of disabled children or disabled 16-17 year olds who access in their own right was not available for this needs assessment. It would be useful to explore data from health and local authority service leads to help to identify who accesses Direct Payments and who requires additional support. It would also be useful to see details of claimants e.g. age, gender, postcode.
Palliative care for children and young people	This data was not available for this needs assessment, although numbers are small, this data would be useful for commissioners to use in order to ensure services are available to meet needs. Additional work would be useful to understand the numbers of children and young people that may be considered suitable for palliative care because the proportion of deaths that occur in hospital is relatively high, suggesting that there is a considerable challenge to improve access to palliative care services for children.

Equipment needs	specialist equipment has not been addressed adequately within this needs assessment. It is recommended that a separate needs assessment be carried out looking at equipment for children and young people, pulling information together from a range of partners including NHS, Local Authority, Special Schools, parents/carers and children/young people. Projection planning would also be useful in terms of equipment needs.
Emotional health and well being needs	The Health Needs Assessment for pupils in Special Schools identified that emotional health was not recorded as being a particular need in complex needs pupils. It is not clear if this is truly the case or because it is perceived that physical need is more important. It is recommended that the emotional health and wellbeing needs of pupils are explored in this group of children and young people as this figure is surprisingly low.
Qualitative feedback from professionals working with children and families	To further assess unmet need it would be useful to engage a range of practitioners working in the field of Children's disability and SEN. They will help to discuss any barriers within pathways for children and their families, and will be able to identify gaps in service provision. Special School head teachers for example would be able to make a worthwhile contribution discussing a range of services and interventions.
Health Service Performance Data	More comprehensive data should be collected from all local health services including those serving Bassetlaw. Data should include current performance levels to further assess needs.
Planned and unplanned admissions to hospital including A&E	Anecdotally we know that disabled children are more likely to have unplanned hospital admissions including visits to accident and emergency departments. This needs assessment however could not confirm this anecdotal information**.** It is difficult to identify disabled children attending hospital from routine data due to the lack of a systematic way of identifying and recording this status, so there may be unmet need if data is not available.
Undertake 'access audits'	It may be worthwhile to consider the development of an access audit of activities including, youth, play and leisure services to ensure that these universal services are inclusive and changes are made where required. It would also be useful to undertake health equity audits to ensure universal health services are also inclusive and engage disabled children and their families.
Housing	Identify local data on families with disabled children and the conditions in which they live (e.g. overcrowding, state of repair etc.)
Transport	Numbers of disabled children requiring transport, geographic spread, projections, analysis of costs – and barriers to participation created by a lack of transport provision.
Bullying	There is no local data on disabled children and their experiences of bullying and hate crime.
Parents/Carers	Intelligence on the demands which local parents and carers (including young carers) of children with profound and multiple difficulties are under is very limited.

Obesity	There is no local data on obesity and disability, as children unable to stand on scales are excluded from the National Child Measurement Programme. The National Child Measurement Programme does not ask to identify if children accessing the programme have a disability. Nationally, children with physical or learning disabilities are identified as at **Immunisations** risk of not being fully immunised. There is currently no local data available to monitor this
Kinship Carers	No local data was available for this needs assessment that would help to identify the proportion of carers who are members of the family (excluding parents). Further work to understand and meet the needs of kinship carers in Nottinghamshire is required.
Workforce development needs	Evidence based practice recommends that a skilled workforce is needed in particular in universal services to ensure that they are inclusive. No data was available regarding how inclusive the local workforce is. It would be worthwhile therefore to assess workforce development needs.

APPENDIX ONE

National Policy Drivers

DfE (2011) **Support and aspiration: A new approach to special educational needs and disability - a consultation**

- Proposals include replacing the present SEN assessment and statement with a new single assessment process leading to an 'Education, Health and Care Plan'; the option of personal budgets by 2014 for all families with children with a statement of SEN or Education, Health and Care Plan; strengthening parents' choice of (state-funded) school; introducing greater independence of the assessment process through a possible role for the voluntary and community sector; and improving support for families with children who have the most complex or serious needs.

DfES and DH (2007) **Aiming High for Disabled Children: Better support for families**

- Launched as the transformation programme for disabled children's services.
- Aiming High for Disabled Children sets out a "core offer" which encompasses minimum standards on information, transparency, participation, assessment and feedback, to make it clear what entitlements and services disabled children, young people and their families can expect.
- Aiming High for Disabled Children piloted Individual Budgets which gave families and disabled young people choice and control to design flexible packages of services which respond to their needs; and spreading good practice on engagement and empowerment of parents.

DH (2011) **NHS at home: community children's nursing service**

- This document sets out the findings of a Department of Health project aimed at identifying and sharing local good practice in community children's nursing (CCN) services (more details at the end of the summary). It illustrates how CCN is a key component of community children's services, and demonstrates the contribution it can make to the future outcomes of integrated children's services.
- It is aimed at commissioners and providers of children's services, in particular to inform Quality, Innovation, Productivity and Prevention (QIPP) plans to reduce hospitalisation, and should be seen alongside the requirement set out in paragraph 4.34 of the *Operating Framework for the NHS in England 2011/12* for 24/7 community services to improve end-of-life care, and the *Palliative Care Funding Review Interim Report* (December 2010).

DH (2010) **The Operating Framework for the NHS in England 2011/12**

- The Operating Framework sets out what PCTs need to implement over the transition year 2011/12. All parts of the health service are required to work across organisational boundaries to respond positively to the NHS reforms, whilst ensuring that service quality and financial performance are maintained and improved at a time of change.
- Specifically the framework asks NHS organisations to pay particular attention to groups with specific needs including disabled children, palliative care, and child and adolescent mental health services (CAMHS), children in care and families with multiple problems.

DH (2010) **National Framework for children and young people's continuing care**

- This framework sets out an equitable, transparent and timely process for assessing, deciding and agreeing bespoke packages of continuing care for those children and young people under the age of 18 who have continuing care needs that cannot be met by existing universal and specialist services alone.

DH & DCSF (2009) **Healthy Lives, Brighter Futures**

- This strategy sets out plans for universal, targeted and specialist support across three life stages – early years and pregnancy; school-age children; and young people – as well as the additional support for children and young people in need of acute or ongoing healthcare.
- It established the funding available in the NHS for palliative care and end-of-life services, short breaks, community equipment and wheelchair services for disabled children and young people
- It set out plans to test and expand new approaches to the provision of services and plans to ensure that all children with complex health needs have an individual care plan.

DH (2009) **Healthy Child Programme: pregnancy and the first five years of life**

- Provides a framework fro improving health outcomes for children aged 0-5 years. The guidance aims to ensure services are integrated, promoted and community based to engage families less inclined to access traditional services.
- 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 authority if it is suspected that a child may have special educational needs.

DH (2009) **Healthy Child Programme: from 5-19 Years**

- The HCP sets out the good practice framework for prevention and early intervention services for children and young people aged 5–19 and recommends how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances.
- Promotes the Early Support Programme (ESP) for disabled children which provides young disabled children and their families with joined-up, co-ordinated services and better, more accessible information. The ESP promotes the 'Team Around the Child' approach, providing a structured framework for lead professionals who are taking on a key worker role with families.
- The HCP also focuses on engaging parents and carers of disabled children to ensure they have clear information regarding local services and care pathways. This builds on the core offer set out in Aiming High (2007).

DH (2008) **Better Care: Better Lives. Improving outcomes and experiences for children, young people and their families living with life limiting and life threatening conditions**

- Aims to improve outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions, ensuring equitable access to high-quality, family-centred, sustainable care and support, with services provided in a setting of choice, according to the child and family's wishes.

DCSF & DH (2005) **Commissioning children and young people's palliative care**

- Designed to help commissioners of health services to apply the children's NSF to children's palliative care and to work with local authorities and other partners

DH (2004) **National Service Framework for Children, Young People and Maternity Services** –Standard 8: Disabled Children and Young People and those with Complex Health Needs

- The NSF establishes clear standards for promoting the health and well-being of children and young people and for providing high quality services that meet their needs. Standard 8 addresses the requirements of children and young people who are disabled and/or who have complex health needs, and their families.

- It aims to support children and young people who are disabled or who have complex health needs, to participate in family and community activities and facilities.
- The standard also aims to ensure health, education and social care services are organised around the needs of children and young people and their families, with co-ordinated multi-agency assessments leading to prompt, convenient, responsive and high-quality multi-agency interventions that maximise the child's ability to reach his or her full potential.
- The standard also aims to ensure that children, young people and their families are actively involved in all decisions affecting them and in shaping local services.

DH (2010) **The National Framework for Children's Continuing Care**

- This framework sets out an equitable, transparent and timely process for assessing, deciding and agreeing bespoke packages of continuing care for those children and young people under the age of 18 who have continuing care needs that cannot be met by existing universal and specialist services alone.

DfE (2008) **BESD Guidance 2008 - The Education of Children and Young People with Behavioural, Emotional and Social Difficulties as a Special Educational Need**[128]

- Local authorities should make sure that schools and early years settings have access to advice and support from educational psychologists, behaviour support services, whether provided centrally or as outreach from a special school, and child and adolescent mental health services (CAMHS). DCSF/DH's *National Service Framework for Children, Young People and Maternity Services* has established clear standards in promoting the health and well-being of children and young people and for providing high quality services. Standard 9 addresses the mental health and psychological well-being of children and young people:

Ofsted (2010) **Special Educations Needs and Disability Review**

- Ofsted highlight how well the legislative framework and arrangements serviced children and young people with have special educational needs and /or disabilities. Ofsted recommend that assessment and identification is well managed and appropriate with a view to ensure consistency in assessment and support plans. They also recommend that there is improved access to quality provision for all children and young people with differing needs not just those with the most complex problems. Ofsted also ask for improved evaluation and accountability to measure improvements in outcomes

DfES & DH (2003) **Together from the Start – Practical Guidance fir professionals working with disabled children (birth to third birthday) and their families.**

- This guidance focuses on the delivery of services to disabled children aged 0-3yrs and their families. The guidance promotes early intervention, good practice and good partnership working. It encourages all partners to support children in all aspects of development including health, education to ensure a good quality of life for children and their families.

ACT (2009) **Right people, right time, right place: planning and developing an effective and responsive workforce for children and young people's palliative care.**

- Sets out what services need to be commissioned throughout the pathway and describes who may provide the services. A tiered approach to learning and

---

[128] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4094607

development, called the Learning Cone is recommended. Four core areas for curriculum development are outlined – communication skills; assessment skills; complex care management and role development.

ACT (2003) **A Guide to the Development of Children's Palliative Care Services**

- Recommends a locally based children's palliative care service, led by a paediatrician or appropriate senior professional with a special interest in childhood disability and life limiting illness.

ACT (2003) **A Framework for the Development of Integrated Multi-Agency Care Pathways for Children with Life Limiting Conditions**

- Recommends locally-based multi-disciplinary team with ready access to a children's hospice and to specialist palliative care advice for families and professionals. A Key Worker is advised to ensure provision is planned, coordinated and appropriate. Emotional and bereavement care is recommended for the whole family, including siblings. Voluntary sector services should be integrated into processes. Staff need appropriate education, experience and support.

DH (2004) **Disabled Children and Young People and those with Complex Care Needs**

- Identifies the importance of supporting parents and strengthening parents in relation to the death of a child

DH (2004) **Making Partnerships work for Patients, Carers and Service Users: A strategic agreement between the Department of Health, the NHS and the voluntary and community sector.**

- Is a 10-year programme intended to stimulate long-term and sustained improvement in children's health? Setting eleven standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood. Standard 8 sets the need to organise services around the need of the child or young person and as far as possible, be integrated to allow people to lead an ordinary life.

NICE (2011) **Autism: recognition, referral and diagnosis of children and young people on the autism spectrum (CG 128)**

- Key recommendations from this guidance include having a local pathway for recognition, referral and diagnostic assessment of possible autism, considerations for how to recognise children and young people with possible autism, and referral criteria and methods of diagnostic assessment.

NICE (2008) **Diagnosis and management of ADHD in children, young people and adults (CG72)**

- This guidance covers the care, treatment and support that children, young people and adults with ADHD should be offered and how families and carers can support people with ADHD.

NICE (2009) **Anti-social personality disorder: treatment, management and prevention (CG77)**

- Anti-social personality disorder is the name given to a condition that affects a person's thoughts, emotions and behaviour. Anti-social means behaving in a way that is disruptive to, and may be harmful to, other people. The advice in the NICE guideline covers: the care, treatment and support that people with anti-social personality disorder and their families or carers should be offered; and the care and treatment that children with conduct problems and their families or carers should be offered. It does not specifically look at treatments not normally available in the NHS or prison health services.

NICE (2005) **Depression in children and young people: identification and management in primary, community and secondary care people (CG28)**

- The NICE clinical guideline on depression in children and young people covers the care children and young people with depression can expect to get from their doctor, nurse or counsellor; the information they can expect to be given; what they can expect from treatment; the kinds of services that can help young people and children with depression, including the family doctor (general practitioner or GP), health staff at school, and specialists in clinics or hospitals.

NICE (2009) **Social and emotional wellbeing in secondary education (PH20)**

- This guidance is for all those who have a responsibility for the social and emotional wellbeing of young people in secondary education. This includes teachers, support staff, governors and professionals with public health as part of their remit working in education (including the independent sector), local authorities, the NHS and the wider public, voluntary and community sectors. It focuses on interventions to support all young people aged 11-19 who attend any education establishment. Social and emotional wellbeing includes being happy, confident and in control, with the ability to solve and cope with problems and have good relationships with other people. The six recommendations cover: strategy, the key principles and conditions, working in partnership with parents, families and young people, the curriculum, and training and professional development.

NICE (2008) **Social and emotional wellbeing in primary education (PH12)**

- This guidance is for teachers and school governors, and for staff in local authority children's services, primary care and child and adolescent mental health services. NICE recommendations include:
    - Local authorities should ensure primary schools provide an emotionally secure environment that prevents bullying and provides help and support for children (and their families) who may have problems.
    - Schools should have a programme to help develop all children's emotional and social wellbeing. It should be integrated it into all aspects of the curriculum and staff should be trained to deliver it effectively.
    - Schools should also plan activities to help children develop social and emotional skills and wellbeing, and to help parents develop their parenting skills.
    - Schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed. Those at higher risk of these problems include looked after children, those in families where there is instability or conflict and those who have had a bereavement.

APPENDIX TWO

Nottingham City and
Nottinghamshire County

NHS Bassetlaw

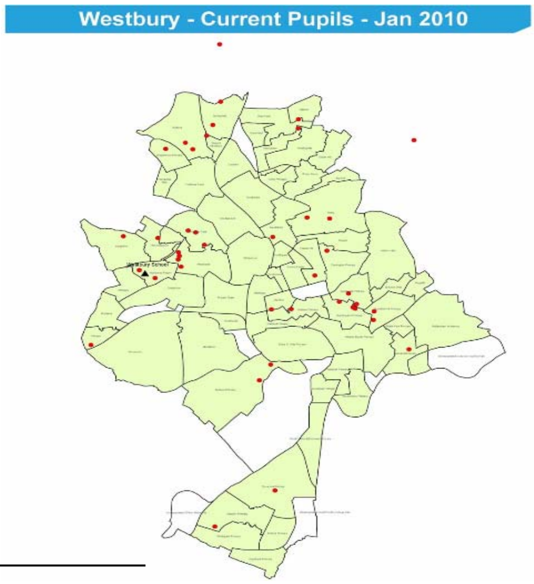
Special Schools Health Needs Survey

12 special schools took part in the Health Needs Assessment, 3 city schools did not participate and therefore the health needs analysis for the city as a whole is incomplete.

1. Participating schools and numbers of pupils[129]

	Name of participating schools	Total pupil Numbers attending school in 20010/11	Total data returns	Percentage Returns
1	ASHLEA SCHOOL	74	74	100
2	BEECH HILL SCHOOL	72	82	87.8
3	BRACKENHILL SCHOOL	93	96	Error 103.2
4	CARLTON DIGBY	57	57	100
5	SCHOOL	Not Known	0	0
	DERRY MOUNT			
6	FOUNTAINDALE	57	57	100
	SCHOOL			
7	FOXWOOD SCHOOL	100	50	50
8	NEWARK ORCHARD	90	14	15.6
	SCHOOL			
9	OAK FIELD SCHOOL	144	144	100
10	REDGATE SCHOOL	25	21	84%
11	ROSEHILL SCHOOL	82	82	100
12	ST GILES SCHOOL	143	134	93.7
13	YEOMAN PARK SCHOOL	100	89	89
	Grand Total	1047	900	

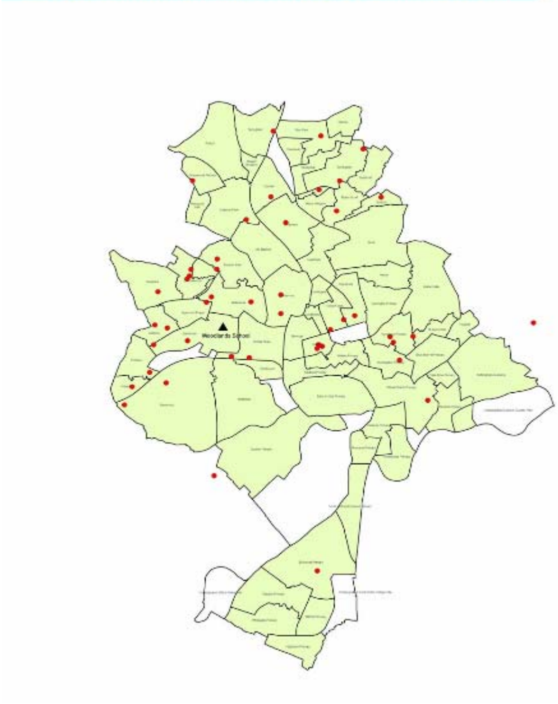
2. Schools Catchment – Nottingham City[130]



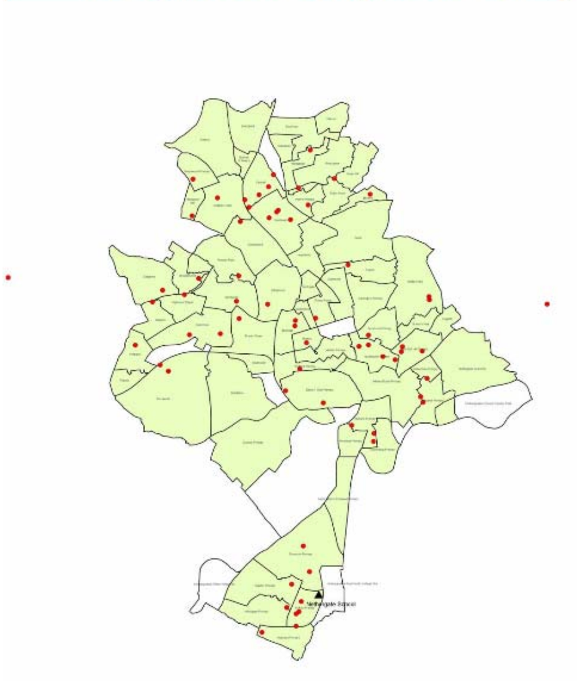
---

[129] Details on missing schools could be added if supplied.

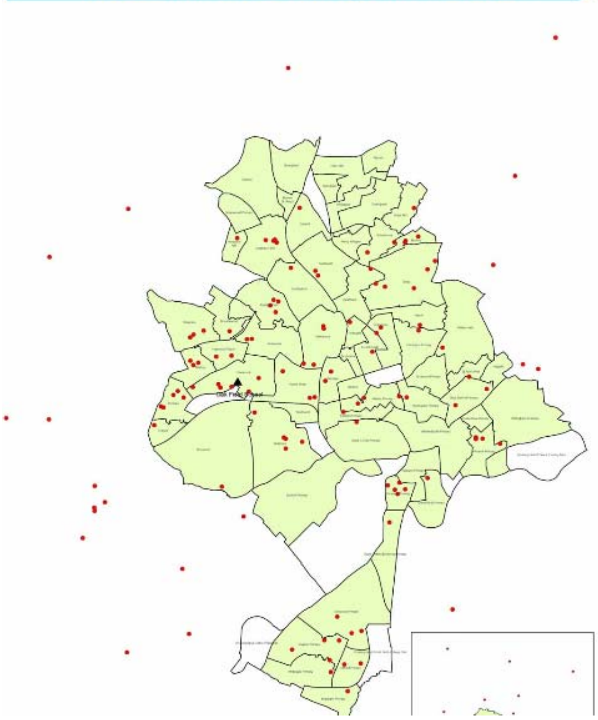
Woodlands - Current Pupils - Jan 2010



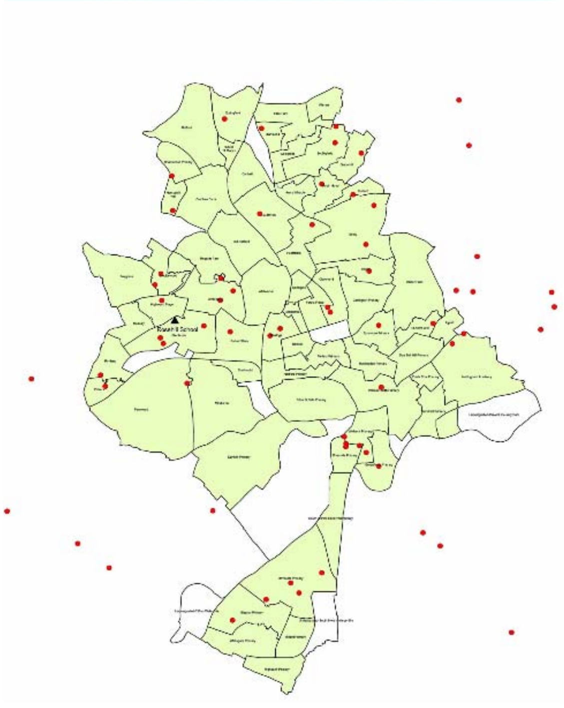
Nethergate - Current Pupils - Jan 2010



Oak Field - Current Pupils - Jan 2010



Rosehill - Current Pupils - Jan 2010



---

[2] Maps supplied by Nottingham City Council only. If data on location of schools is supplied we can provide maps for all schools, including school location.

3. Analysis of Dataset

The questionnaire assessed individual pupil need across a number of areas (e.g. hearing, sleep, behaviour, feeding) and for a number of services (e.g. physiotherapy, continence). Many children had needs in a number of areas or for a number of services. In order to combine the data to identify complexity and severity of need within the pupil population needs were reassigned to 4 point scale according to the table below. Pupils were then categorised as high, medium or low need according to following schema (high = >5 Level 3 needs, medium = 1-5 Level 3 needs and Low = no level 3 needs). Alternative methods to look at clustering of need are possible and would be preferable to this form of analysis but were precluded by timescales.

NEEDS	0	1	2	3
Feeding	0 - Not stated	1 - No support / intervention required	2 - Oral requires help with cutting / chopping food	3 - Oral requires feeding 4 - Gastrostomy 5 - NG tube
Sight	0 - Not stated	1 - No support / intervention required	2 - Glasses	3 - Partially sighted 4 - Blind
Hearing	0 - Not stated	1 - No support / intervention required	2 - Hearing impairment / hearing aids	3 - Hearing loss / deaf
Personal Care	0 - Not stated	1 - No support / intervention required	2 - Some assistance	3 - Full assistance
Continence	0 - Not stated	1 - No support / intervention required	2 - Continent require support 3 - Pads at night	4 - Doubly incontinent 5 - Catheterizes
Moving & Handling	0 - Not stated	1 - No support / intervention required	2 - M&H (1 carer)	3 - M&H (2 carers)
Physiotherapy	0 - Not stated	1 - No support / intervention required	2 - Develop a plan with school staff only	3 - Plan + 1 identified need 4 - Plan + 2 identified needs 5 - Plan + 3 or more identified needs
Occupational Therapy	0 - Not stated	1 - No support / intervention required	2 - Develop a plan with school staff only	3 - Plan + 1 identified need 4 - Plan + 2 identified needs 5 - Sensory needs identified
Wheelchair	0 - Not stated	1 - No support / intervention required	2 - Wheelchair for distance	3 - Electric wheelchair 4 - Assisted wheelchair
Seizures	0 - Not stated	1 - No seizures	2 - Seizures - no rescue medication	3 - Seizures - with rescue medication
Communication	0 - Not stated	1 - No support / intervention required	2 - Speaks clearly to a familiar person 3 - Some words	4 - Sign language / aided language 5 - Communication aid 6 - Vocalisation and non verbal communication
SALT	0 - Not stated	1 - No support / intervention required	2 - Develop a plan with school staff only	3 - 1:1 session 4 - Group session

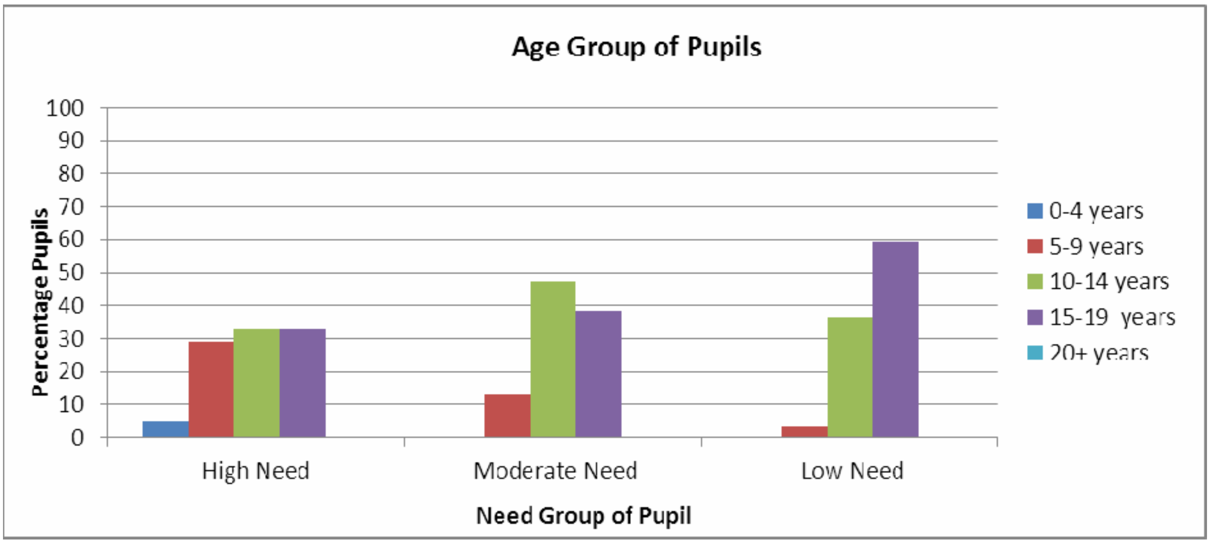
				5 - Communication equipment or system
Airway	0 - Not stated	1 - No support / intervention required	2 - Inhaler 3 - Suction	4 - Oxygen 5 - Tracheostomy 6 - Ventilated
Meds	0 - Not stated	1 - No medication	2 - Simple medication	3 - Complex medication (as and when needed and requires measuring) 4 - Paraldehyde
Injection/Pump Medication	0 - Not stated	1 - No injection / pump	2 - Regular PRN / injection	3 - Medication pump / ace procedure 4 - Portacath or shunt
Sleep	0 - Not stated	1 - No support / intervention required	2 - Poor sleep / sleep intervention	
Behaviour	0 - Not stated	1 - No support / intervention required	2 - Challenging behaviour 3 - Behaviour plan	4 - Medication for behaviour 5 - Behaviour prevents accessing activity
Emotional Health	0 - Not stated	1 - No support / intervention required	2 - Educational Psychologist	3 - Referred to CAMHS 4 - CAMHS client

4. Overall levels of Need

LEVEL OF NEED	Number	Percentage
High Needs (>5 Grade 3 needs)	232	22.2
Moderate Needs (1-5 Grade 3 needs)	449	42.9
Low Needs (0 Grade 3 needs)	219	20.9
Unknown (No Response)	147	14.0

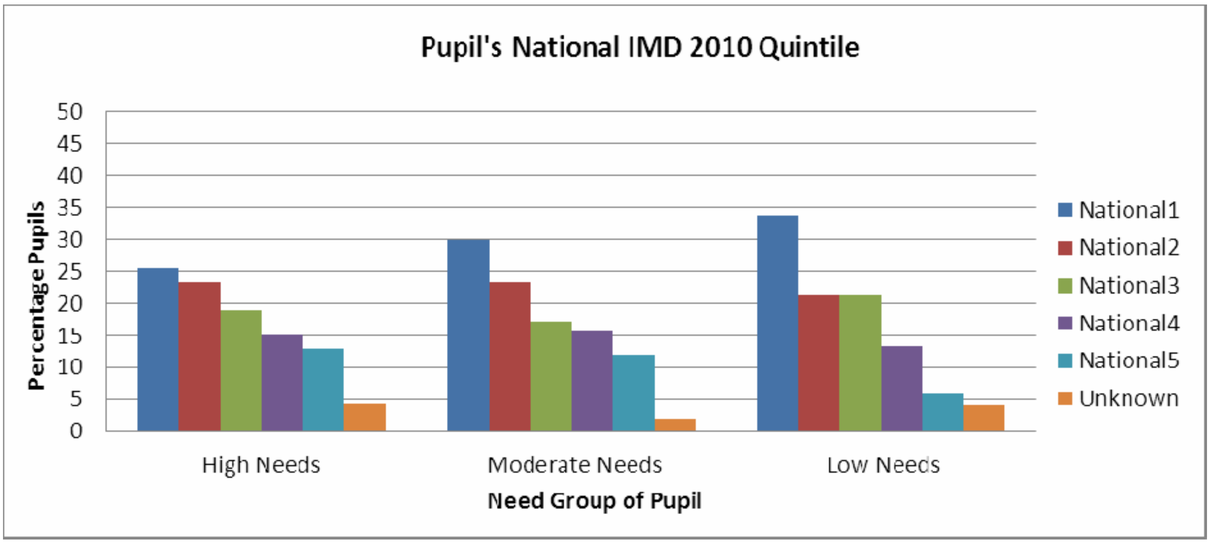
5. Need and Age of Pupils

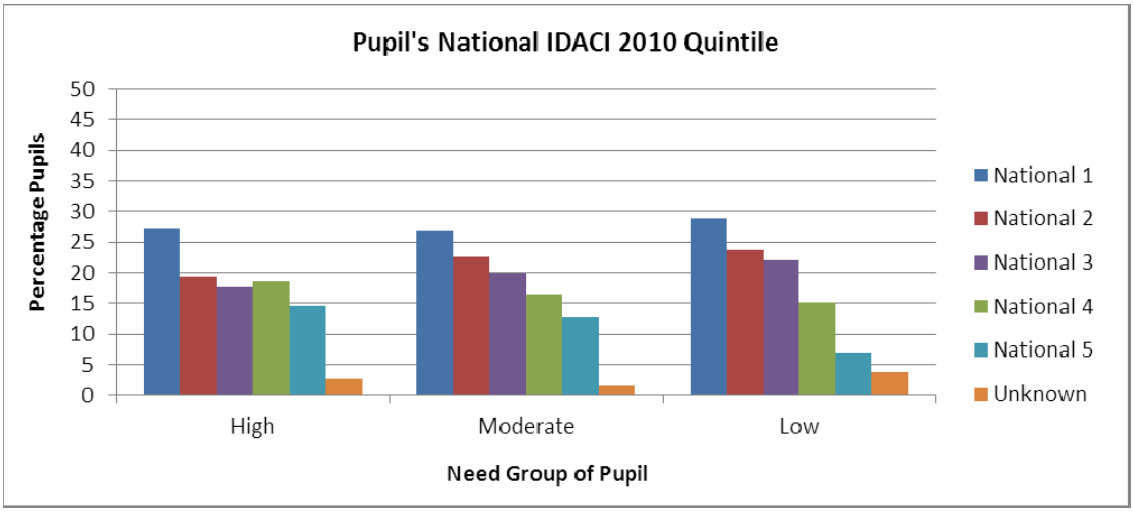
This data relates to pupils attending schools: only those in the highest need are likely to attend before the age of 5 years and for this category need is distributed relatively evenly across the age bands. For those with moderate levels of need there are lower percentages in the younger age group (5-9 years) than the other two categories, perhaps reflecting a differential ability to manage such needs within mainstream services. For those with lowest need the highest percentage is in the oldest age group, which may indicate an inability to provide for this group in mainstream settings.



6. Need and Deprivation

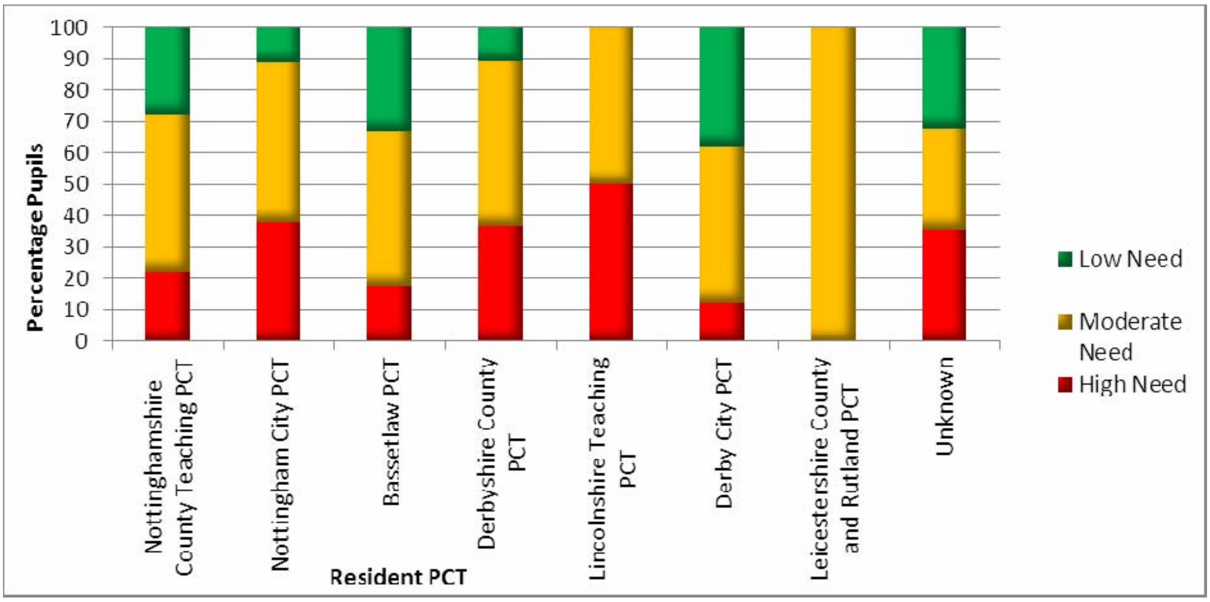
This demonstrates a social gradient in need based on postcode deprivation score. Pupils who come from the most deprived areas form the greatest percentage within each level of need, and those in the least deprived the lowest. The gradient increases as the level of need moves from high to low. This may be explained by increasing level of moderate and low needs in relation to deprivation or reflect ability to meet such needs with relatively less home / community resource.



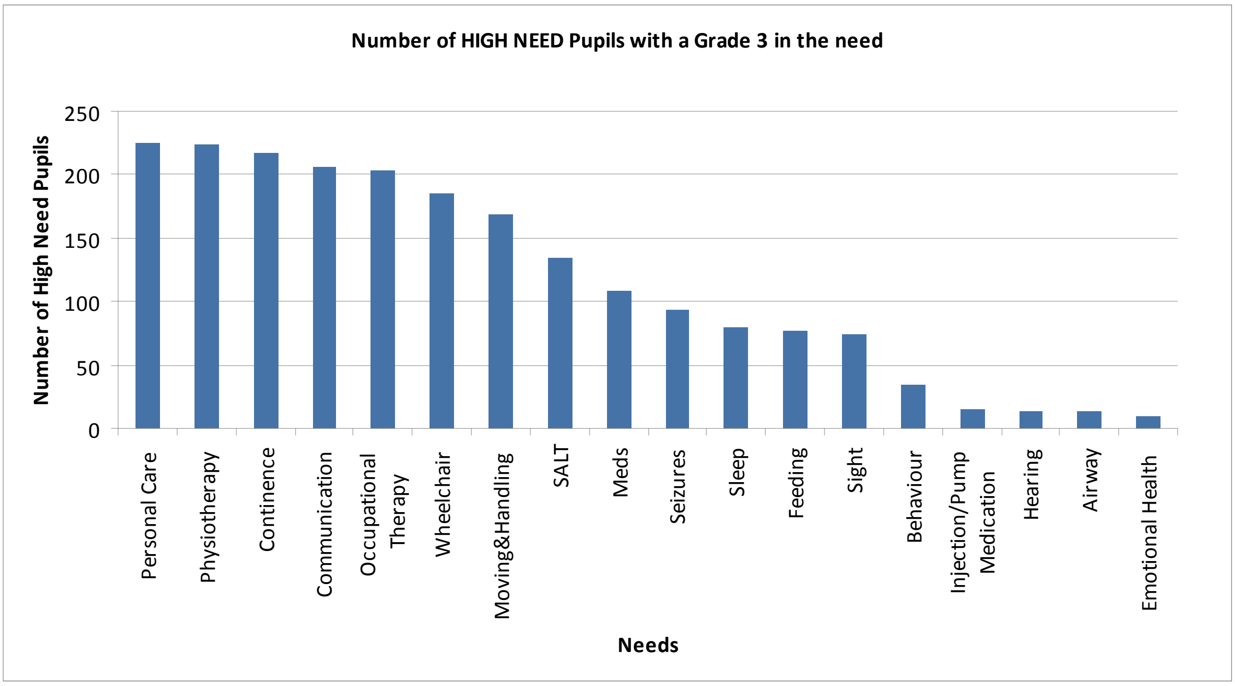


7. Need by area of residence

A relatively higher proportion of pupils from the city have higher needs. This probably reflects the higher levels of deprivation in the city. The relatively lower need in Derby City may reflect small numbers or a factor such as the ability to travel leading to a selected population. Please note that not all data from Nottingham City was collected and data from Lincolnshire and Derbyshire relates to relatively small numbers.

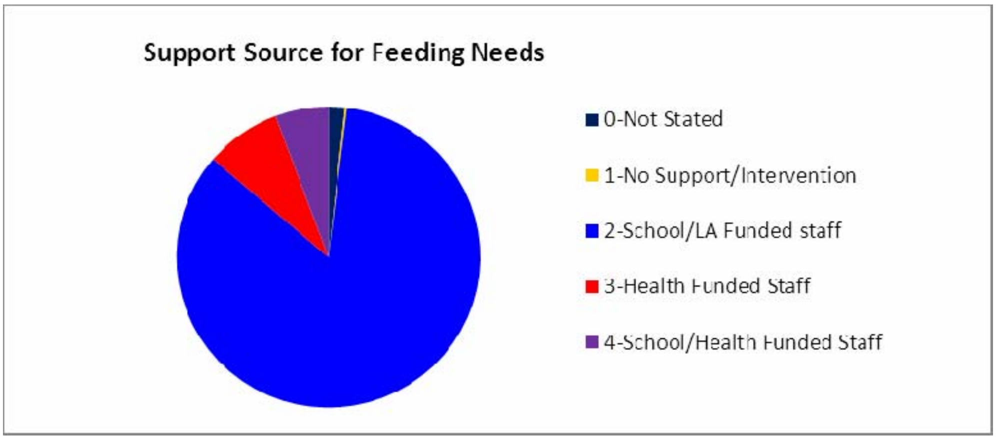


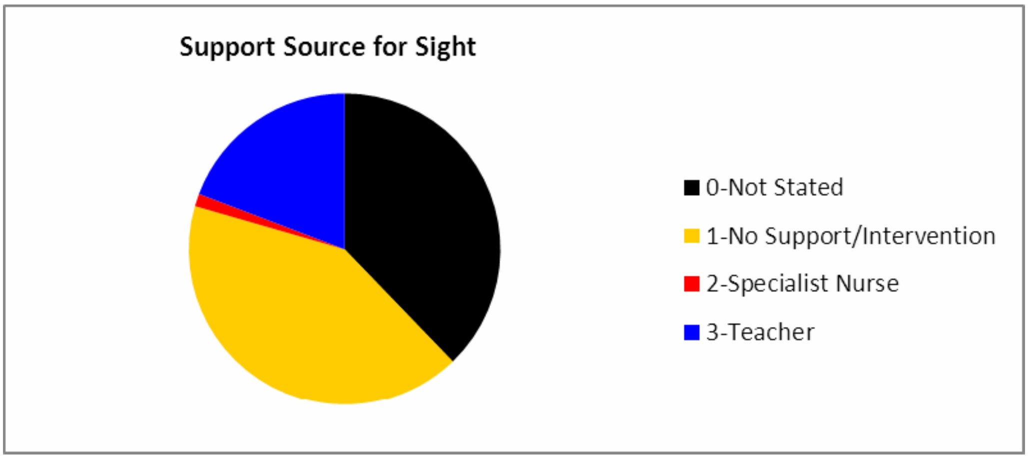
8. Type of need in pupils with complex needs



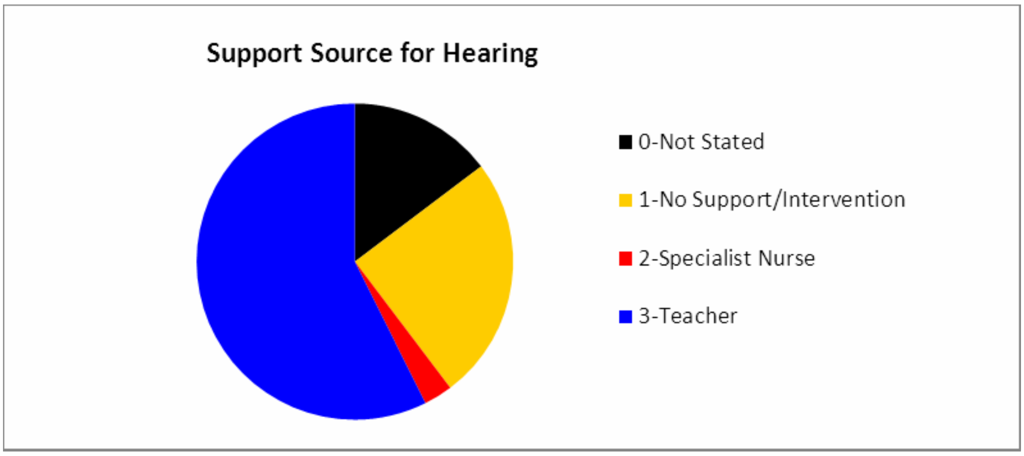
Pupils with high level of needs commonly require support for personal care, communication and moving and handling. Service need includes physiotherapy, continence, occupational therapy and wheelchair support. A small number have specialised medical needs such as pump injection and airway. Emotional health is not recorded as being a particular need in complex needs pupils. It is not clear if this is truly the case or because it is perceived that physical need is more important. The (Project Group) report recommends that the emotional health and wellbeing needs of pupils is explored in this group of children and young people i.e., CAHMS as this figure is surprisingly low.

9. Types of need and source or type of support

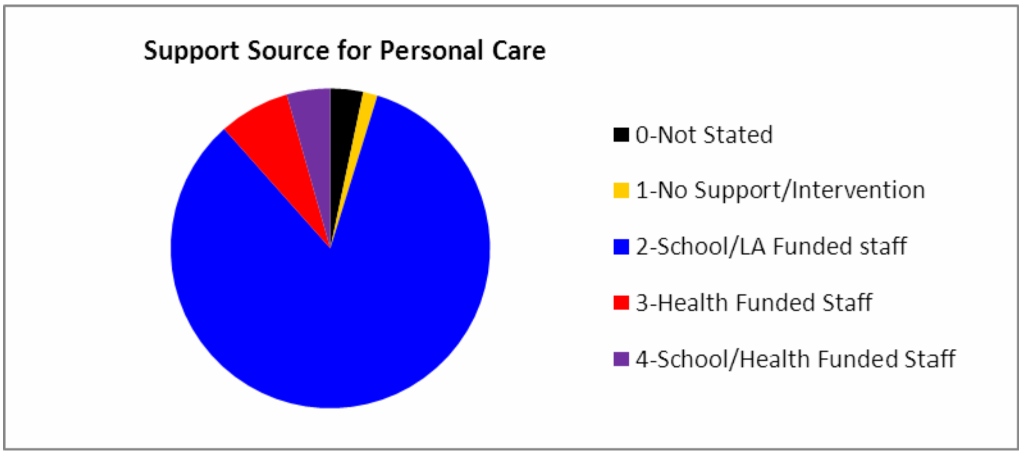




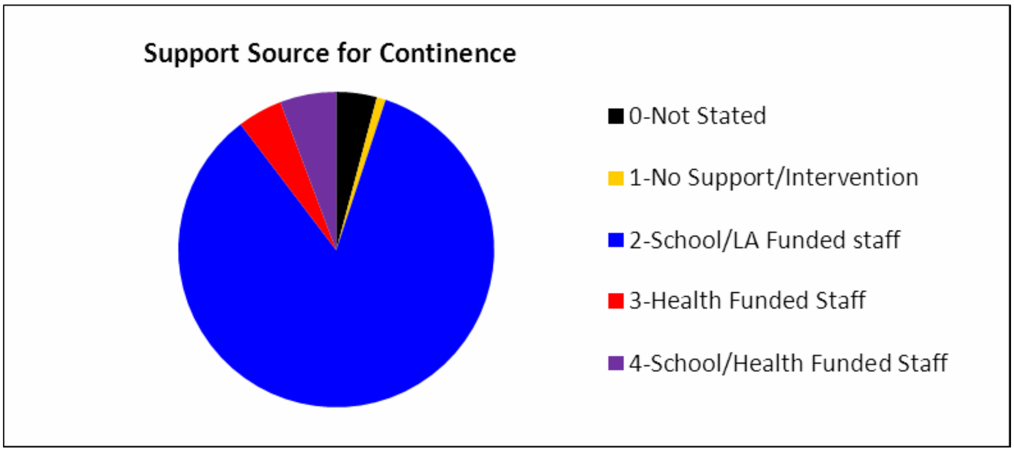
Support Source for Sight



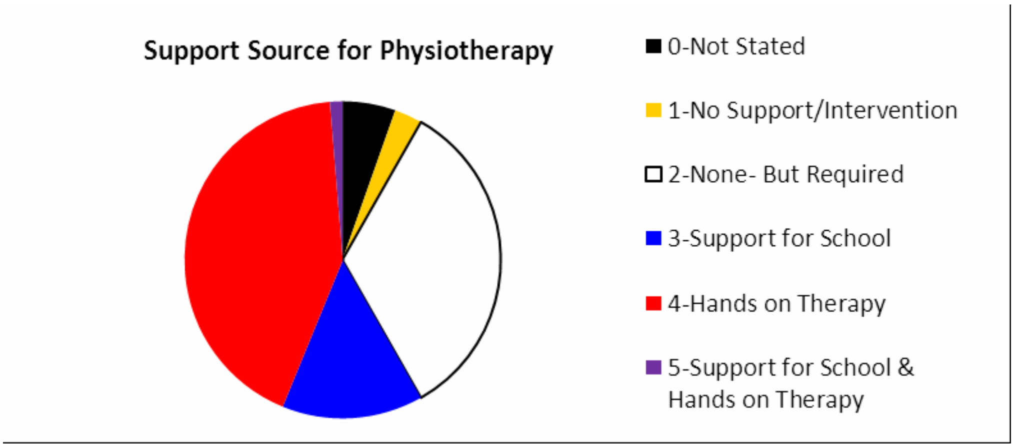
Support Source for Hearing

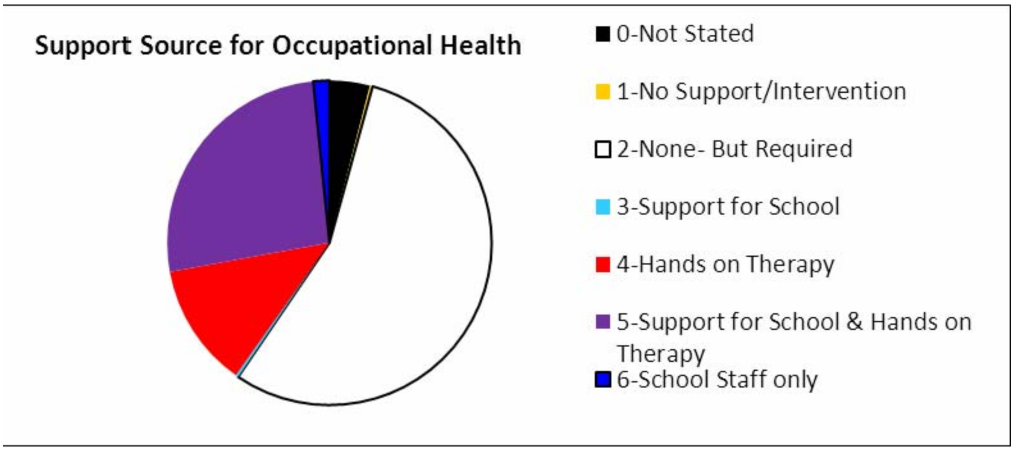


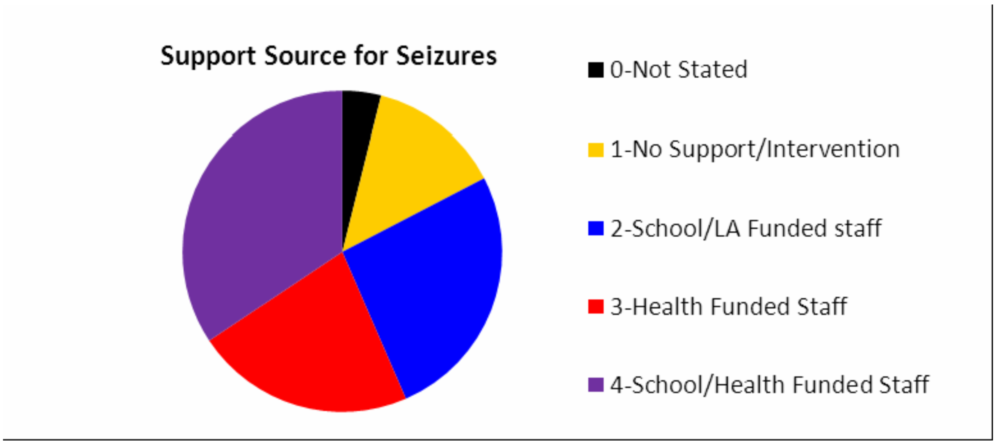
Support Source for Personal Care

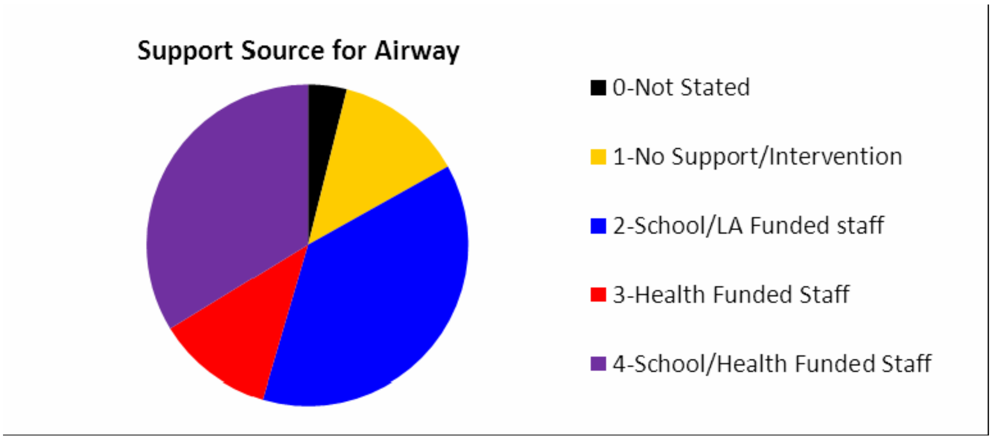


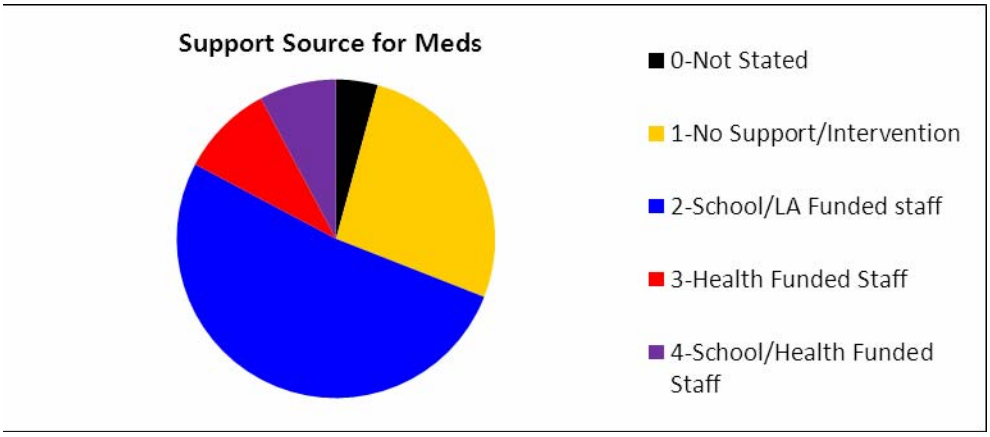
Support Source for Continence

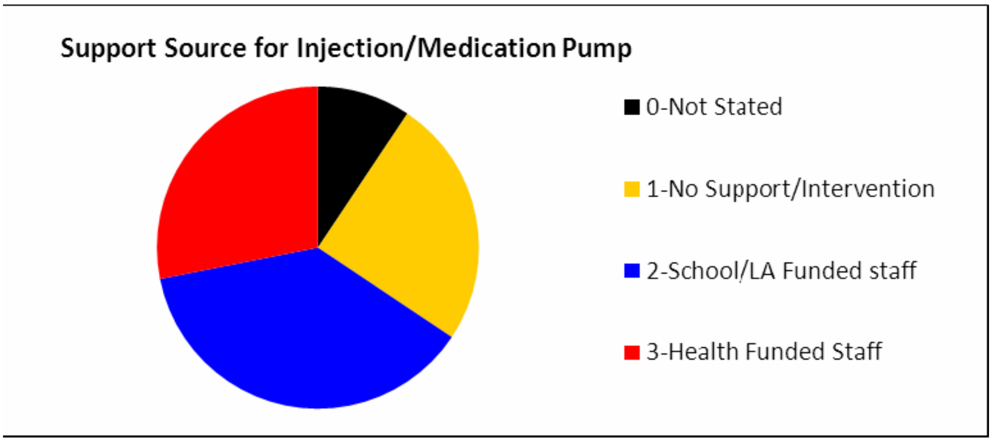

Support Source for Physiotherapy
0-Not Stated
1-No Support/Intervention
2-None- But Required
3-Support for School
4-Hands on Therapy
5-Support for School & Hands on Therapy

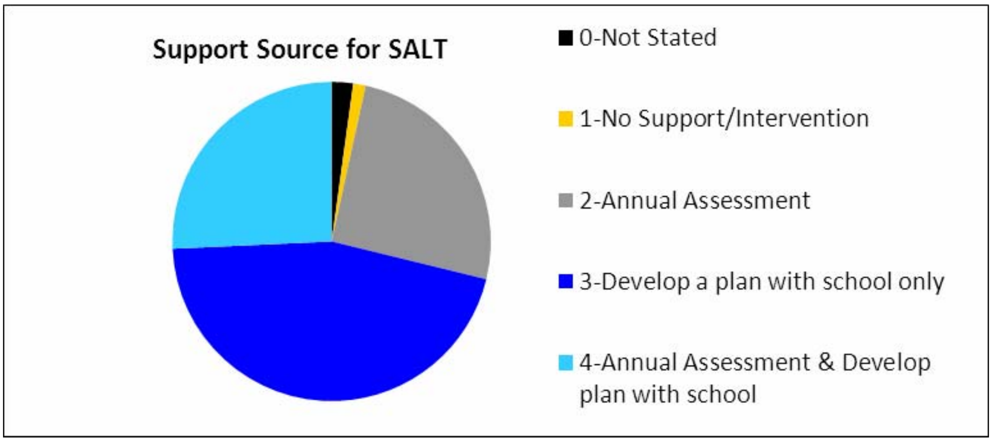

Support Source for Occupational Health
0-Not Stated
1-No Support/Intervention
2-None- But Required
3-Support for School
4-Hands on Therapy
5-Support for School & Hands on Therapy
6-School Staff only

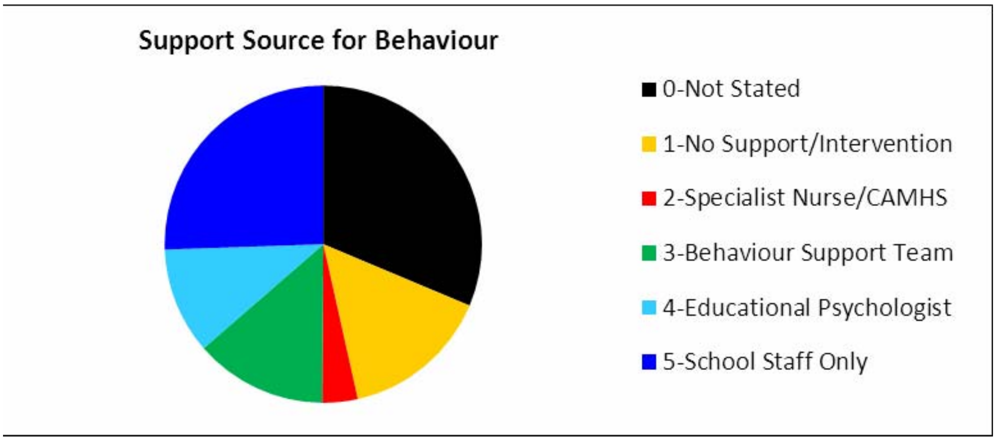

Support Source for Seizures
0-Not Stated
1-No Support/Intervention
2-School/LA Funded staff
3-Health Funded Staff
4-School/Health Funded Staff

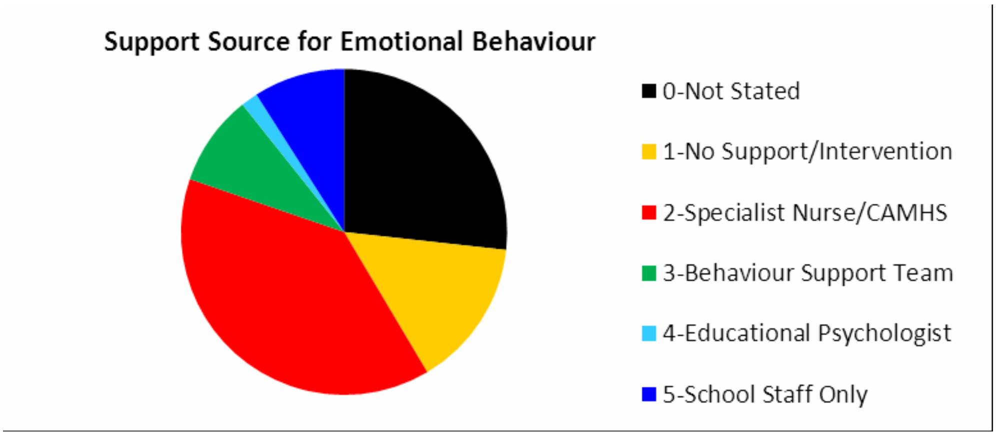

Support Source for Airway
0-Not Stated
1-No Support/Intervention
2-School/LA Funded staff
3-Health Funded Staff
4-School/Health Funded Staff


Support Source for Meds


Support Source for Injection/Medication Pump


Support Source for SALT

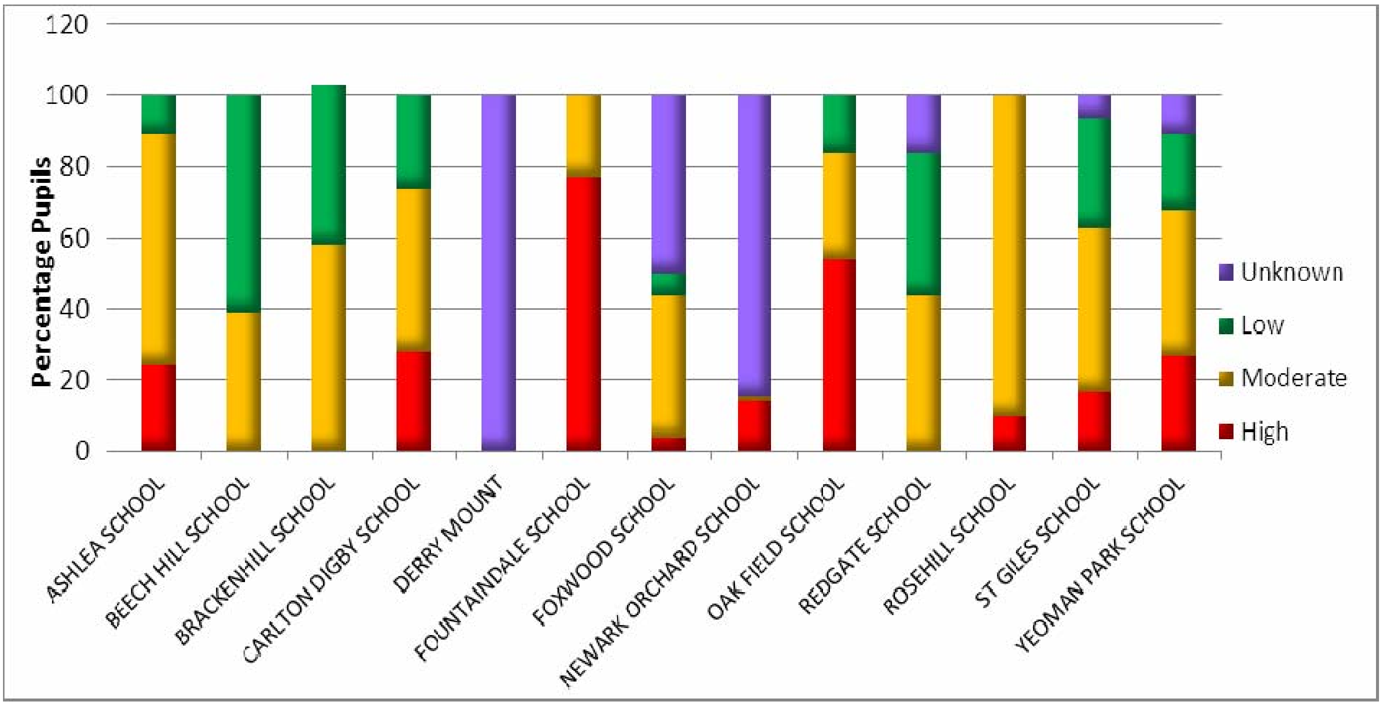

Support Source for Behaviour



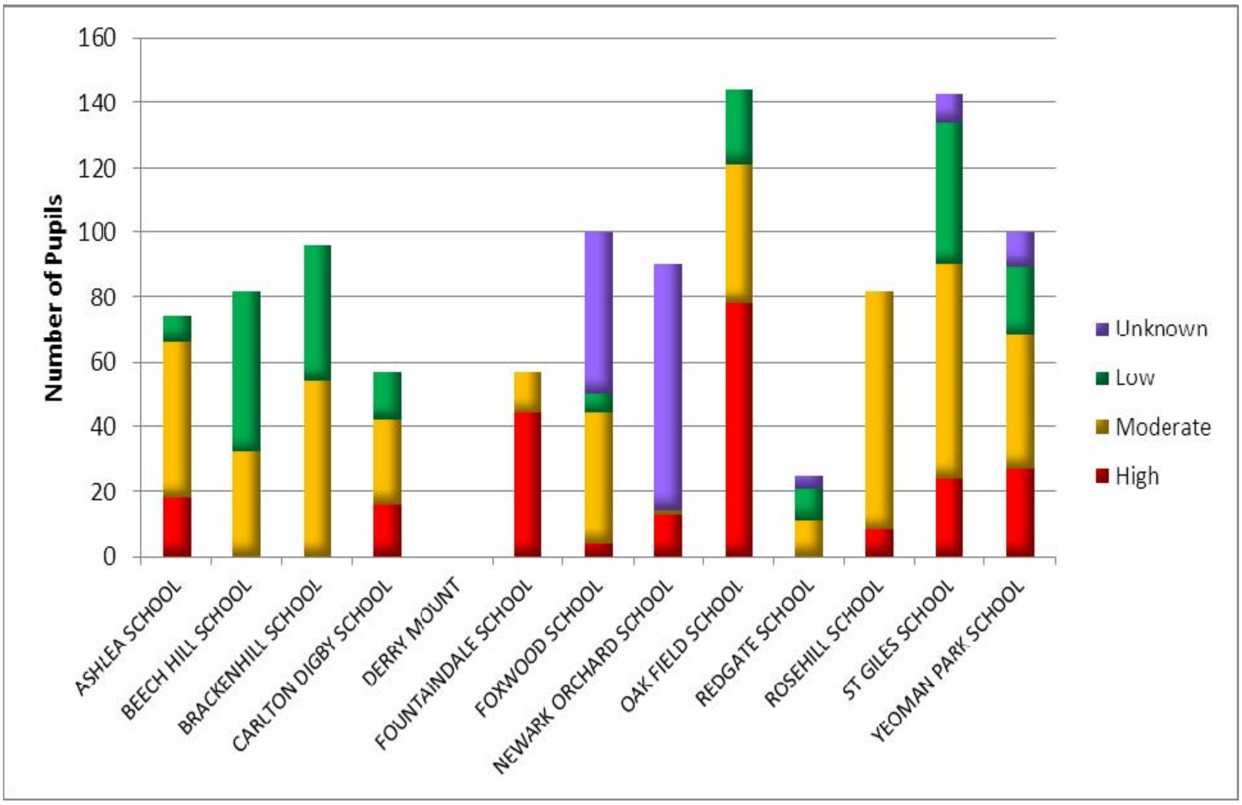
9. Need by school

Overall

The following diagram shows the percentage of pupils in various need categories by school: Oakfield and Fountaindale schools have highest percentage of pupils with the most complex/highest level needs; Beech Hill and Redgate have a greater proportion of pupils with moderate/low need.

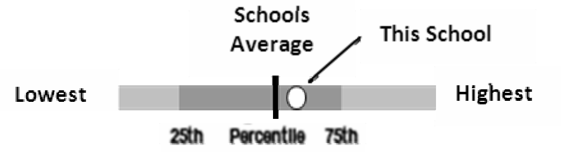


The following diagram shows the number of pupils in various need categories by school. Oakfield has the highest number of high need pupils and Beech Hill the lowest. Derry Mount School is unknown.



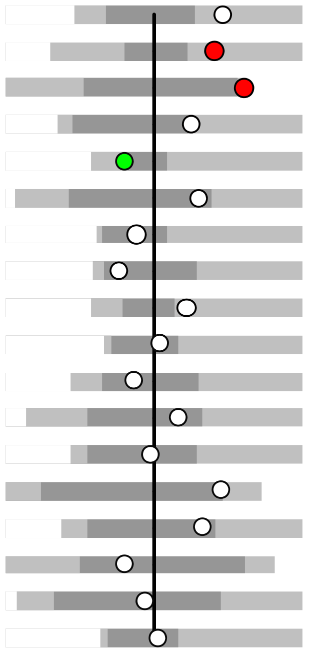
10. Individual school profiles (spine chart comparisons with key)

🔴 Significantly better than Schools average
○ Not significantly different from Schools average
🟢 Significantly worse than Schools average



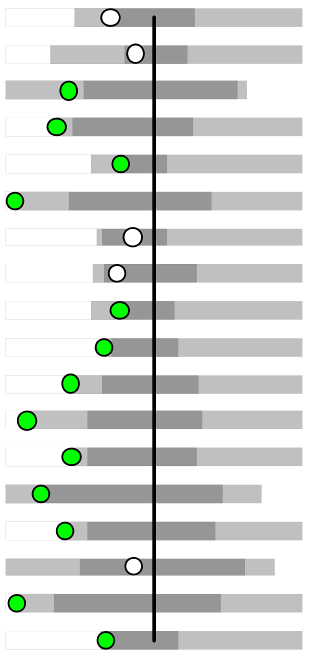
ASHLEA

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	11	14.9	8.0	0.0	○	22.8
2	**Behaviour**	44	59.5	40.0	6.7	🔴	87.8
3	**Communication**	60	81.1	56.3	15.6	🔴	82.0
4	**Continence**	41	55.4	42.7	9.8	○	93.0
5	**Emotional Health**	12	16.2	30.3	1.1	🟢	100.0
6	**Feeding**	42	56.8	43.7	2.4	○	87.7
7	**Hearing**	3	4.1	5.9	0.0	○	21.1
8	**Injection/Pump**	1	1.4	3.1	0.0	○	10.5
9	**Meds**	31	41.9	30.4	8.5	○	82.5
10	**Moving and Handling**	20	27.0	23.8	0.0	○	94.7
11	**Occupational Therapy**	21	28.4	36.7	1.2	○	100.0
12	**Personal Care**	44	59.5	52.3	15.6	○	94.7
13	**Physiotherapy**	26	35.1	36.6	1.2	○	100.0
14	**SALT**	52	70.3	53.0	15.6	○	80.0
15	**Seizures**	22	29.7	21.7	6.7	○	45.6
16	**Sight**	17	23.0	27.9	2.4	○	48.6
17	**Sleep**	15	20.3	21.1	7.3	○	36.0
18	**Wheelchair**	20	27.0	25.0	0.0	○	94.7

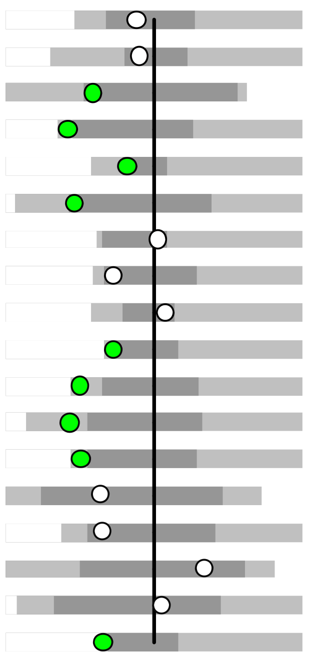


BEECH HILL

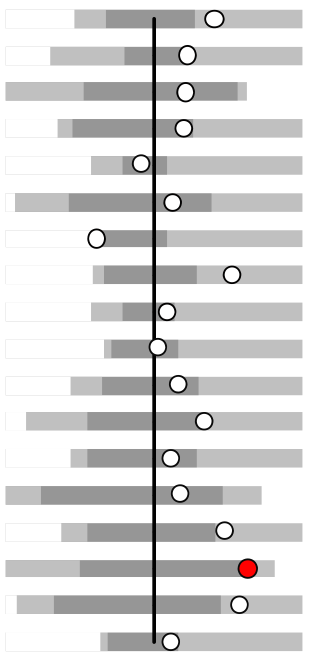
	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	3	3.7	8.0	0.0	○	22.8
2	**Behaviour**	28	34.1	40.0	6.7	○	87.8
3	**Communication**	27	32.9	56.3	15.6	🟢	82.0
4	**Continence**	8	9.8	42.7	9.8	🟢	93.0
5	**Emotional Health**	12	14.6	30.3	1.1	🟢	100.0
6	**Feeding**	2	2.4	43.7	2.4	🟢	87.7
7	**Hearing**	3	3.7	5.9	0.0	○	21.1
8	**Injection/Pump**	1	1.2	3.1	0.0	○	10.5
9	**Meds**	15	18.3	30.4	8.5	🟢	82.5
10	**Moving and Handling**	0	0.0	23.8	0.0	🟢	94.7
11	**Occupational Therapy**	1	1.2	36.7	1.2	🟢	100.0
12	**Personal Care**	13	15.9	52.3	15.6	🟢	94.7
13	**Physiotherapy**	1	1.2	36.6	1.2	🟢	100.0
14	**SALT**	20	24.4	53.0	15.6	🟢	80.0
15	**Seizures**	6	7.3	21.7	6.7	🟢	45.6
16	**Sight**	20	24.4	27.9	2.4	○	48.6
17	**Sleep**	6	7.3	21.1	7.3	🟢	36.0
18	**Wheelchair**	2	2.4	25.0	0.0	🟢	94.7



BRACKENHILL

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	6	6.3	8.0	0.0		22.8
2	**Behaviour**	34	35.4	40.0	6.7		87.8
3	**Communication**	38	39.6	56.3	15.6		82.0
4	**Continence**	13	13.5	42.7	9.8		93.0
5	**Emotional Health**	17	17.7	30.3	1.1		100.0
6	**Feeding**	19	19.8	43.7	2.4		87.7
7	**Hearing**	6	6.3	5.9	0.0		21.1
8	**Injection/Pump**	1	1.0	3.1	0.0		10.5
9	**Meds**	33	34.4	30.4	8.5		82.5
10	**Moving and Handling**	4	4.2	23.8	0.0		94.7
11	**Occupational Therapy**	5	5.2	36.7	1.2		100.0
12	**Personal Care**	27	28.1	52.3	15.6		94.7
13	**Physiotherapy**	5	5.2	36.6	1.2		100.0
14	**SALT**	38	39.6	53.0	15.6		80.0
15	**Seizures**	13	13.5	21.7	6.7		45.6
16	**Sight**	35	36.5	27.9	2.4		48.6
17	**Sleep**	21	21.9	21.1	7.3		36.0
18	**Wheelchair**	1	1.0	25.0	0.0		94.7

CARLTON DIGBY

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	8	14.0	8.0	0.0		22.8
2	**Behaviour**	29	50.9	40.0	6.7		87.8
3	**Communication**	37	64.9	56.3	15.6		82.0
4	**Continence**	30	52.6	42.7	9.8		93.0
5	**Emotional Health**	14	24.6	30.3	1.1		100.0
6	**Feeding**	28	49.1	43.7	2.4		87.7
7	**Hearing**	0	0.0	5.9	0.0		21.1
8	**Injection/Pump**	4	7.0	3.1	0.0		10.5
9	**Meds**	20	35.1	30.4	8.5		82.5
10	**Moving and Handling**	15	26.3	23.8	0.0		94.7
11	**Occupational Therapy**	27	47.4	36.7	1.2		100.0
12	**Personal Care**	38	66.7	52.3	15.6		94.7
13	**Physiotherapy**	25	43.9	36.6	1.2		100.0
14	**SALT**	34	59.6	53.0	15.6		80.0
15	**Seizures**	19	33.3	21.7	6.7		45.6
16	**Sight**	25	43.9	27.9	2.4		48.6
17	**Sleep**	17	29.8	21.1	7.3		36.0
18	**Wheelchair**	19	33.3	25.0	0.0		94.7

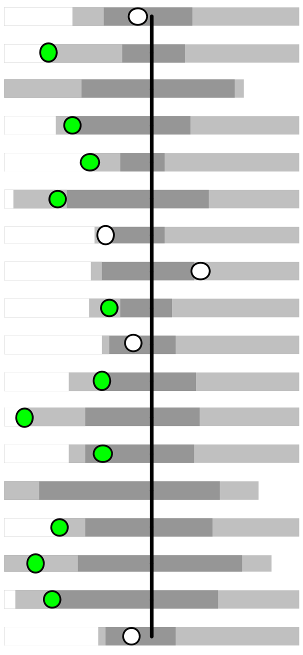
FOUNTAINDALE

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	13	22.8	8.0	0.0	🔴	22.8
2	**Behaviour**	9	15.8	40.0	6.7	🟢	87.8
3	**Communication**	44	77.2	56.3	15.6	○	82.0
4	**Continence**	53	93.0	42.7	9.8	🔴	93.0
5	**Emotional Health**	34	59.6	30.3	1.1	🔴	100.0
6	**Feeding**	50	87.7	43.7	2.4	🔴	87.7
7	**Hearing**	12	21.1	5.9	0.0	🔴	21.1
8	**Injection/Pump**	6	10.5	3.1	0.0	🔴	10.5
9	**Meds**	47	82.5	30.4	8.5	🔴	82.5
10	**Moving and Handling**	54	94.7	23.8	0.0	🔴	94.7
11	**Occupational Therapy**	55	96.5	36.7	1.2	🔴	100.0
12	**Personal Care**	54	94.7	52.3	15.6	🔴	94.7
13	**Physiotherapy**	53	93.0	36.6	1.2	🔴	100.0
14	**SALT**	34	59.6	53.0	15.6	○	80.0
15	**Seizures**	26	45.6	21.7	6.7	🔴	45.6
16	**Sight**	25	43.9	27.9	2.4	🔴	48.6
17	**Sleep**	17	29.8	21.1	7.3	○	36.0
18	**Wheelchair**	54	94.7	25.0	0.0	🔴	94.7

FOXWOOD

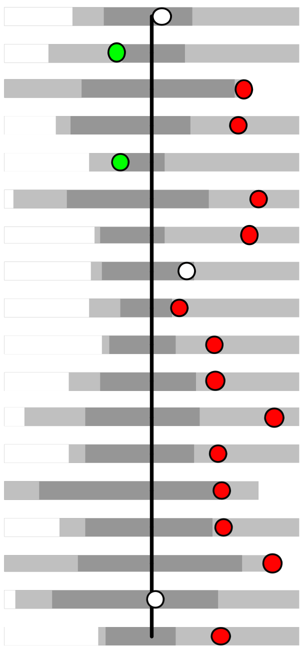
	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	2	2.0	8.0	0.0	🟢	22.8
2	**Behaviour**	32	32.0	40.0	6.7	○	87.8
3	**Communication**	23	23.0	56.3	15.6	🟢	82.0
4	**Continence**	15	15.0	42.7	9.8	🟢	93.0
5	**Emotional Health**	44	44.0	30.3	1.1	🔴	100.0
6	**Feeding**	16	16.0	43.7	2.4	🟢	87.7
7	**Hearing**	6	6.0	5.9	0.0	○	21.1
8	**Injection/Pump**	2	2.0	3.1	0.0	○	10.5
9	**Meds**	22	22.0	30.4	8.5	○	82.5
10	**Moving and Handling**	3	3.0	23.8	0.0	🟢	94.7
11	**Occupational Therapy**	24	24.0	36.7	1.2	🟢	100.0
12	**Personal Care**	37	37.0	52.3	15.6	🟢	94.7
13	**Physiotherapy**	11	11.0	36.6	1.2	🟢	100.0
14	**SALT**	23	23.0	53.0	15.6	🟢	80.0
15	**Seizures**	14	14.0	21.7	6.7	○	45.6
16	**Sight**	10	10.0	27.9	2.4	🟢	48.6
17	**Sleep**	9	9.0	21.1	7.3	🟢	36.0
18	**Wheelchair**	4	4.0	25.0	0.0	🟢	94.7

NEWARK ORCHARD



NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1 **Airway**	6	6.7	8.0	0.0	○	22.8
2 **Behaviour**	6	6.7	40.0	6.7	🟢	87.8
3 **Communication**	14	15.6	56.3	15.6		82.0
4 **Continence**	14	15.6	42.7	9.8	🟢	93.0
5 **Emotional Health**	1	1.1	30.3	1.1	🟢	100.0
6 **Feeding**	14	15.6	43.7	2.4	🟢	87.7
7 **Hearing**	1	1.1	5.9	0.0	○	21.1
8 **Injection/Pump**	5	5.6	3.1	0.0	○	10.5
9 **Meds**	14	15.6	30.4	8.5	🟢	82.5
10 **Moving and Handling**	14	15.6	23.8	0.0	○	94.7
11 **Occupational Therapy**	14	15.6	36.7	1.2	🟢	100.0
12 **Personal Care**	14	15.6	52.3	15.6	🟢	94.7
13 **Physiotherapy**	14	15.6	36.6	1.2	🟢	100.0
14 **SALT**	14	15.6	53.0	15.6		80.0
15 **Seizures**	6	6.7	21.7	6.7	🟢	45.6
16 **Sight**	7	7.8	27.9	2.4	🟢	48.6
17 **Sleep**	10	11.1	21.1	7.3	🟢	36.0
18 **Wheelchair**	14	15.6	25.0	0.0	○	94.7

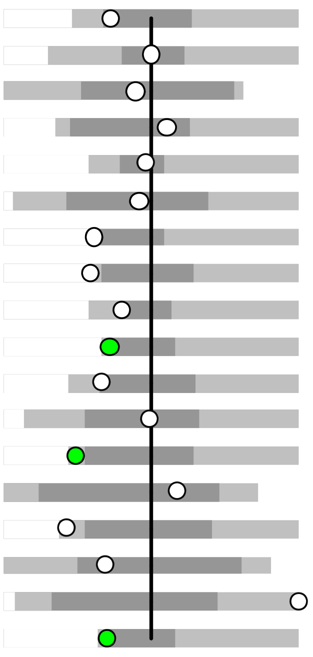
OAK FIELD



NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1 **Airway**	13	9.0	8.0	0.0	○	22.8
2 **Behaviour**	41	28.5	40.0	6.7	🟢	87.8
3 **Communication**	118	81.9	56.3	15.6	🔴	82.0
4 **Continence**	104	72.2	42.7	9.8	🔴	93.0
5 **Emotional Health**	22	15.3	30.3	1.1	🟢	100.0
6 **Feeding**	109	75.7	43.7	2.4	🔴	87.7
7 **Hearing**	23	16.0	5.9	0.0	🔴	21.1
8 **Injection/Pump**	7	4.9	3.1	0.0	○	10.5
9 **Meds**	58	40.3	30.4	8.5	🔴	82.5
10 **Moving and Handling**	78	54.2	23.8	0.0	🔴	94.7
11 **Occupational Therapy**	92	63.9	36.7	1.2	🔴	100.0
12 **Personal Care**	126	87.5	52.3	15.6	🔴	94.7
13 **Physiotherapy**	94	65.3	36.6	1.2	🔴	100.0
14 **SALT**	102	70.8	53.0	15.6	🔴	80.0
15 **Seizures**	48	33.3	21.7	6.7	🔴	45.6
16 **Sight**	70	48.6	27.9	2.4	🔴	48.6
17 **Sleep**	31	21.5	21.1	7.3	○	36.0
18 **Wheelchair**	83	57.6	25.0	0.0	🔴	94.7

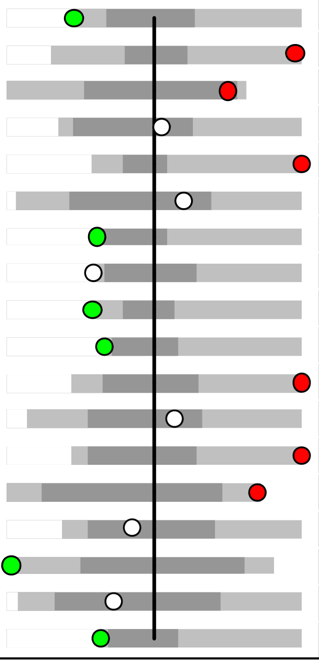
REDGATE

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	1	4.0	8.0	0.0	○	22.8
2	**Behaviour**	10	40.0	40.0	6.7	○	87.8
3	**Communication**	13	52.0	56.3	15.6	○	82.0
4	**Continence**	12	48.0	42.7	9.8	○	93.0
5	**Emotional Health**	7	28.0	30.3	1.1	○	100.0
6	**Feeding**	10	40.0	43.7	2.4	○	87.7
7	**Hearing**	0	0.0	5.9	0.0	○	21.1
8	**Injection/Pump**	0	0.0	3.1	0.0	○	10.5
9	**Meds**	5	20.0	30.4	8.5	○	82.5
10	**Moving and Handling**	1	4.0	23.8	0.0	🟢	94.7
11	**Occupational Therapy**	4	16.0	36.7	1.2	○	100.0
12	**Personal Care**	13	52.0	52.3	15.6	○	94.7
13	**Physiotherapy**	1	4.0	36.6	1.2	🟢	100.0
14	**SALT**	15	60.0	53.0	15.6	○	80.0
15	**Seizures**	2	8.0	21.7	6.7	○	45.6
16	**Sight**	5	20.0	27.9	2.4	○	48.6
17	**Sleep**	9	36.0	21.1	7.3	○	36.0
18	**Wheelchair**	1	4.0	25.0	0.0	🟢	94.7

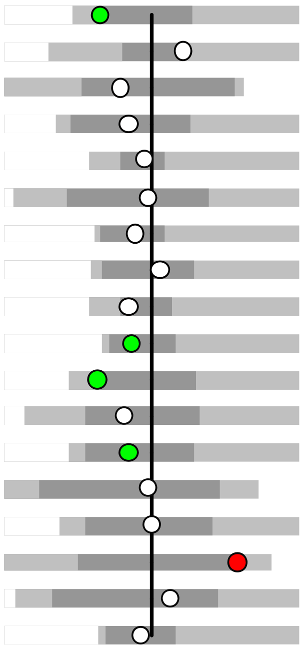


ROSE HILL

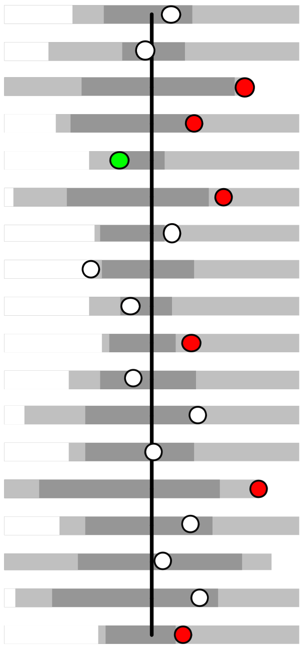
	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	0	0.0	8.0	0.0	🟢	22.8
2	**Behaviour**	72	87.8	40.0	6.7	🔴	87.8
3	**Communication**	63	76.8	56.3	15.6	🔴	82.0
4	**Continence**	37	45.1	42.7	9.8	○	93.0
5	**Emotional Health**	82	100.0	30.3	1.1	🔴	100.0
6	**Feeding**	43	52.4	43.7	2.4	○	87.7
7	**Hearing**	0	0.0	5.9	0.0	🟢	21.1
8	**Injection/Pump**	0	0.0	3.1	0.0	○	10.5
9	**Meds**	7	8.5	30.4	8.5	🟢	82.5
10	**Moving and Handling**	0	0.0	23.8	0.0	🟢	94.7
11	**Occupational Therapy**	82	100.0	36.7	1.2	🔴	100.0
12	**Personal Care**	48	58.5	52.3	15.6	○	94.7
13	**Physiotherapy**	82	100.0	36.6	1.2	🔴	100.0
14	**SALT**	65	79.3	53.0	15.6	🔴	80.0
15	**Seizures**	15	18.3	21.7	6.7	○	45.6
16	**Sight**	2	2.4	27.9	2.4	🟢	48.6
17	**Sleep**	14	17.1	21.1	7.3	○	36.0
18	**Wheelchair**	0	0.0	25.0	0.0	🟢	94.7



ST GILES

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	4	2.8	8.0	0.0		22.8
2	**Behaviour**	72	50.3	40.0	6.7		87.8
3	**Communication**	68	47.6	56.3	15.6		82.0
4	**Continence**	50	35.0	42.7	9.8		93.0
5	**Emotional Health**	39	27.3	30.3	1.1		100.0
6	**Feeding**	61	42.7	43.7	2.4		87.7
7	**Hearing**	6	4.2	5.9	0.0		21.1
8	**Injection/Pump**	5	3.5	3.1	0.0		10.5
9	**Meds**	32	22.4	30.4	8.5		82.5
10	**Moving and Handling**	20	14.0	23.8	0.0		94.7
11	**Occupational Therapy**	19	13.3	36.7	1.2		100.0
12	**Personal Care**	64	44.8	52.3	15.6		94.7
13	**Physiotherapy**	38	26.6	36.6	1.2		100.0
14	**SALT**	75	52.4	53.0	15.6		80.0
15	**Seizures**	31	21.7	21.7	6.7		45.6
16	**Sight**	61	42.7	27.9	2.4		48.6
17	**Sleep**	33	23.1	21.1	7.3		36.0
18	**Wheelchair**	29	20.3	25.0	0.0		94.7

YEOMAN PARK

	NEED	Number	%	All Schools Avg	All Schools Lowest	Schools Range	All Schools Best
1	**Airway**	10	10.0	8.0	0.0		22.8
2	**Behaviour**	38	38.0	40.0	6.7		87.8
3	**Communication**	82	82.0	56.3	15.6		82.0
4	**Continence**	57	57.0	42.7	9.8		93.0
5	**Emotional Health**	15	15.0	30.3	1.1		100.0
6	**Feeding**	65	65.0	43.7	2.4		87.7
7	**Hearing**	8	8.0	5.9	0.0		21.1
8	**Injection/Pump**	0	0.0	3.1	0.0		10.5
9	**Meds**	23	23.0	30.4	8.5		82.5
10	**Moving and Handling**	43	43.0	23.8	0.0		94.7
11	**Occupational Therapy**	29	29.0	36.7	1.2		100.0
12	**Personal Care**	66	66.0	52.3	15.6		94.7
13	**Physiotherapy**	38	38.0	36.6	1.2		100.0
14	**SALT**	80	80.0	53.0	15.6		80.0
15	**Seizures**	28	28.0	21.7	6.7		45.6
16	**Sight**	30	30.0	27.9	2.4		48.6
17	**Sleep**	26	26.0	21.1	7.3		36.0
18	**Wheelchair**	40	40.0	25.0	0.0		94.7

11. Preliminary observations

City schools seem to draw from a wide area rather than the local population. This may be related to the nature of the needs and school provision but reasons for this could be further explored.

It is not clear although it is thought to be likely that this is a historical legacy arising from the fact that Autism based provision is based in the city and that children and young people with these needs are placed there.

There is a strong relationship between level of need and deprivation. The gradient is reproduced within each need level, and may reflect prevalence of need or resources available within the family.

Expressed needs may reflect ability to address needs within the mainstream provision, particularly for those with ‘low needs’. Provision within special schools therefore needs to be considered in the context of wider provision.

There is considerable heterogeneity in schools: sizes and level and nature of needs amongst pupils making comparison from this data at the school level difficult. Further work could establish clusters of types of need seen typically together and spine chart type analyses help to characterise pupil need for services at the individual school level. However, interpretation of the data may need to take into account variability in criteria / thresholds between schools for assessing need. The (Project Group) report recommends that a pool of knowledgeable head teachers from special schools is available to consult and comment on provision planning to potentially reduce ‘out of county’ provision.

Ann Berry

Public Health Manager (& Project Lead)

NHS Nottinghamshire County

December 2011

APPENDIX THREE
Special School Catchment area and school pupil residence tables

Notes regarding the following tables:

1. Initial data for Nottinghamshire Special School pupils was taken from the School Census (October 2009), with additional data from Capita ONE (eg. home address) and GIS software (District / Ward identification)
2. Includes pupils who are sole or dual main registrations
3. Excludes pupils with a confidential address
4. Numbers from 1 to 5 inclusive have been suppressed and replaced in the table by a cross (x)
5. Where the value is zero, this has been replaced in the table by a hyphen (-)

Figure 3A.1 Number of Special School Pupils living in Ashfield District by designated School and ward of residence

		Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**			**Newark & Sherwood**	**Rushcliffe**	**Total by Ward**
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Ashfield	Hucknall Central	x	x	-	x	-	-	-	-	x	-	-	4+
	Hucknall East	x	-	-	x	-	-	-	-	-	-	-	2+
	Hucknall North	x	x	-	-	x	-	-	-	-	-	-	3+
	Hucknall West	9	x	-	x	x	x	-	-	x	-	-	14+
	Jacksdale	x	-	-	-	-	-	-	-	-	-	-	1+
	Kirkby in Ashfield Central	x	-	-	-	-	-	-	-	x	-	-	2+
	Kirkby in Ashfield East	13	x	-	-	x	-	x	x	-	-	-	17+
	Kirkby in Ashfield West	x	-	-	-	-	-	x	-	x	-	-	3+
	Selston	x	x	-	x	-	-	-	-	x	-	-	4+
	Sutton in Ashfield Central	x	-	x	-	-	-	x	x	x	-	-	5+
	Sutton in Ashfield East	13	x	-	-	-	-	x	-	x	-	-	16+
	Sutton in Ashfield North	6	-	-	-	-	-	x	-	8	-	-	15+
	Sutton in Ashfield West	x	x	-	-	x	-	x	x	x	-	-	6+
	Underwood	x	-	-	x	-	-	-	-	x	-	-	3+
	Woodhouse	x	-	-	-	-	-	-	-	-	-	-	1+
	Total by Notts Special School	**52+**	**7+**	**1+**	**5+**	**4+**	**1+**	**6+**	**3+**	**17+**	**0**	**0**	**143**

Figure 3A.2 Number of special school pupils living in Bassetlaw District by designated school and ward of residence

		Ashfield		Bassetlaw	Broxtowe	Gedling		Mansfield			Newark & Sherwood	Rushcliffe	Total by Ward
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Bassetlaw	Beckingham	-	-	x	-	-	-	-	-	-	-	-	1+
	Blyth	-	-	x	-	-	-	-	-	-	-	-	1+
	Carlton	-	-	16	-	-	-	-	-	-	-	-	16
	Clayworth	-	-	x	-	-	-	-	-	-	-	-	1+
	East Markham	-	-	x	-	-	-	-	-	-	-	-	1+
	East Retford East	-	-	x	-	-	-	-	-	-	-	-	1+
	East Retford North	-	-	13	-	-	-	-	-	-	-	-	13
	East Retford South	-	-	x	-	-	-	-	-	-	-	-	1+
	East Retford West	-	-	10	-	-	-	-	-	-	-	-	10
	Everton	-	-	x	-	-	-	-	-	-	-	-	1+
	Harworth	-	-	8	-	-	-	-	-	-	-	-	8
	Langold	-	-	6	-	-	-	-	-	-	-	-	6
	Misterton	-	-	x	-	-	-	-	-	-	-	-	1+
	Rampton	-	-	x	-	-	-	-	-	-	-	-	1+
	Ranskill	-	-	x	-	-	-	-	-	-	-	-	1+
	Sturton	-	-	x	-	-	-	-	-	-	-	-	1+
	Sutton	-	-	x	-	-	-	-	-	-	-	-	1+
	Tuxford and Trent	-	-	6	-	-	-	-	-	-	x	-	7+
	Welbeck	-	-	x	-	-	-	-	x	-	-	-	2+
	Worksop East	-	x	12	-	-	-	-	-	-	-	-	13+
	Worksop North East	-	x	x	-	-	-	-	-	-	-	-	2+
	Worksop North	-	x	8	-	-	-	-	-	-	-	-	9+
	Worksop North West	-	x	x	-	-	-	-	-	-	-	-	2+
	Worksop South East	-	-	7	-	-	-	-	-	-	-	-	7

	Worksop South	-	-	x	-	-	-	-	-	-	-	-	1+
Total by Notts Special School		**0**	**4+**	**102+**	**0**	**0**	**0**	**0**	**1+**	**0**	**1+**	**0**	**131**

Figure 3A.3 Number of special school pupils living in Broxtowe Borough by designated school and ward of residence

		Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**			**Newark and Sherwood**	**Rushcliffe**	**Total by Ward**
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Broxtowe	Attenborough	-	-	-	x	-	-	-	-	-	-	-	1+
	Awsworth	-	-	-	x	-	-	-	-	-	-	-	1+
	Beeston Central	-	-	-	x	-	-	-	-	-	-	-	1+
	Beeston North	-	-	-	x	-	-	-	-	-	-	x	2+
	Beeston Rylands	-	-	-	x	-	-	-	-	-	-	-	1+
	Beeston West	-	-	-	x	-	-	-	-	-	-	-	1+
	Bramcote	-	-	-	x	-	-	-	-	-	-	-	1+
	Brinsley	x	x	-	x	-	-	-	-	-	-	-	3+
	Chilwell East	-	-	-	x	-	-	-	-	-	-	x	2+
	Chilwell West	-	-	-	6	-	-	-	-	-	-	-	6
	Cossall and Kimberley	x	x	-	x	-	-	-	-	-	-	-	3+
	Eastwood North and Greasley (Beauvale)	-	-	-	x	-	-	-	-	-	-	-	1+
	Eastwood South	-	x	-	8	x	-	-	-	-	-	-	10+
	Greasley (Giltbrook and Newthorpe)	-	-	-	x	x	-	-	-	-	-	-	2+
	Nuthall East and Strelley	-	-	-	x	-	-	-	-	-	-	-	1+
	Nuthall West and Greasley (Watnall)	-	-	-	x	-	-	-	-	-	-	-	1+
	Stapleford North	-	-	-	x	-	-	-	-	-	-	-	1+
	Stapleford South East	-	x	-	-	-	-	-	-	-	-	-	1+

	Stapleford South West	-	-	-	x	-	-	-	-	-	-	-	1+
	Toton and Chilwell Meadows	-	-	-	x	x	x	-	-	-	-	-	3+
Total by Notts Special School		**2+**	**4+**	**0**	**31+**	**3+**	**1+**	**0**	**0**	**0**	**0**	**2+**	**72**

Figure 3A.4 Number of special school pupils living in Gedling Borough by designated school and ward of residence

		Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**			**Newark and Sherwood**	**Rushcliffe**	**Total by Ward**
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Gedling	Bestwood Village	-	-	-	-	-	x	-	-	-	-	-	1+
	Bonington	-	-	-	-	x	x	-	-	-	-	-	2+
	Burton Joyce and Stoke Bardolph	-	-	-	-	-	x	-	-	-	-	-	1+
	Calverton	-	-	-	-	x	x	-	-	-	-	-	2+
	Carlton Hill	-	-	-	-	x	x	-	-	-	x	-	3+
	Carlton	-	-	-	x	-	x	-	-	-	-	-	2+
	Daybrook	-	-	-	-	x	x	-	-	-	-	-	2+
	Gedling	-	-	-	-	x	x	-	-	-	-	x	3+
	Killisick	x	-	-	-	-	-	-	-	-	-	-	1+
	Kingswell	-	-	-	x	-	x	-	-	-	-	-	2+
	Lambley	-	x	-	-	-	-	-	-	-	-	x	2+
	Mapperley Plains	-	x	-	-	x	x	-	-	-	-	x	4+
	Netherfield and Colwick	-	x	-	-	-	x	-	-	-	-	-	2+
	Phoenix	-	-	-	-	-	x	-	-	-	-	-	1+
	Porchester	-	-	-	x	-	x	-	-	-	x	x	4+
	Ravenshead	-	x	-	-	-	-	-	-	x	-	-	2+
	St. James	-	-	-	-	x	x	-	-	-	-	x	3+

	St. Mary's	-	-	-	-	x	6	-	-	-	-	-	7+
	Valley	-	-	-	-	x	x	-	-	-	-	-	2+
	Woodborough	-	-	-	-	-	-	-	-	-	-	x	1+
	Woodthorpe	-	-	-	-	x	x	-	-	-	-	x	3+
Total by Notts Special School		**1+**	**4+**	**0**	**3+**	**10+**	**22+**	**0**	**0**	**1+**	**2+**	**7+**	**86**

Figure 3A.5 Number of special school pupils living in Mansfield District by designated school and ward of residence

		Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**			**Newark and Sherwood**	**Rushcliffe**	**Total by Ward**
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Mansfield	Abbott	-	-	-	-	-	-	-	-	x	-	-	1+
	Berry Hill	-	x	-	-	-	-	-	-	-	-	-	1+
	Brick Kiln	-	x	-	-	-	-	x	-	-	-	-	2+
	Broomhill	-	-	-	-	-	-	x	-	-	-	-	1+
	Bull Farm and Pleasley Hill	-	-	-	-	-	-	x	-	x	x	-	3+
	Carr Bank	-	-	-	-	x	-	x	-	-	-	-	2+
	Grange Farm	-	-	-	-	-	-	-	-	x	-	-	1+
	Holly	-	-	-	-	-	-	x	-	x	-	-	2+
	Kings Walk	-	x	-	-	-	-	-	-	-	-	-	1+
	Kingsway	-	-	-	-	-	-	-	-	x	-	-	1+
	Ladybrook	-	-	-	-	-	-	x	-	x	-	-	2+
	Manor	-	-	-	-	-	-	-	-	x	-	-	1+
	Market Warsop	-	-	-	-	-	-	x	x	-	-	-	2+
	Maun Valley	-	-	-	-	-	-	x	x	-	-	-	2+
	Meden	-	x	-	-	-	-	-	-	x	-	-	2+
	Netherfield	-	-	-	-	-	-	x	-	-	-	-	1+
	Newgate	-	-	-	-	-	-	-	-	x	-	-	1+

	Newlands	-	x	-	-	-	-	-	x	-	-	-	2+
	Oak Tree	-	x	-	-	-	-	x	-	-	-	-	2+
	Oakham	x	-	-	-	x	-	x	-	x	-	-	4+
	Park Hall	x	x	-	-	-	-	-	-	x	-	-	3+
	Peafields	-	-	-	-	-	-	x	-	-	-	-	1+
	Penniment	x	x	-	-	-	-	x	x	x	-	-	5+
	Racecourse	-	-	-	-	-	-	-	-	x	-	-	1+
	Ransom	x	-	-	-	-	-	-	-	-	-	-	1+
	Sandhurst	-	-	-	-	-	-	x	-	x	-	-	2+
	Warsop Carrs	-	-	-	-	-	-	x	x	-	-	-	2+
	Woodhouse	-	x	-	-	-	-	x	-	x	-	-	3+
	Yeoman Hill	-	-	-	-	-	-	-	x	x	-	-	2+
Total by Notts Special School		**4+**	**9+**	**0**	**0**	**2+**	**0**	**16+**	**6+**	**16+**	**1+**	**0**	**89**

Figure 3A.6 Number of special school pupils living in Newark & Sherwood District by designated school and ward of residence

		Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**			**Newark & Sherwood**	**Rushcliffe**	**Total by Ward**
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Newark and Sherwood	Balderton North	-	-	-	-	-	-	-	-	-	8	-	8
	Balderton West	-	-	-	-	-	-	-	-	-	8	-	8
	Beacon	-	x	-	-	-	-	-	-	-	x	-	2+
	Blidworth	-	-	-	-	-	-	x	-	x	x	-	3+
	Boughton	-	x	x	-	-	-	x	x	x	x	-	6+
	Bridge	-	-	-	-	-	-	-	-	-	6	-	6
	Castle	-	-	-	-	-	-	-	-	-	6	-	6
	Caunton	-	-	x	-	-	x	-	-	-	-	-	2+
	Clipstone	-	-	-	-	-	-	x	x	-	x	-	3+
	Collingham and Meering	-	-	-	-	-	-	-	-	-	x	-	1+

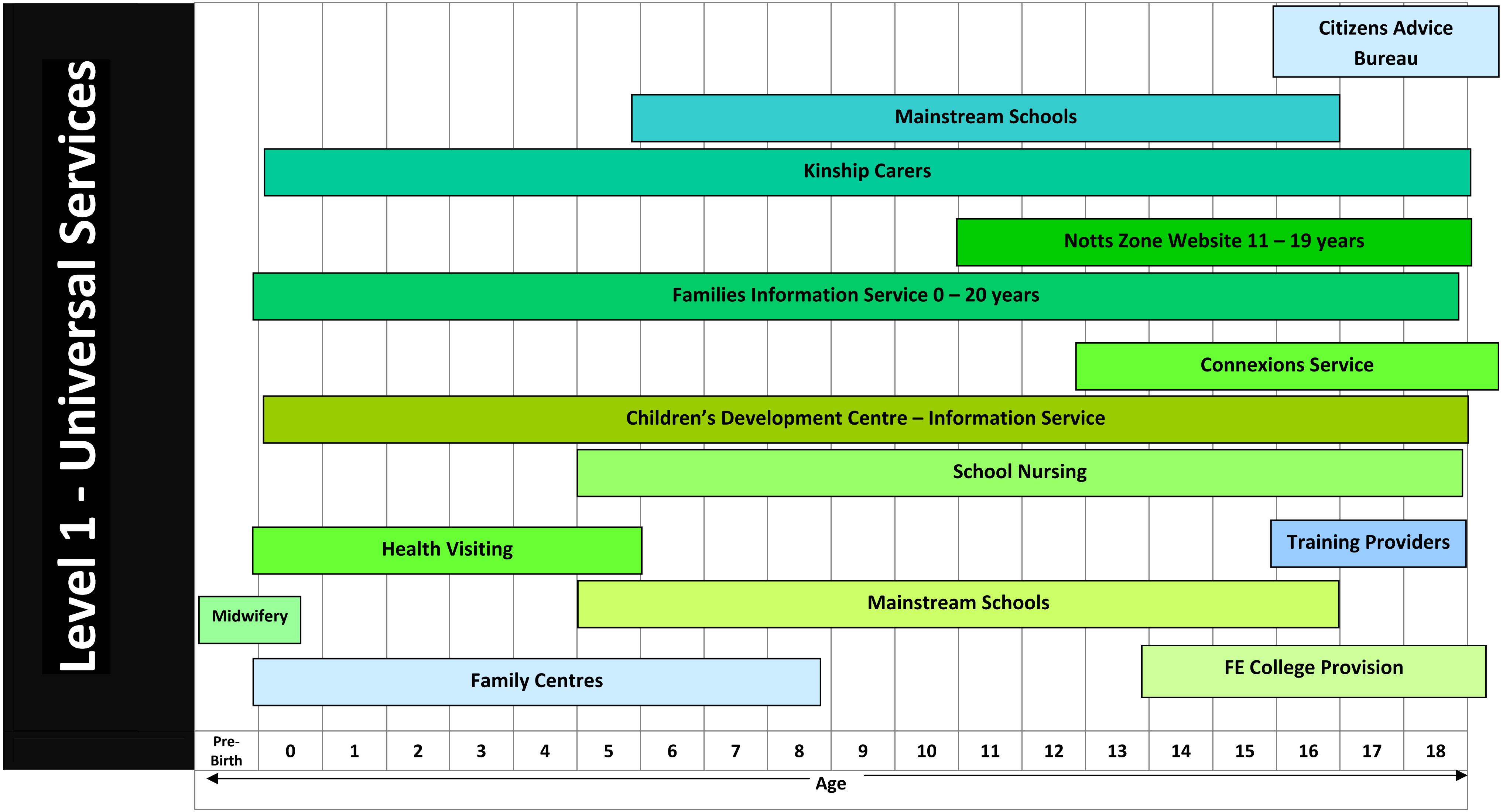
	Devon	-	-	-	-	-	-	-	-	-	10	x	11+
	Edwinstowe	-	x	-	-	-	-	x	x	x	x	-	5+
	Farndon	-	x	-	-	-	x	-	-	-	x	x	4+
	Farnsfield and Bilsthorpe	-	x	-	-	-	-	-	x	x	x	-	4+
	Lowdham	-	-	-	-	-	-	-	-	-	-	x	1+
	Magnus	-	-	-	-	-	-	-	-	-	7	-	7
	Muskham	-	-	-	-	-	-	-	-	-	x	-	1+
	Ollerton	-	x	-	-	-	-	6	x	x	x	-	10+
	Rainworth	-	x	x	-	-	-	x	x	x	-	-	5+
	Southwell East	-	x	-	-	-	-	-	-	x	x	x	4+
	Southwell North	-	-	-	-	-	-	-	-	-	x	-	1+
	Southwell West	-	x	-	-	-	-	-	-	-	x	-	2+
	Sutton-on-Trent	-	-	x	-	-	-	-	-	-	-	-	1+
Total by Notts Special School		**0**	**9+**	**4+**	**0**	**0**	**2+**	**11+**	**6+**	**7+**	**58+**	**4+**	**147**

Figure 3A.7 Number of special school pupils living in Rushcliffe Borough by designated school and ward of residence

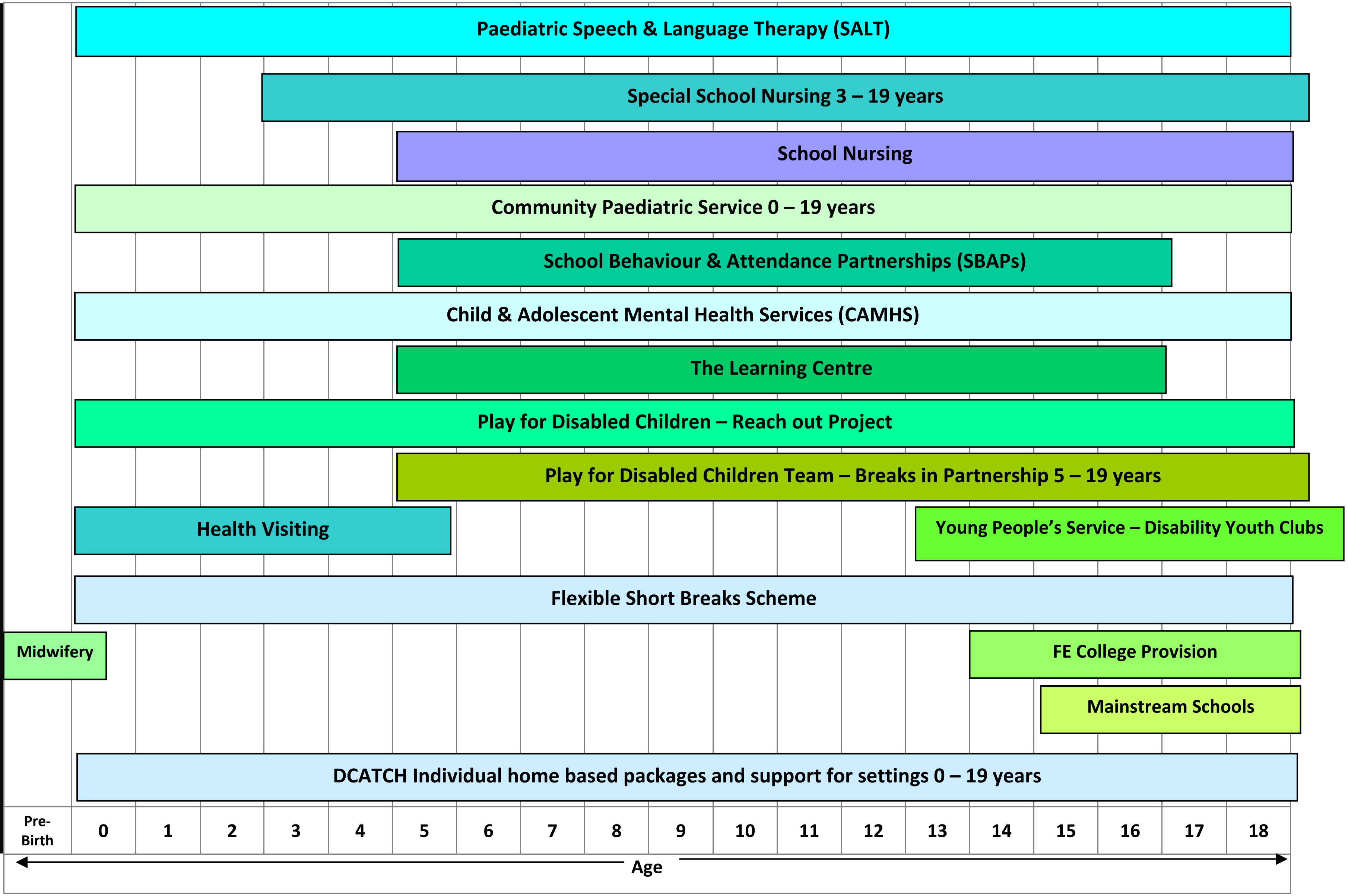
		Ashfield		**Bassetlaw**	**Broxtowe**	**Gedling**		**Mansfield**			**Newark & Sherwood**	**Rushcliffe**	**Total by Ward**
	Ward	Bracken Hill Special (Kirkby in Ashfield East Ward)	Fountaindale Special (Sutton in Ashfield East Ward)	St. Giles Special (East Retford West Ward)	Foxwood Special Foundation (Bramcote Ward)	Derrymount Special (St. Mary's Ward)	Digby Special (Porchester Ward)	Beech Hill Special (Abbott Ward)	Redgate Special (Broomhill Ward)	Yeoman Park Special (Park Hall Ward)	Orchard Special (Castle Ward)	Ash Lea Special (Cotgrave Ward)	
Rushcliffe	Abbey	-	-	-	x	-	-	-	-	-	-	x	2+
	Bingham East	-	-	-	-	-	-	-	-	-	x	x	2+
	Bingham West	-	-	-	-	x	-	-	-	-	-	x	2+
	Compton Acres	-	-	-	-	-	-	-	-	-	-	x	1+
	Cotgrave	-	-	-	-	-	x	-	-	-	-	x	2+
	Cranmer	-	-	-	-	-	-	-	-	-	-	x	1+
	Edwalton Village	-	-	-	-	-	-	-	-	-	-	x	1+
	Gamston	-	-	-	-	-	-	-	-	-	-	x	1+

	Gotham	-	-	-	-	x	-	-	-	-	-	-	1+
	Keyworth North	-	-	-	-	-	-	-	-	-	-	x	1+
	Keyworth South	-	-	-	-	-	-	-	-	-	x	x	2+
	Lady Bay	-	x	-	-	-	-	-	-	-	-	x	2+
	Leake	-	-	-	-	-	-	-	-	-	-	x	1+
	Lutterell	-	-	-	x	-	-	-	-	-	-	x	2+
	Melton	-	-	-	x	-	-	-	-	-	-	-	1+
	Musters	-	-	-	-	-	-	-	-	-	-	x	1+
	Oak	-	-	-	-	-	-	-	-	-	-	x	1+
	Ruddington	-	-	-	-	x	-	-	-	-	-	7	8+
	Stanford	-	-	-	-	-	-	-	-	-	-	x	1+
	Thoroton	-	x	-	-	-	-	-	-	-	-	-	1+
	Tollerton	-	-	-	-	x	-	-	-	-	-	x	2+
	Trent Bridge	-	-	-	-	-	-	-	-	-	-	x	1+
	Trent	-	-	-	-	-	-	-	-	-	x	-	1+
	Wiverton	-	x	-	x	-	-	-	-	-	x	x	4+
	Wolds	-	-	-	x	-	-	-	-	-	-	-	1+
Total by Notts Special School		**0**	**3+**	**0**	**5+**	**4+**	**1+**	**0**	**0**	**0**	**4+**	**26+**	**61**

APPENDIX FOUR



Level 2 – Early Intervention Services



Paediatric Speech & Language Therapy (SALT)

Special School Nursing 3 – 19 years

School Nursing

Community Paediatric Service 0 – 19 years

School Behaviour & Attendance Partnerships (SBAPs)

Child & Adolescent Mental Health Services (CAMHS)

The Learning Centre

Play for Disabled Children – Reach out Project

Play for Disabled Children Team – Breaks in Partnership 5 – 19 years

Health Visiting

Young People's Service – Disability Youth Clubs

Flexible Short Breaks Scheme

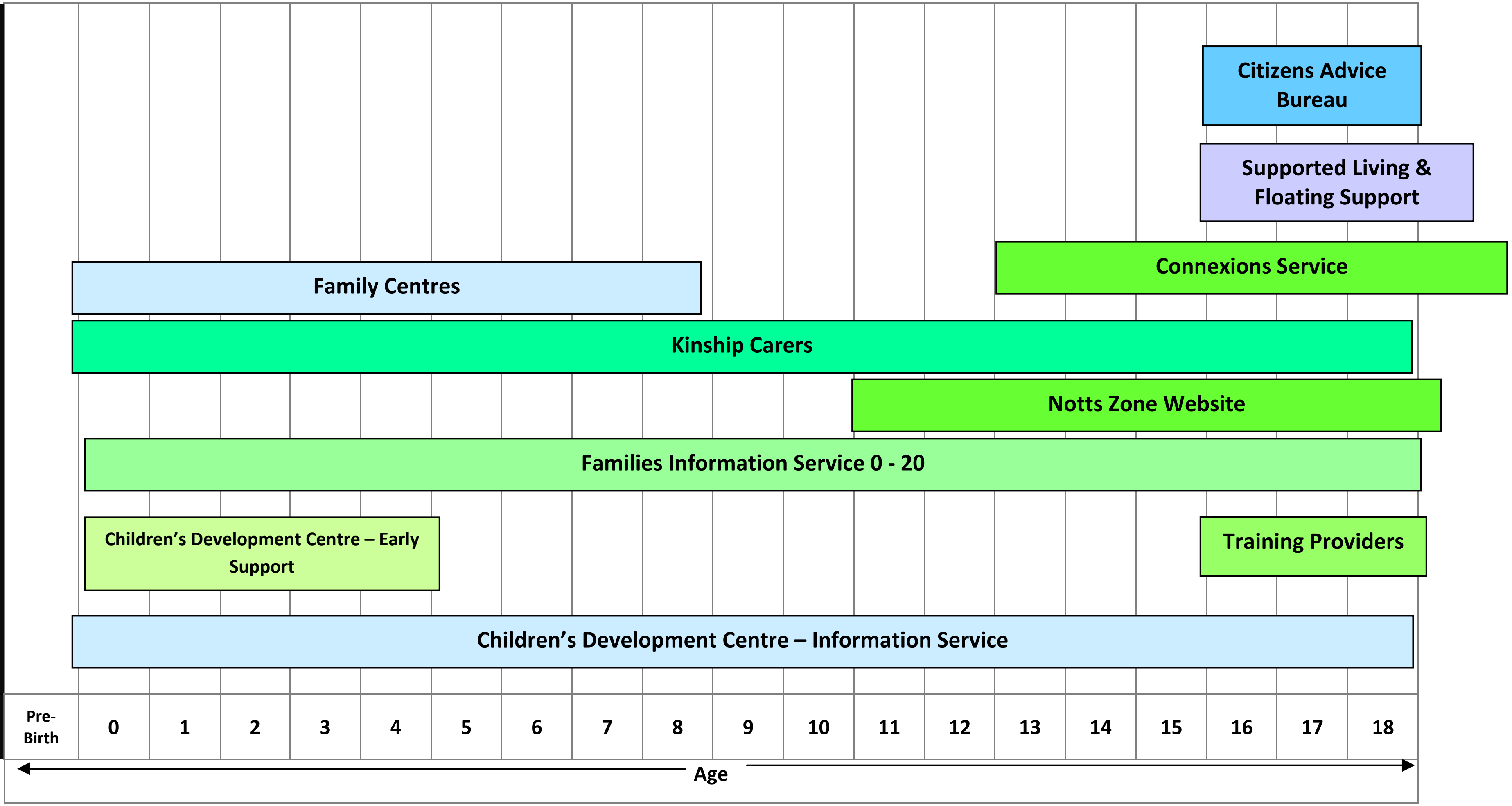
Midwifery

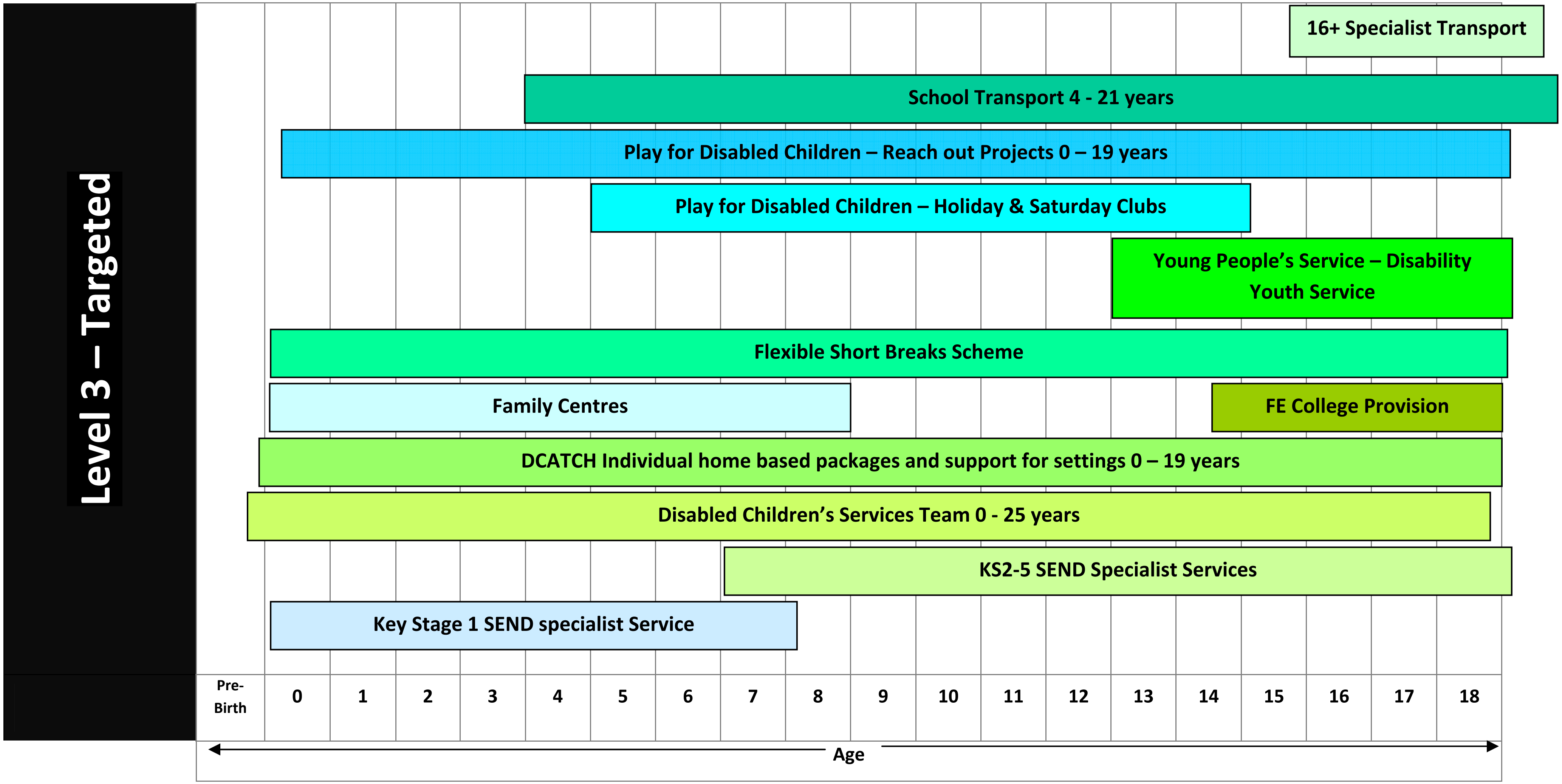
FE College Provision

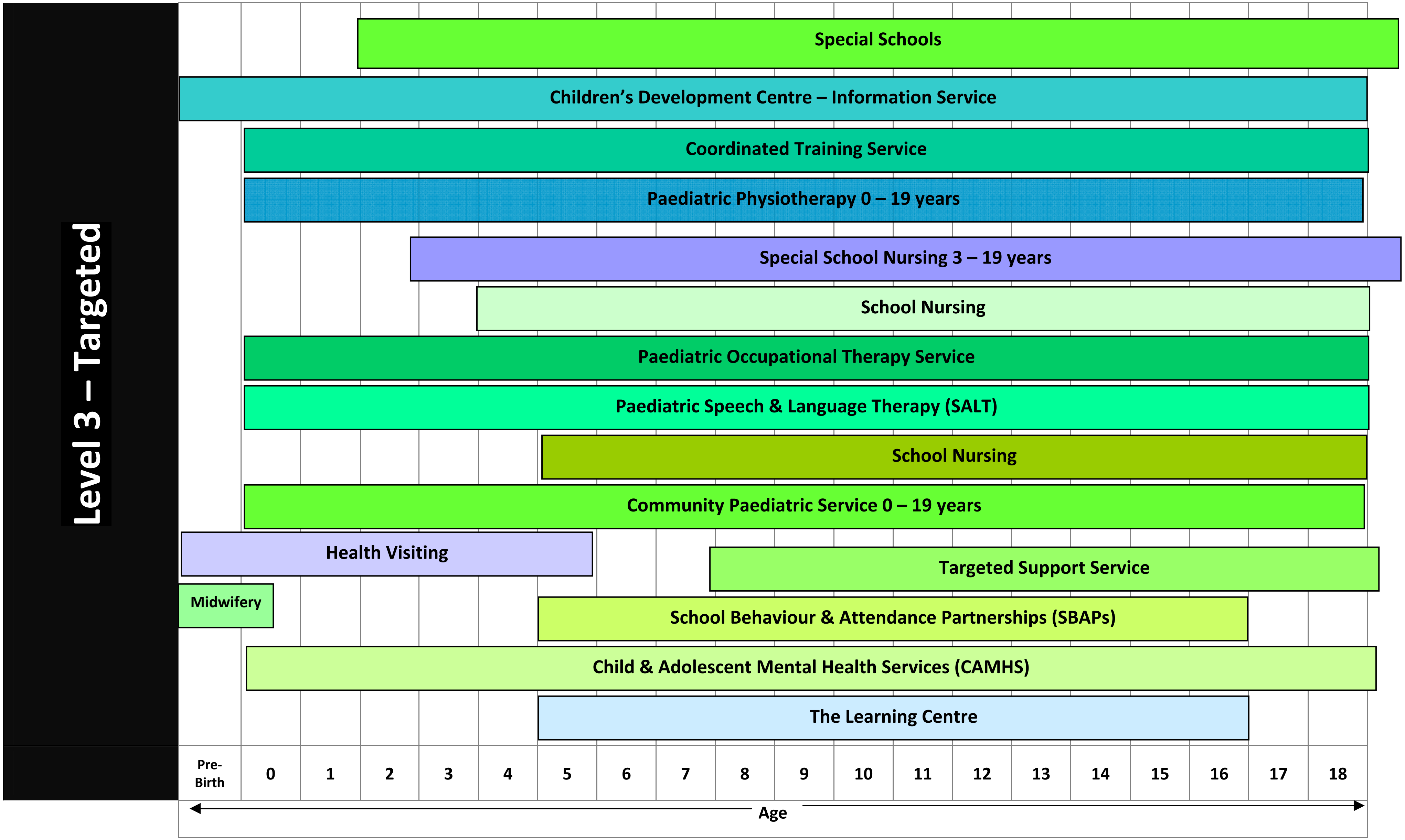
Mainstream Schools

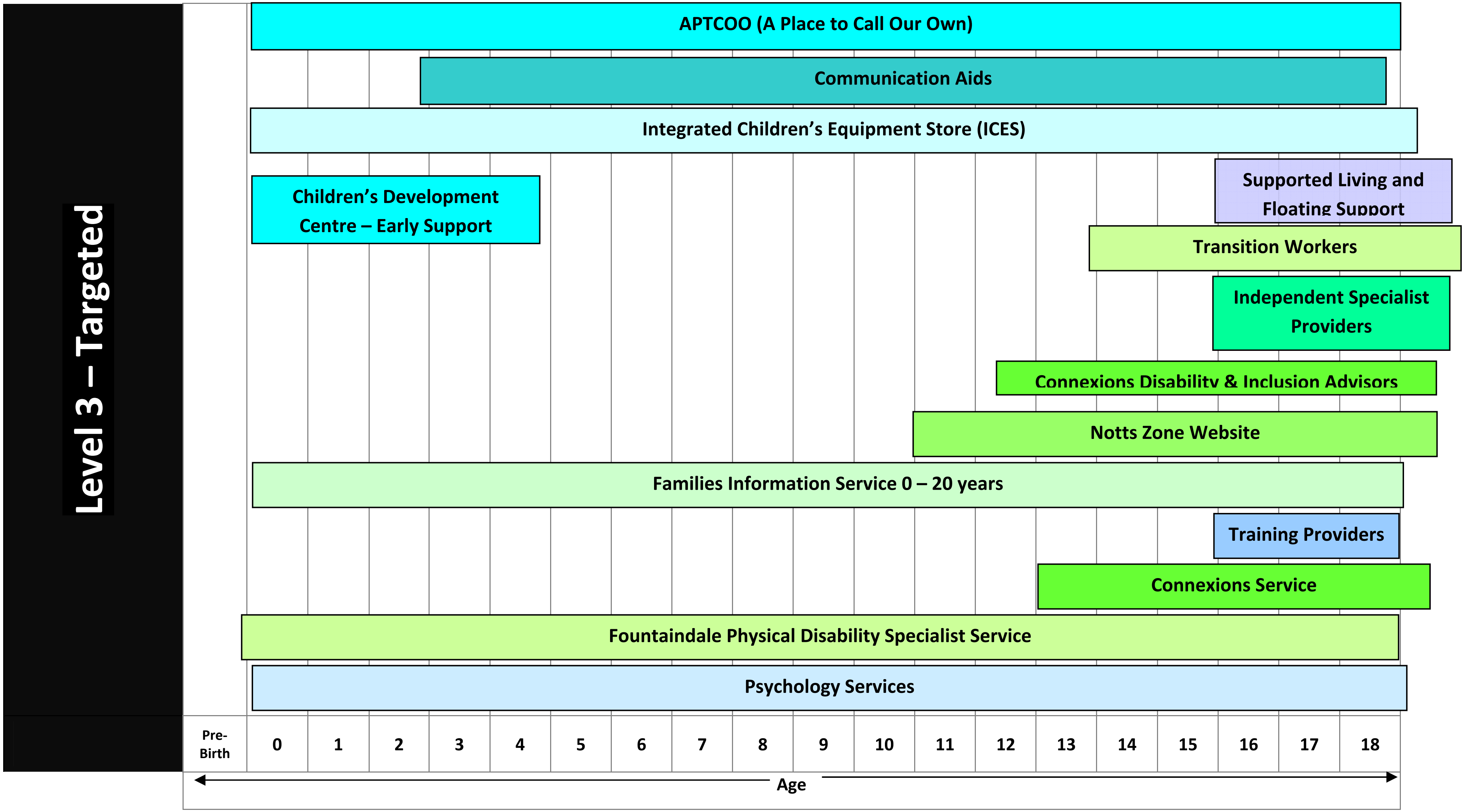
DCATCH Individual home based packages and support for settings 0 – 19 years

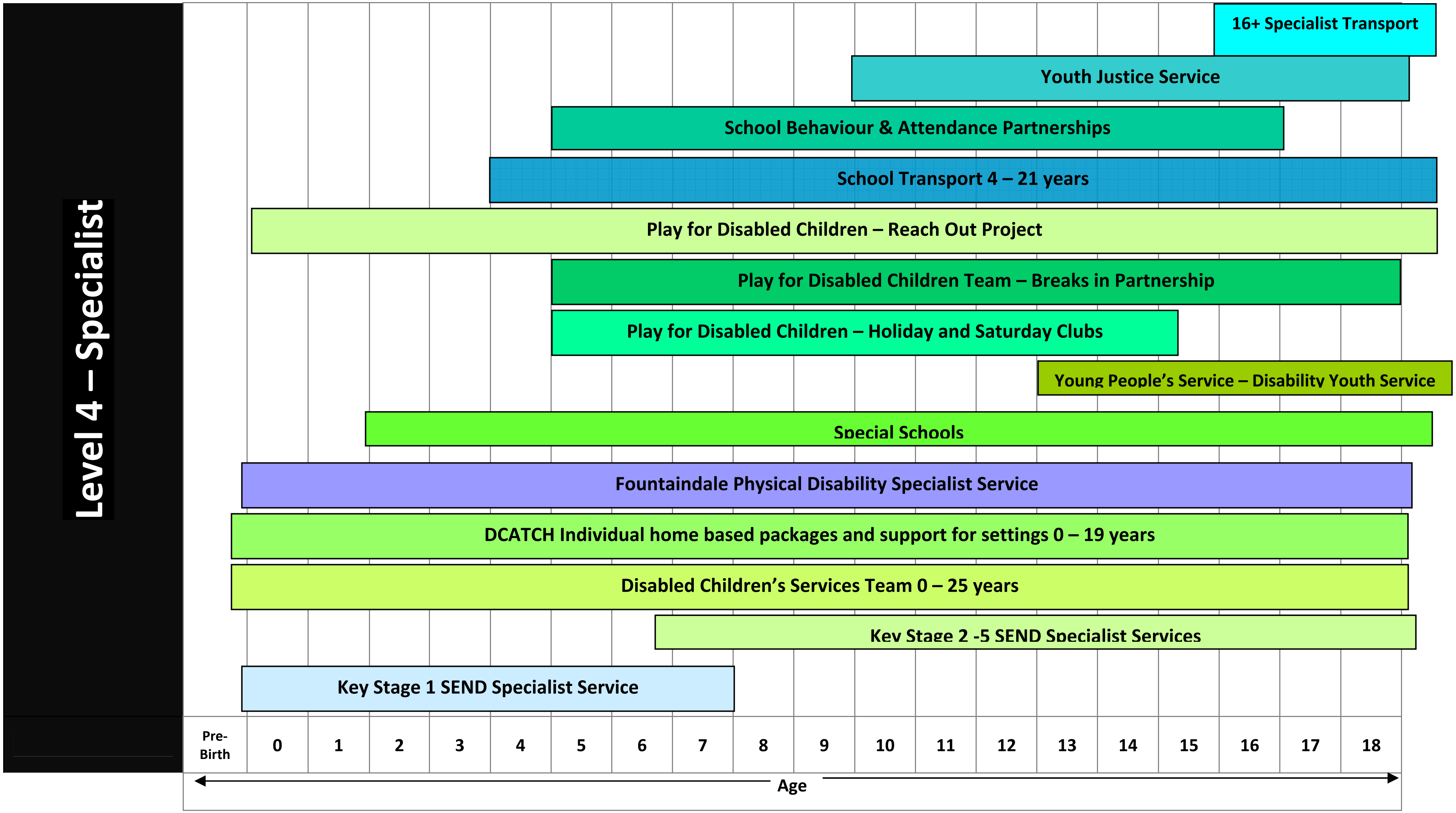
Level 2 – Early Intervention Services

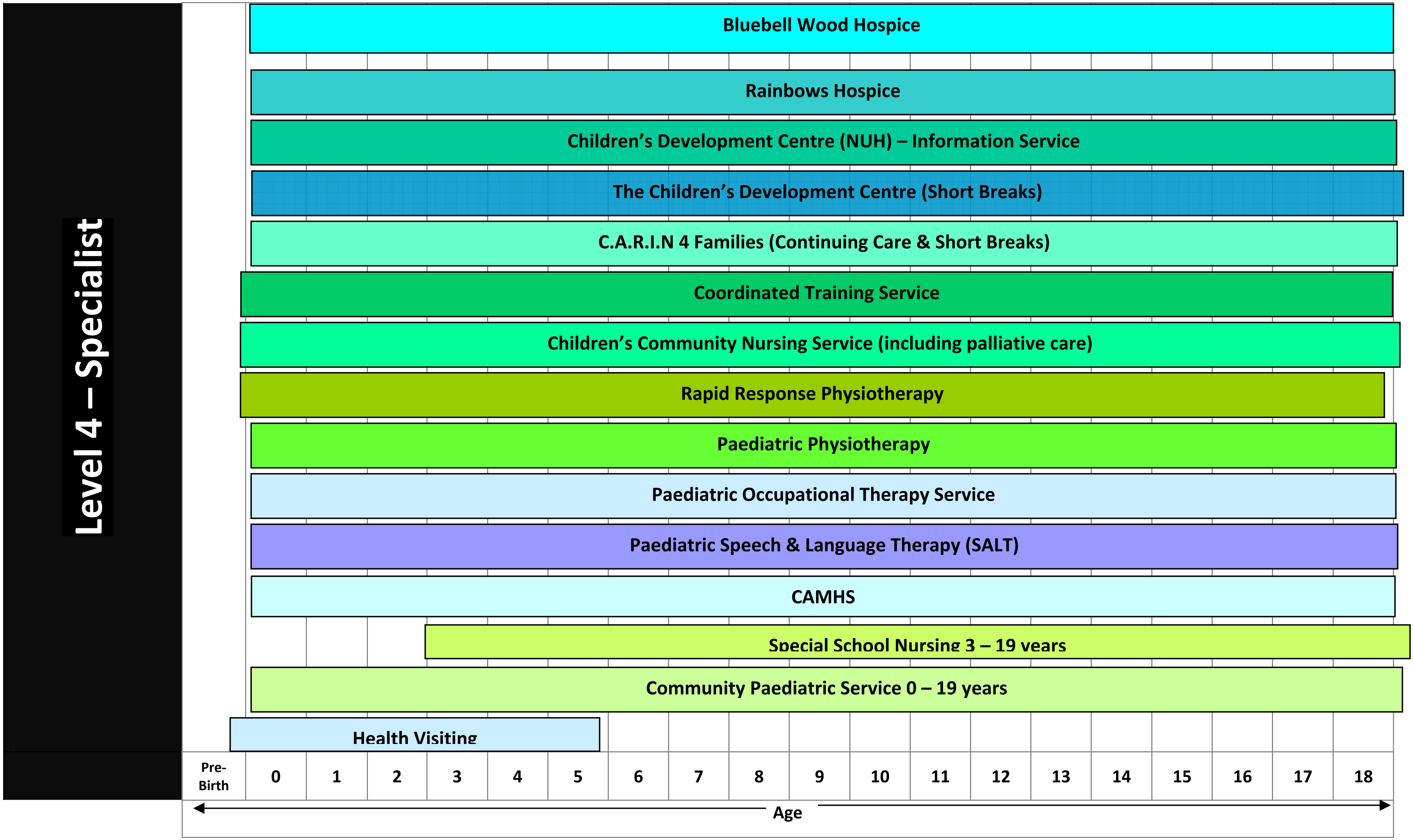



Level 3 – Targeted
16+ Specialist Transport
School Transport 4 - 21 years
Play for Disabled Children – Reach out Projects 0 – 19 years
Play for Disabled Children – Holiday & Saturday Clubs
Young People’s Service – Disability Youth Service
Flexible Short Breaks Scheme
Family Centres
FE College Provision
DCATCH Individual home based packages and support for settings 0 – 19 years
Disabled Children’s Services Team 0 - 25 years
KS2-5 SEND Specialist Services
Key Stage 1 SEND specialist Service
Pre-Birth
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
Age

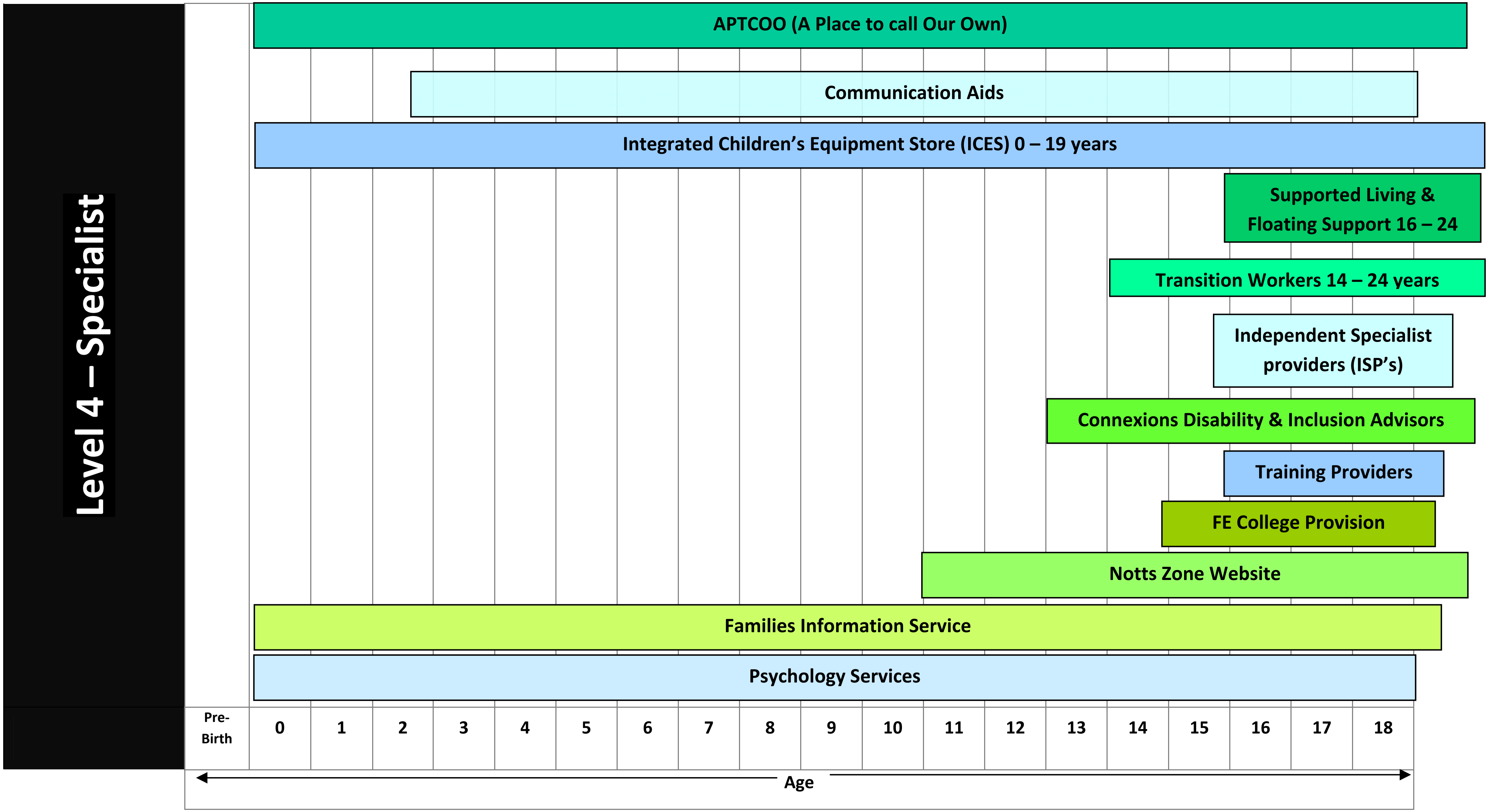

Level 3 – Targeted
Special Schools
Children's Development Centre – Information Service
Coordinated Training Service
Paediatric Physiotherapy 0 – 19 years
Special School Nursing 3 – 19 years
School Nursing
Paediatric Occupational Therapy Service
Paediatric Speech & Language Therapy (SALT)
School Nursing
Community Paediatric Service 0 – 19 years
Health Visiting
Targeted Support Service
Midwifery
School Behaviour & Attendance Partnerships (SBAPs)
Child & Adolescent Mental Health Services (CAMHS)
The Learning Centre
Pre-Birth
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
Age


Level 3 – Targeted
APTCOO (A Place to Call Our Own)
Communication Aids
Integrated Children's Equipment Store (ICES)
Children's Development Centre – Early Support
Supported Living and Floating Support
Transition Workers
Independent Specialist Providers
Connexions Disability & Inclusion Advisors
Notts Zone Website
Families Information Service 0 – 20 years
Training Providers
Connexions Service
Fountaindale Physical Disability Specialist Service
Psychology Services
Pre-Birth
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
Age


Level 4 – Specialist
16+ Specialist Transport
Youth Justice Service
School Behaviour & Attendance Partnerships
School Transport 4 – 21 years
Play for Disabled Children – Reach Out Project
Play for Disabled Children Team – Breaks in Partnership
Play for Disabled Children – Holiday and Saturday Clubs
Young People's Service – Disability Youth Service
Special Schools
Fountaindale Physical Disability Specialist Service
DCATCH Individual home based packages and support for settings 0 – 19 years
Disabled Children's Services Team 0 – 25 years
Key Stage 2 -5 SEND Specialist Services
Key Stage 1 SEND Specialist Service
Pre-Birth
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
Age


Level 4 – Specialist
Bluebell Wood Hospice
Rainbows Hospice
Children's Development Centre (NUH) – Information Service
The Children's Development Centre (Short Breaks)
C.A.R.I.N 4 Families (Continuing Care & Short Breaks)
Coordinated Training Service
Children's Community Nursing Service (including palliative care)
Rapid Response Physiotherapy
Paediatric Physiotherapy
Paediatric Occupational Therapy Service
Paediatric Speech & Language Therapy (SALT)
CAMHS
Special School Nursing 3 – 19 years
Community Paediatric Service 0 – 19 years
Health Visiting
Pre-Birth
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
Age

Level 4 – Specialist



Service Mapping

Summary of services available for Disabled Children, Young People and Families affected by Disability in Nottinghamshire

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	Disability Type	Locality		
School and family specialist services: **Early Years /Key Stage 1 and KS2-5 SEND Specialist Services**	0-7 7-19	Children and young people with complex special educational needs and disabilities including: deafness, visual impairment, early years, autism, communication and interaction, cognition and learning difficulties and dyslexia	Nottinghamshire	3,4	Educational support to children and young people with the most complex special educational needs and disabilities, to their families and to the schools/settings they attend. Support includes home teaching programmes; provision of guidance, information and support to parents/carers; planning for admission to early years settings and schools; transition and reintegration support programmes; provision of advice, guidance and training on a range of issues to mainstream school staff working with children and young people with SEND, including support to access resources. Also provide additional support to pupils on the autistic spectrum disorder and ICT support to schools.
Children's Social Care Disabled Children's Team	0-25	All disabilities	Nottinghamshire	3,4	Services available include: aids; equipment; adaptations to the home; help with personal care; sitters and befrienders who can help with care at home or going out and joining in something different; overnight short breaks either with a carer or in a residential home; help for carers; direct payments
DCATCH (Disabled Children's	0-19	Children with complex needs or older children who cannot	Nottinghamshire	2,3,4	Individual packages of childcare tailored to meet a child's or, young person's specific needs. This is provided in the family home whilst parents are at work or attending

---

[131] **TIER/S**
Tier 1 = universal,
Tier 2 = early intervention,
Tier 3 = targeted
Tier 4 = specialist

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	Disability Type	Locality		
Access to Childcare)- Individual home based packages		access mainstream childcare			vocational training course
DCATCH- Support for settings	0-19	Disabled children, young people	Nottinghamshire	2,3,4	A contribution towards 1:1 support whilst a child is in a mainstream childcare setting either while parents are working or the child is accessing their 2,3 or 4 year entitlement.
Family Centres	Disabled children aged 0-8 years and their family	Universal	Nottinghamshire	1,2,3	Support to disabled children under the age of 8 and their parents
Special Schools	2-19 (varies for each school)	Severe/complex	Nottinghamshire	3, 4	Currently 11 special schools in Nottinghamshire. Each one offers special teaching arrangements for certain types of need. All children have significant special educational needs; all staff have specialist knowledge and expertise. Classes are small and specialist equipment is available.
Fountaindale Physical Disability Specialist Service	0-19	, Children with Physical/medical disabilities. complex healthcare needs	Nottinghamshire	3,4	Support to children and young people with physical disabilities, complex healthcare needs and additional personal care needs, to their families and to the school/settings they attend. Support includes: • Administration and co ordination of the Disabled Pupils Access Panel (DPAP) • Specialist curriculum access advice and training to schools and settings including PE and ICT assessment and provision of equipment. • Provision to schools/settings of specialist seating systems. • Provision of individual pupil manual handling risk assessments and specialist equipment identified within

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	Disability Type	Locality		
					them. • Provision of individual pupil personal and intimate care plans. • Support to children and young people, their families and school/settings with transition across phases/schools • Administration and provision of manual handling training specific to staff/parents/carers moving and handling children and young people with physical disabilities. • Storage and delivery of specialist equipment.
Specialist Equipment Loan Scheme					Loan of specialist seating, toileting, lifting and handling equipment to support children and young people accessing provision in private, voluntary and independent childcare settings. Provision of manual handling advice and training.
Mainstream Schools	5-16	Universal	Nottinghamshire	1,2	Specialist support and funding available for adaptations to enable disabled pupils to access mainstream provision
FE College Provision	16-25 funded by the YPLA 25 plus funded by the SFA Some pre-16 funded by schools direct	General FE Colleges support learners with a range of learning difficulties, physical disabilities and emotional/behavioural difficulties. Admission criteria determined by individual institution	Nottingham City and Nottinghamshire There are five General Further Education Colleges supporting Nottinghamshire learners: • Lincoln College (Newark campus) • NCN (City based) • North Nottinghamshire College • South Nottingham College (including the former Castle College)	1,2,3,4	All of the General Further Education Colleges in Nottinghamshire offer customised provision for learners with learning difficulties and/or disabilities, generally under the banner of Foundation studies or similar. Such programmes typically comprise a combination of vocational provision; functional skills; and skills to develop independence. Each College has its own entry criteria – formal academic qualifications are seldom stipulated but the capacity and willingness to learn is generally a prerequisite. Colleges use their Additional Learning Support budget to support learners with LLDD by providing, for example, customised resources or 1-1 /small group support. The capacity of mainstream colleges to meet the needs of learners with complex learning, physical or emotional difficulties varies between institutions, with complex emotional/behavioural difficulties and physical disabilities requiring significant therapeutic and medical interventions

Name of Service	**Target Group**			**Tier[131]**	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
			- West Nottinghamshire College In addition, the Brackenhurst campus of Nottingham Trent University offers FE funded Foundation studies programmes for learners with learning difficulties/disabilities. Bilborough 6th form college, although located in the City, draws a significant number of learners from the County. It does not offer customised programmes for learners with LLDD, but will support academically able learners with physical disabilities or high functioning learning difficulties on its mainstream programmes		generally proving more problematic to accommodate within mainstream.
Flexible Short Breaks Scheme	0-19	Children and young people with: ASD; health needs; severe disability and challenging behaviour	Nottinghamshire	2,3	Currently offer disabled children and young people up to 100 hours of short break provision per year from a menu of services including access to holiday and play activities in mainstream or specialist settings, and sitting and befriending services provided by an Approved Provider. The hours allocated can be used flexibly throughout the

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	Disability Type	Locality		
					year at regular intervals, or in blocks, such as school holidays. This varies between providers. Intended for those who are not receiving other short break services
Young People's Service - Disability Youth Service	13-24	Across all disability groups.	Nottinghamshire	2,3,4	Currently service provides weekly youth clubs across all districts, Nottinghamshire Pioneers young disabled people's youth forum, half term activities & discos, residential programme from May – Sept of weekends, 5 day breaks and 1 7 day breaks. Saturday gardening & arts clubs in Mansfield, Newark & Stapleford.
Play for Disabled Children - Saturday Clubs	5-14	Severe/complex	Nottinghamshire	4	Provision of 5 hours of short breaks play in a specialist setting on a Saturday, twice a month for 12 months.
Play for Disabled Children - Holiday Club	5-14	Severe/complex	Nottinghamshire	3,4	Provision of 5 hours of short breaks play in a specialist setting, once a week during 11 weeks of the school holidays.
Play for Disabled Children Team - Breaks in Partnership	5-19	Severe/complex	Nottinghamshire	2,3,4	Provision of agreed number of short breaks play hours per annum during the holidays or after school in a supported universal setting.
Play for Disabled Children - Reach Out Project	0-19	Severe/complex	Nottinghamshire	2,3,4	Specialist workforce bank trained to support disabled children and young people with high level and complex needs
School Transport	4-21	All	Nottinghamshire	3,4	Provided in accordance with Home to School transport policy
16+ Specialist Transport	16-25	All disabilities that prevent young people using public transport	Nottinghamshire	3,4	Post 16 special transport for FE colleges
The Learning Centre	5-16	Children and Young People Excluded from School including those with SEND	Nottinghamshire	1,2,3	The Short Stay School within the Behaviour and Attendance Service provides out of school provision for children and young people who are aged between 5-16 years. This provision is only intended for short periods of time whilst new schools are identified for learners, or when

Name of Service	**Target Group**			**Tier**[131]	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
					they are away from their schools for health related reasons
Child & Adolescent Mental Health Services (CAMHS)	0-18	Children and young people with mental health problems	Nottinghamshire	2,3,4	Aim - 'All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, have access to timely, integrated, high quality, multidisciplinary mental health services to ensure effective assessment, treatment and support, for children and young people and their families.' There is also a specialist LD service.
School Behaviour and Attendance Partnerships (SBAPs)	5-16		Nottinghamshire	2,3,4	Each School Behaviour and Attendance Partnership (SBAP) has an allocation of staff time to support school improvement in behaviour and attendance. Staff will work with schools to plan strategies for both individual children and young people and strategically at a whole school level.
Youth Justice Service	10-18	Vulnerable children and young people	Nottinghamshire	4	The Youth Offending Service is made up of seconded staff from the Police, Social Services, Probation, Education & Health, working together towards the prevention of offending and re-offending by children and young people. The service has three main purposes: • To Protect the Public From Harm • To Safeguard children and young people who are victims of crime or who are in the youth justice system • To prevent offending by young people There are three local teams supported by specialist Prevention, Intensive Interventions and Quality Assurance units based centrally.
Targeted Support Service	8-18	Vulnerable children and young people	Nottinghamshire	3	The service provides specialist support to young people who are at risk of: involvement with anti social behaviour, being out of education, training, and employment, homelessness, developing problems with drugs and alcohol, missing from home.

Name of Service	**Target Group**			**Tier**[131]	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
Midwifery	All pregnant women up to baby 1 month of age	Universal	Nottinghamshire	1,2,3,	Universal services for all pregnant women and babies up to the age of 1 month. Delivery of the Healthy Child Programme.
Health Visiting	0-5	Universal	Nottinghamshire	1,2,3, 4	Universal service for all pre school children. Health Visitors implement the Healthy Child Programme.
Community Paediatric Service	0-19	Children with identified additional health needs.	Nottinghamshire and Nottingham City	2,3,4	NUH and SFHT deliver community paediatrics. There are six service strands (general community paediatric clinics, neuro-disability clinics, life shortening conditions service, medical support to schools including special schools, Children in Care service, Child Protection Service. Delivery of statutory requirement to offer medical support to schools including special schools, Children in Care and Child Protection Service.
School Nursing	5-18	Universal	Nottinghamshire	1,2,3	Health service provision in mainstream schools. Delivery of the Healthy Child Programme.
Special School Nursing	3-19	Children with complex healthcare needs, physical/medical disabilities.	Nottinghamshire	2,3,4	Health service provision in Special Schools. Includes the universal delivery of the healthy child programme. Care of children with complex care needs in special schools to enable them to access education.
Paediatric Speech and Language Therapy (SALT)	0-18	Children with speech and language and communication difficulties.	Nottinghamshire and Nottingham City (North and South Teams)	2, 3, 4	Assess, diagnoses and designs care packages to targeted and specific groups of children with speech, language and communication difficulties. Also provide intervention to ensure the safety, health and well-being with specific groups of children with eating and drinking difficulties. There is a North and South Team
Paediatric Occupational Therapy Service	0-18	Children with Learning Disabilities, Physical Disabilities and complex care needs. For children	Nottinghamshire (excluding Bassetlaw) and Nottingham City	3, 4	North and South Teams, as well as Therapeutic Support Team (includes Learning Disabilities, Physical Disabilities and complex care needs). The service follows 3 broad strands and pathways a) children with physical disabilities, b) children with Learning Disabilities and c) children with

Name of Service	**Target Group**			**Tier[131]**	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
		registered with GPs in Nottinghamshire (excluding Basssetlaw)			functional and co-ordination disabilities. They provide packages of care which enhance the functional potential of children's every day tasks and activities, at home e.g. dressing and self care skills, in school e.g. access to the curriculum, handwriting etc, and with leisure pursuits. They work in partnership with parents and carers, and other professionals and agencies to reduce the impact of the children's disability to ensure the best outcome for the child and family.
Paediatric Physiotherapy	0-18	CYP with Learning Disabilities, Physical Disabilities and complex care needs.	Nottinghamshire (excluding Bassetlaw) and Nottingham City	3, 4	Paediatric Physiotherapy for CYP with Learning Disabilities, Physical Disabilities and complex care needs.
Rapid Response Physiotherapy	0-18	children and young people with severe disability, life limiting and life threatening conditions	Nottingham City and the South of the County. NB does not include Bassetlaw	4	A rapid response respiratory physio service for children and young people with severe disability, life limiting and life threatening conditions. The service focuses on children and young people who have spent prolonged periods in hospital with chest infections. To assess and treat children's acute respiratory conditions in the community, to prevent hospital admissions. It also provides training to parents and carers, and a range of staff to enable children to continue to access other activities such as education and short breaks.
Children's Community Nursing Service (including palliative care)	0-18	Children and young people with: acute, short term and long term conditions; children and young people with disabilities and continuing care needs and CYP with Life limiting and life threatening illness	County wide service with 3 providers NUH. SFH & CHP.	4	Provides a home based nursing services to identified children and young people. This includes planned end of life care to children and young people with life limiting and life threatening conditions. A pilot project has been running since January 2011 to work towards a more integrated Children's Community Nursing service. This is currently being evaluated with the view to develop a fully integrated, equitable, countywide service.

Name of Service	**Target Group**			**Tier**[131]	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
		including palliative and end of life care (including neonates)			
Coordinated Training Service	0-18	Parents/carers who have a child with an additional health need and workers who provide care/service to this group of children	Nottinghamshire (excluding Bassetlaw)	3,4	A coordinated training service delivered by NUH, that provides a range of clinical competency based training and assessment to parents/ carers and any worker who providers care/service to a child with an additional health need.
C.A.R.I.N 4 Families (Continuing Care and Short Breaks)	0-18	Children and young people who have complex health care needs and have an assessed continue care need	Nottinghamshire (excluding Bassetlaw)	4	Continuing Care - A nursing care service to children and young people aged 0-18 that have complex health care needs that require on going nursing support. Nursing care is delivered in the child's home or other settings for prolonged periods of time e.g overnight care Short Breaks – A short breaks service to children and young people with complex health care needs who require regular nursing intervention. This service is provided predominantly in the child's home or other community settings.
The Children's Development Centre (Short Breaks)	0-19	Children and young people with complex health care and/or physical disabilities and/or learning disabilities	Nottingham City and the South of the County. NB does not include Bassetlaw	4	Overnight short breaks and day care to children and young people identified in column 3. Provide parents and carers with a break from the caring role.
Children's Development Centre – Information Service	All	Professionals, parents and carers of disabled children	Nottingham City and the South of the County	1,2,3,4	Provided by The Children's Development Centre, City Hospital Campus. This is an on site staffed library providing a range of information, advice and guidance on children's disability issues, services and conditions.
Children's Development Centre – Early	Preschool children	Children with severe and complex health needs or disabilities	Nottingham City and the South of the County	2 & 3	Provides early intervention, coordination and integrated partnership working to preschool children with severe and complex health needs or disabilities, to ensure their health

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	**Disability Type**	**Locality**		
Support					and well being is maximised. Also provides families with high quality family centred service with an opportunity to have a 'team around the child' with a named lead professional and a key worker
Rainbows Hospice	0-30	Children and Young People with life limiting and life threatening conditions and their families	Nottinghamshire and Nottingham City	4	Provides residential hospice support, palliative care (symptom control, end of life care, bereavement support and family support)
Bluebell Wood Hospice	0-18	Children and Young People with life limiting and life threatening conditions and their families	Bassetlaw (Nottinghamshire children ad hoc provision)	4	Provides residential hospice support, palliative care (symptom control, end of life care, bereavement support and family support)
Psychology Services	0-18	Psychological needs	Nottinghamshire	3,4	Educational Psychologists give advice to schools, parents and Local Authorities on the needs and difficulties of children and on ways of helping them learn.
Training Providers	16-18	Mild to moderate learning difficulties/ disabilities. Mild to moderate emotional and behavioural difficulties	There are some 10 private training providers, funded by the YPLA, operating in Nottingham City and Nottinghamshire delivering Foundation Learning.	1, 2, 3, 4	Foundation Learning is a programme of study for learners operating predominantly at or below level 1, including what were previously described as entry or pre-entry levels. Foundation Learning programmes comprise three elements: • Vocational qualification • Functional skills • Personal and social development Foundation Learning programmes typically last from six months to a year and operate on a roll on roll off basis. There are flexibilities within the funding guidance to ensure that learners with learning difficulties/ disabilities are given sufficient time to achieve their qualifications. A significant percentage of FL learners will have some kind of learning or behavioural difficulty, but generally towards the milder end of the spectrum. Nottinghamshire County Council's own

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	Disability Type	Locality		
					Skills for Employment provision deals with more complex/challenging learners and the AAA programme is specifically targeted at learners with learning difficulties and/or disabilities.
Training Providers	SENCOs	All	Nottinghamshire	3,4	Training, support and networks to SENCO to facilitate the work they do to support children and young people with special educational needs in their schools
CAB	16+	Universal	Nottinghamshire	1,2	Free confidential advice eg welfare rights, employment problems, housing, money management etc
IRIS	Parents and Carers	Parents and Carers of disabled children	Nottingham City and Nottinghamshire	2,3,4	Information service (website and quarterly newsletter) for parents of children and young people with disabilities
Parent Partnership	Parents and Carers	Parents and Carers of disabled children	Nottingham City and Nottinghamshire	2,3,4	Provide impartial advice, information and support about educational issues to parents and carers of children with special educational needs and disabilities
Families Information Service	0-20, parents and carers	Universal	Nottinghamshire	1,2,3,4	Free impartial guidance and information for families and signposting service on a range of family issues
Parentzone website	Parents and carers	Universal	Nottinghamshire	1,2,3,4	A website that provides information and opportunities to get involved in the community, things to do and for parents to have their say
Notts Zone website	11-19, parents, carers, youth workers, teachers	Universal	Nottinghamshire	1,2,3,4	A website designed by young people for young people aged 11-19, parents, carers, teachers and youth workers to find out about things to do for young people in Nottinghamshire
Connexions Service	13-24	Universal offer, with additional support for learners with learning difficulties/disabilities	Nottingham City and Nottinghamshire	1,2,3	The Connexions Service has historically provided impartial advice and guidance to young people in schools and supported transitions to appropriate destinations post-16 to reduce the number of young people categorised as NEET (Not in Employment, Education or Training). The universal

Name of Service	Target Group			Tier[131]	Commentary (what does the service provide?
	Age	Disability Type	Locality		
					Connexions service will cease to operate at the end of March 2012 and the responsibility for providing support services to vulnerable young people will rest with Local Authorities directly. IAG support for young people with learning difficulties and disabilities will be included in the Targeted Support arrangements being put in place by the LA
Connexions Disability and Inclusion Advisors	13-24	Learners with a Statement of Special Educational needs or categorised as School Action Plus and in receipt of HLN funding	Nottinghamshire (similar arrangements in place in Nottingham City)	3, 4	Connexions has a small team of specialist Disability and Inclusion advisers who support learners with the most significant learning difficulties/disabilities to transition to appropriate learning or other provision at the end of compulsory education and, if appropriate, post-college up until the age of 25. The advisers are responsible for completing Section 139A assessments for their clients and working with them, their families and other professional agencies to agree appropriate transition pathways. Although the delivery structure may change, this support service will continue under the Targeted Support Umbrella as part of the contract between Futures and the Local Authority from April 2012.
Sort it online website (connexions)	11 – 24	universal	Nottingham City and Nottinghamshire	1	Offers comprehensive information to support option and transition choices - Key features include: • Planning changes - your transition plan • Your choices • Foundation Learning • Money matters • Help with travelling Also includes FETCH, website signposting Young people will be able to access information through the National Careers service website www.direct.gov.uk and helpline.

Name of Service	**Target Group**			**Tier[131]**	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
Passportfolio / My Choice Notts website (connexions)	11 – 24	Universal	Nottingham City and Nottinghamshire	1	Offers a complete online progression planning package. In September 2011 Passportfolio *extra* was launched. It was developed for all foundation learners. It offers a simplified navigation of the website, new quizzes. In the next few months Passportfolio extra will be supported by Widgit Point software for those users that find the use of symbols helpful. Foundation learning providers and ISPs have been invited to include their course information in the course database on the weBsite.
Independent Specialist Providers (ISP's)	16-25 funded by the YPLA, commissioned by Local Authorities	Profound and multiple learning difficulties/ physical disabilities and in some cases emotional and behavioural difficulties	There are approaching 60 YPLA approved Independent Specialist Providers operating in England and Wales. Only 1, Portland College, is based in Nottinghamshire but Landmarks (Creswell); RNIB (Loughborough) and Homefields (Leicestershire) can also be accessed on a non-residential basis.	3, 4	Independent Specialist Colleges provide customised support, on either a day or residential basis, for learners with complex needs. The majority provide a range of specialist interventions such as speech and language therapy; hydrotherapy and physiotherapy as well as educational provision and are able to support learners requiring significant medical intervention and/or with high personal care needs. Provision at such colleges is expensive – typically around £70,000 for residential placements – and Local Authority commissioners therefore stipulate that places at ISCs can only be considered if there are no appropriate mainstream options available. Nottinghamshire County Council, in common with most Local Authorities, is looking to reduce the number of out of area residential placements and to move away from the standard three year placement model operated previously by the Learning and Skills Council.
What next publication (Connexions)	16	Universal	Nottinghamshire	1	The What Next for Me publication supports the transition from 16. Further printing of this booklet is to be confirmed.
Transition workers	14-24	Young people with learning and physical disabilities	Nottinghamshire	3,4	Support to service users and their families who will be eligible for adult social care to ensure relevant services are available when they reach 18 years of age
Supported Living	16-24	Any vulnerable young	Nottinghamshire	2,3,4	Supported Living – hostel or dispersed supported housing

Name of Service	**Target Group**			**Tier**[131]	**Commentary (what does the service provide?**
	Age	**Disability Type**	**Locality**		
Floating Support		adult			or supported lodgings for any homeless, vulnerable young person Floating Support - for any 16+ in their own home or needing support to remain independent, avoid eviction or find independent accommodation
Integrated Children's Equipment Store (ICES)	0-19	Children with complex health needs requiring specialist equipment	Nottinghamshire South and Nottingham City	3,4	Following an assessment by a health practitioner, ICES order specialist equipment for local children and young people. ICES are also responsible for maintenance of equipment
Communication aids	3-19	Communication needs	Nottingham City and Nottinghamshire	3,4	Joint funded panel that provides aids to children with complex communication needs. Have to be registered with a PCT in Nottinghamshire.
Kinship Carers	All	Universal	Nottinghamshire	1,2	Support provided to extended family members who care for children who are unable to live with their parents
APTCOO (A Place to Call Our Own)	0-19	Families with children and young people who have special needs	Nottinghamshire	3,4	Provide practical, emotional and educational support to vulnerable children, young people and their families. This includes: telephone helpline or face to face support; crisis support; 1:1 bereavement support before and after death. (Not a counselling service, someone to talk to); sensory room and toy library. Also offer a wide range of different support groups e.g. Aspergers, Autism, Down Syndrome and disability support groups; family play sessions – weekly and school holidays; Parent Partnership drop-in sessions; training workshops e.g. makaton, sleep clinic, behaviour strategies

For more information about this needs assessment:

Geoff Hamilton geoff.hamilton@nottscc.gov.uk

Irene Kakoullis irene.kakoullis@nottscc.gov.uk

Telephone: 0115 9774431

www.nottinghamshire.gov.uk/improvetheeffectivenessofservicesfordisabledchildren