KENT PUBLIC HEALTH OBSERVATORY

Kent SEND Health Needs Assessment Update

June 2020

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Introduction

This update has been collated using the available published data to compliment the Kent [Special educational needs and disability] SEND health needs assessment [HNA] which was undertaken in the year prior to the SEND inspection in March 2019. The Kent SEND HNA is published on the Kent public health observatory website.[1]

The aim of this document is twofold.

Firstly, to highlight where there has been notable change from the findings identified from the data sets which were available at the time the Kent SEND health needs assessment was undertaken.

Secondly to provide further insight into the health needs of the SEND population.

It should be noted that any changes identified in this document provide limited information as they are only seen against one other timeframe. They can however provide points for further exploration.

The underlying question is what the current education and health needs of children and young people are aged 0-25 with SEND.

[1] https://www.kpho.org.uk/__data/assets/pdf_file/0017/104471/JSNA-CYP-SEND-and-Learning-Disability-Report.pdf

Summary of findings

- ✓ The proportion of pupils with an EHCP has significantly increased at all ages from 4-15 years and the proportion receiving SEND support has reduced across all ages from 4-15 years.
- ✓ Differences across ethnic groups:
  - ➢ The crude rate of pupils with SEND support are significantly higher amongst Irish heritage and gypsy roman travellers and those of dual heritage white and black Caribbean.
  - ➢ The crude rate of pupils with EHCP are highest amongst those of dual heritage white and black Caribbean and high amongst those for whom information re ethnicity is not known.
  - ➢ Of note the areas with populations with higher proportion of BAME have much lower recorded prevalence of autism which have also reduced from 2018 to 2019.
- ✓ Approximately 1 in 5 of primary and secondary pupils and 1 in 7 pupils in special school with SEN support have social, emotional and mental health as a primary need
- ✓ The proportion of children in need offered SEND support has reduced over the time period presented and halved amongst those known to the youth offending team. This maybe a reflection of the system changes in the integrated children's services.
- ✓ The opportunities to improve health outcomes of those with a learning disability are not being fully utilised.
- ✓ The absence of robust systematic processes for diagnosis of foetal alcohol spectrum disorder is likely to mean that many children and young people are not receiving appropriate support.

Whole system recommendations to improve health and educational outcomes

Long term

1. Reduce the prevalence of all preventable causes of learning disability through the active promotion and embedding of the benefits of preconception care
2. Establish a process which develops the level of knowledge and a shift in practice to:

✓ Identify the adversities children requiring EHCPs or ASD diagnostic assessment have experienced

✓ Support and help the families understanding of adverse and trauma on child development

✓ Empower children to share and know that they have a safe place to talk in school

Short to medium term

3. Incorporate sensory needs assessments as a core component in the development of EHCPs: make and monitor the adjustments needed.
4. Undertake a sensory needs assessment for all C & YP waiting for an ASD assessment implementing interventions or modifications as identified.
5. Explore the reasons for the change in the proportions with an EHCP and offered SEN support and whether this has enabled improved support for pupils
6. Explore whether assessments provide opportunity to identify social emotional mental health need amongst those where it is not the primary but a significant need and to incorporate and establish systems to identify need and provide the appropriate levels of support
7. Work with the CCG lead to support families of all medicated children and young people who have an EHCP or receive SEN support to access an annual medicine review and record in their care plans.
8. Raise awareness of FASD through a robust and system wide training programme and development of an assessment process that identifies FASD early.

Immediate

9. Promote the CMO guidance[2] that if you are pregnant or think you could become pregnant; the safest approach is not to drink alcohol at all.

[2] CMO 2016 *Low risk drinking guidelines* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs_report.pdf

10. Enable and facilitate those aged 14 plus with a learning disability to access an annual health check. Promote and include it as part of the core offer.
11. Ensure that the ethnic group of all pupils with EHCP or SEN support is recorded and review through annual audit

Figures

1. Prevalence Update

1.1 Background

The causes of learning disabilities are varied, develop at different times, present and identified differently. The environment of the development of the foetus and infant, specific infections or external environments may contribute and impact on neural development. These are outlined below.

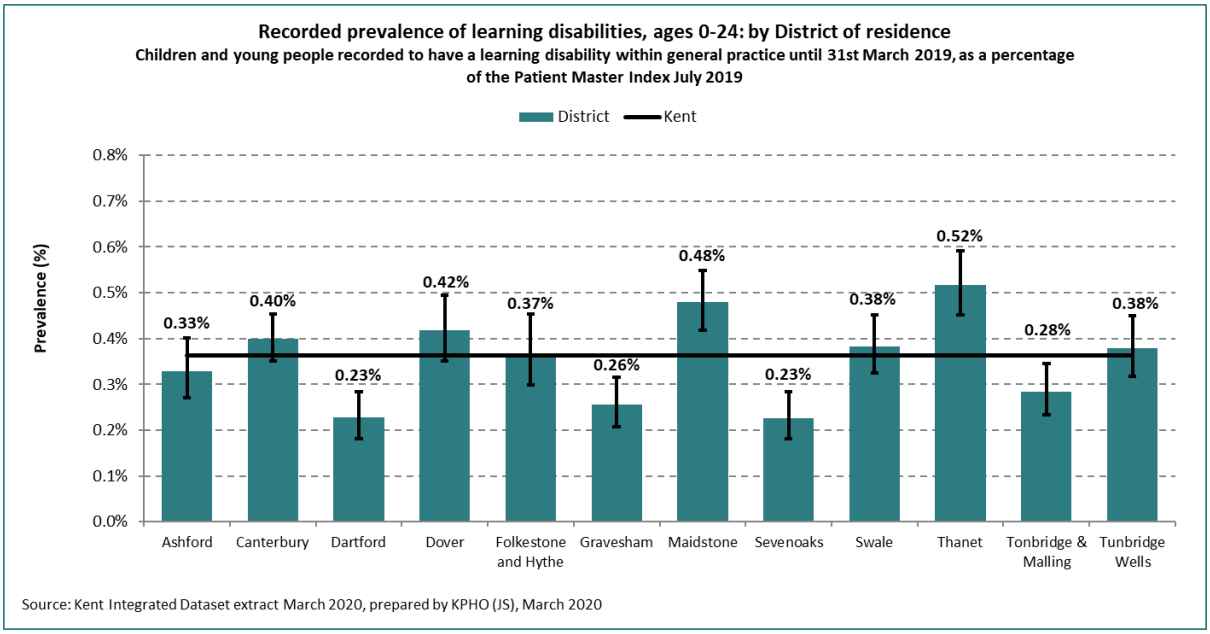
- Antenatally - Chromosome and genetic abnormalities
- Environmental/societal issues: alcohol in pregnancy, smoking in pregnancy, maternal weight
- Infections: Rubella during pregnancy and post-natal meningitis, measles or encephalitis
- Global development delay- includes abuse, neglect, accident

In turn these can lead to children requiring additional and differing support to manage their behaviours, physical and mental health conditions in order to maximise their learning and educational outcomes. Consequently, those children with SEND could be supported by a wide range of professionals and carers.

1.1.1 Overview of the population recorded to have a learning disability

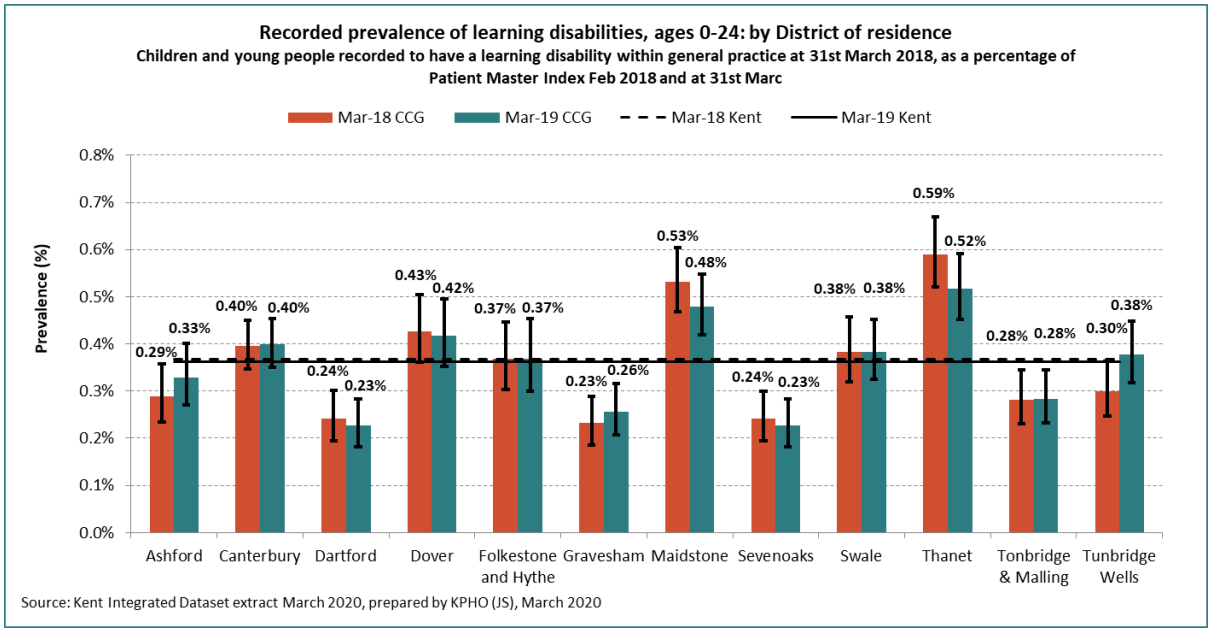
The following two figures present an overview of the prevalence of those aged 0-24 years known to and registered with a learning disability in general practice. To be registered has required specialist diagnosis. These figures show that Maidstone and Thanet districts have significantly different prevalence to the Kent average.

Figure 1: Population aged 0- 24 years recorded to have a learning disability within general practice on the general practice LD register



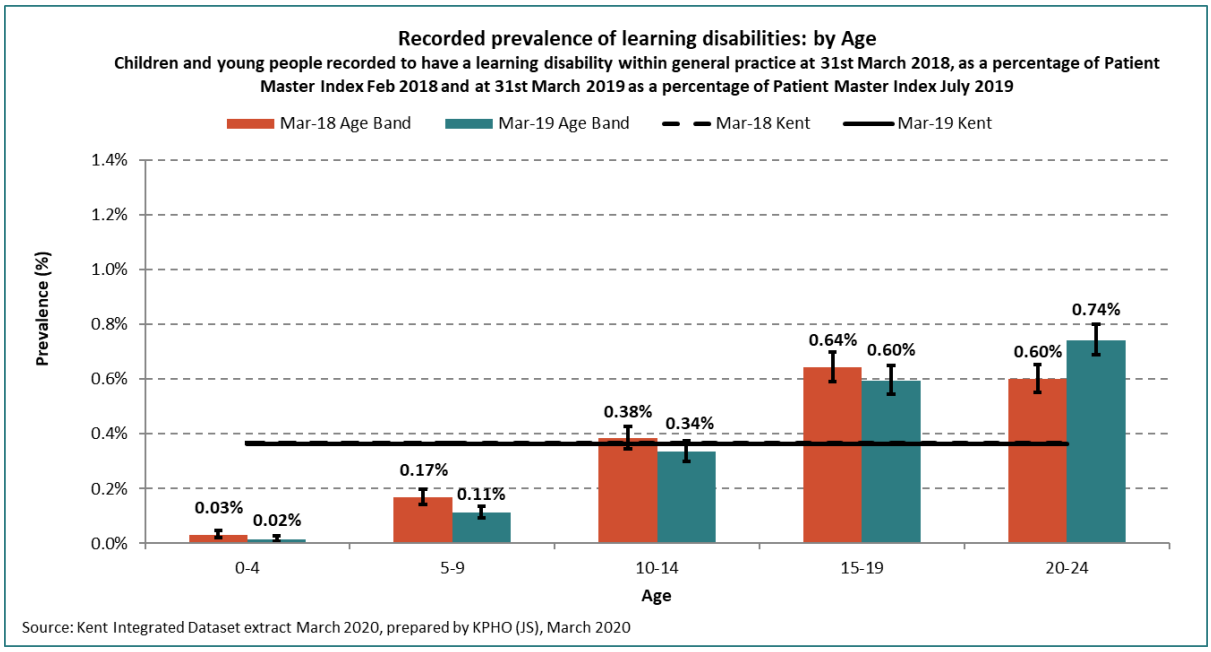
Source: Kent Integrated Dataset extract March 2020, prepared by KPHO (JS), March 2020

Figure 2: Population aged 0- 24 years recorded to have a learning disability within general practice by district of residence 2018 and 2019.



The breakdown of recorded prevalence of learning disability by age does not necessarily provide an accurate overview of 0-24year olds with a learning disability but as will be seen in subsequent presentation could reflect the age at which some disabilities are identified.

Figure 3: Population aged 0- 24 years recorded to have a learning disability within general practice as a proportion of the patient master index 2018 and 2019



1.2 Population with SEND support or EHC plan

The office for the Children commissioner on April 27th, 2020 published local authority profiles of vulnerable children[3] from data to 31st March 2019. The figure below provides an estimated overview of children with SEND with or without an EHC plan amongst 0-17-year olds in Kent in relation to other local authorities in England.

Figure 4: Estimated overview and rate of children with SEND with or without an EHC plan 0-17year olds Kent, 2019

Group	Indicator	Estimate	rate	Percentile rank amongst LAs (0 = Lowest rate, 100 = Highest rate)	Source
Children with SEND	Children with SEND but no EHC plan	25,460	74.9 per 1000 0-17 yr olds	14	DfE statistics
	Children with EHC plan	8,726	25.7 per 1000 0-17 yr olds	74	DfE statistics

Source: Office for the children's Commissioner, 2020

1.2.1 Pre school

Presentation of information on EHCPs illustrated a change in the proportion of children aged 4 with an EHCP. There are many factors which stakeholders suggest may have contributed to this change.

- Over the last two years there has been an increase in referrals to early years LIFT.
- Specialist Teachers are seeing children earlier
- Parents are increasingly making requests for EHCPs which is suggested is due to parental confidence in what the school can provide without an EHCP.

> *Parents with young Hearing Impaired (HI) children are requesting an EHCP as their child will only continue to have Specialist HI Speech and Language therapy at school if they have one.*

- Some schools appear to be asking parents to apply for a needs assessment before the child starts school
- Increased access to specialist nursery interventions at the county's special school nurseries. This would enable a needs assessment to be made earlier.
- Some national charities/parents' organisations/medical professionals tell parents to make an application for a statutory assessment.

[3] https://www.childrenscommissioner.gov.uk/our-work/vulnerable-children/local-vulnerability-profiles/

Parents are often under the impression that they need an EHCP to access support.

The data from the districts from 2016/17 – 2018/19 regarding the number of referrals to LIFT and the subsequent number of referrals to a specialist teacher are incomplete with absence of information in some years and no information from one district. This may be a reflection of a difference in the ways that it is recorded. From the available data analysis would suggest that there has been a 47.3% increase in LIFT referrals from 2016/17 – 2018/19 and over the same time period a 51.4% increase in referrals to specialist teachers.

1.2.2 School age

The following figures show the distribution of pupils with SEND support or EHCP plan in Kent by gender, age, district, ethnicity and school phase over one school year to September 2019. Where there are comparators from the data sets presented in the HNA these are included.

Figure 5: School aged pupils with SEND support or EHCP in Kent by gender, 2018/19

Gender	Pupils	Pupils % by gender	Pupils with SEND support	SEND support % by gender	Pupils with an EHCP	EHCP % by gender
Female	103,816	48.8%	7,048	6.78%	2,040	1.96%
Male	109,091	51.2%	13,502	12.37%	5,862	5.3%
Grand Total	**212,907**	**100%**	**20,550**	-	**7,902**	-

Source: KCC

This highlights the significant difference in the proportion of males receiving SEND support or with an EHCP plan. The gender difference in Kent mirrors gender differences in terms of offered SEN or EHCP in England. That said the identification of support seen in England in 2019 with 4.4% of males and 1.7% females having SEN support and 15% males and 8% females with an EHCP[4] is in contrast to Kent where the proportion of identified support is shown to be highest amongst those with SEND not EHCP.

Although some of the information presented below in figure 6 is incomplete, that shown suggests that the proportion of pupils with an EHCP has significantly increased at all ages from 4-15 years. The greatest proportion with an EHCP is seen at age 11. Over the same period the proportion receiving SEND support has reduced at all ages from 4-15 years.

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf 2019

Figure 6: School aged pupils with SEND support or EHCP in Kent, by age, August 2016 and 2018

Age as at August 2018	Pupils	Pupils % by age	Pupils with SEND support	SEND support % by age		Pupils with an EHCP	EHCP % by age	
				August 2016	August 2018		August 2016	August 2018
4	17,715	8.3%	1,065	6.1%	5.2%	437	1.7%	5.5%
5	18,158	8.5%	1,593	8.5%	7.8%	522	1.9%	6.6%
6	18,921	8.9%	1,975	9.9%	9.6%	562	2.1%	7.1%
7	18,517	8.7%	2,115	11.2%	10.3%	599	2.3%	7.6%
8	18,289	8.6%	2,191	10.9%	**10.7%**	606	2.5%	7.7%
9	18,193	8.5%	2,158	11.8%	10.5%	725	2.9%	9.2%
10	17,992	8.5%	2,089	11.9%	10.2%	792	3.0%	10.0%
11	18,246	8.6%	1,772	9.5%	8.6%	821	3.5%	**10.4%**
12	17,494	8.2%	1,587	8.9%	7.7%	711	3.4%	9.0%
13	16,950	8.0%	1,378	7.8%	6.7%	745	3.5%	9.4%
14	16,499	7.7%	1,323	8.0%	6.4%	702	3.8%	8.9%
15	15,855	7.4%	1,296	8.0%	6.3%	666	3.8%	8.4%
16-17	78	0.04%	8		0.0%	14		0.2%
Grand Total	**212907**	**100%**	**20550**		**100%**	**7902**		**100%**

Source: KCC

The following figure illustrates a changing picture in terms of identified need for SEND support and EHC plans over the time frame presented. The highest proportion of pupils receiving SEND support live in the district of Gravesham at 12.1%. The greatest increase in the proportion of those receiving SEND support live in Maidstone, Dartford and Sevenoaks districts. A decrease in the proportion receiving SEND support is seen in the those living in the districts of Swale, Thanet and Tunbridge Wells.

Figure 7: School aged pupils with SEND support or EHCP in Kent by residential district: Jan 2017 and Jan 2019

Residential District	Pupils		Pupils with SEND support		% of pupils with SEND support		Pupils with an EHCP		% of pupils with an EHCP	
	January 2017	January 2019	January 2017	January 2019	January 2017	January 2019	January 2017	January 2019	January 2017	January 2019
Ashford	18081	18,486	1686	1,839	9.3%	9.9%	442	607	2.4%	3.3%
Canterbury	17589	17,593	1659	1,716	9.4%	9.8%	546	697	3.1%	4.0%
Dartford	14755	15,980	1255	1,578	8.5%	9.9%	338	499	2.3%	3.1%
Dover	14427	14,686	1434	1,569	9.9%	10.7%	430	561	3.0%	3.8%
Folkestone & Hythe	13686	13,820	1516	1,589	11.1%	11.5%	427	562	3.1%	4.1%
Gravesham	15336	15,685	1806	1,899	11.8%	12.1%	403	531	2.6%	3.4%
Maidstone	21621	22,651	1645	1,818	7.6%	8.0%	624	821	2.9%	3.6%
Sevenoaks	14112	14,443	1093	1,261	7.7%	8.7%	321	443	2.3%	3.1%
Swale	20386	20,884	2362	2,244	11.6%	10.7%	798	1,059	3.9%	5.1%
Thanet	18797	18,769	2019	1,903	10.7%	10.1%	623	834	3.3%	4.4%
Tonbridge & Malling	17286	17,790	1338	1,413	7.7%	7.9%	467	634	2.7%	3.6%
Tunbridge Wells	14248	14,455	1117	1,078	7.8%	7.5%	299	390	2.1%	2.7%
KENT	**200324**	**205,242**	**18930**	**19,907**	**9.4%**	**9.7%**	**5718**	**7,638**	**2.8%**	**3.7%**

Source: KCC

The higher proportion of pupils with an EHCP live in the district of Swale at 5.1%. **The greatest increase in the proportion of those with an EHCP live in Swale, Thanet and Folkestone & Hythe districts**. All districts have had an increase in the proportion of pupils with an EHCP over the time frame presented. This may be a reflection and indication of the significant waiting list to access a service which diagnoses ASD or the ability of staff to identify children and young people requiring additional support and plan of care.

There are many mainstream schools with special units across the districts in Kent. This may be reflected in the differences in the proportion of EHCP pupils not in special schools, with 7 in 10 pupils not in special school with an EHCP attending school in the districts of Dartford, Swale and Tonbridge and Malling. This is in contrast to the proportion of pupils, 3 in 10, with an EHCP not attending special school in the districts of Maidstone, Swale and Tunbridge Wells.

Figure 8: School aged pupils with SEND support or EHCP in Kent by district of school attended from Jan 2019

School District	School pupils	Pupils with SEND support	% of pupils with SEND support	Pupils with an EHCP	% of pupils with an EHCP	Special school pupils	% of EHCP pupils in special schools	EHCP pupils not in special schools	% EHCP pupils not in special schools
Ashford	18,335	1,809	9.9%	658	3.6%	381	57.9%	277	*42.1%*
Canterbury	18,210	1,858	10.2%	771	4.2%	322	41.8%	449	*58.2%*
Dartford	18,687	1,817	9.7%	465	2.5%	113	24.3%	352	*75.7%*
Dover	14,995	1,567	10.5%	565	3.8%	207	36.6%	358	*63.4%*
Folkestone & Hythe	13,877	1,586	11.4%	506	3.6%	296	58.5%	210	*41.5%*
Gravesham	16,516	1,982	12.0%	412	2.5%	199	48.3%	213	*51.7%*
Maidstone	23,611	1,836	7.8%	941	4.0%	610	64.8%	331	*35.2%*
Sevenoaks	12,310	1,085	8.8%	558	4.5%	354	63.4%	204	*36.6%*
Swale	21,267	2,303	10.8%	874	4.1%	237	27.1%	637	*72.9%*
Thanet	18,632	1,862	10.0%	905	4.9%	536	59.2%	369	*40.8%*
Tonbridge & Malling	19,813	1,669	8.4%	725	3.7%	210	29.0%	515	*71.0%*
Tunbridge Wells	16,654	1,176	7.1%	522	3.1%	325	62.3%	197	*37.7%*
KENT	**212,907**	**20,550**	**9.7%**	**7,902**	**3.7%**	**3,790**	**48.0%**	**4,112**	***52.0%***

Source: KCC

The next figure shows an increase in the proportion of pupils with an EHCP in primary school from 2017 – 2019 and a decrease in the proportion at special school with an EHCP. The proportion of pupils receiving SEND support remains similar in all school phases across the same time frame.

Figure 9: School aged pupils with SEND support or EHCP by school phase, January 2017 and 2019

School Type	Pupils		Pupils % by school type		Pupils with SEND support		SEND support % by school type		Pupils with an EHCP		EHCP % by school	
	Jan 2017	Jan 2019	Jan 2017	Jan 2019	Jan 2017	Jan 2019	Jan 2017	Jan 2019	Jan 2017	Jan 2019	Jan 2017	Jan 2019
Primary	122332	125,043	59.4%	58.7%	12376	13,046	64.2%	63.5%	1532	2,512	26.2%	31.8%
Secondary	75844	79,744	36.8%	37.5%	6425	6,915	33.3%	33.6%	1091	1,492	18.6%	18.9%
All-through	4266	4,330	2.0%	2.0%	459	589	2.3%	2.9%	63	108	1%	1.4%
Special	3163	3,790	1.5%	1.8%	13		0.06%	0.0%	3150	3,790	53.9%	48.0%
Grand Total	**205,605**	**212,907**		**100%**	**19,273**	**20,550**		**100%**	**5,836**	**7,902**		**100%**

Source: KCC

1.2.3 Ethnicity and SEND

The Kent SEND health needs assessment[5] specifically highlighted gypsy Romany travellers [GRT] who had been shown to be three times more likely than white British children to have SEN, have poor access to SEN support and have the lowest attainment of all groups of children.

Analysis of 2019 SEN pupil data at an England level[6] identified that SEN was most prevalent in travellers of gypsy Roma and Irish heritage at 26% and 30% respectively. In addition, the proportion of pupils with an EHCP was highest amongst black Caribbean and travellers of Irish heritage at 4.4% and 4.5% respectively.

The disproportionate differences observed when looked at by ethnic groups are replicated in Kent and are illustrated in presentation of crude rates in figure 10.

This shows that the crude rate of pupils with SEND support is higher amongst Irish heritage and gypsy roman travellers and those of dual heritage white and black Caribbean. In addition, the crude rate of pupils with EHCP is highest amongst those of dual heritage white and black Caribbean and high amongst those for whom information re ethnicity is not known and traveller of Irish heritage.

[5] Kent SEND health needs assessment 2019 https://www.kpho.org.uk/__data/assets/pdf_file/0017/104471/JSNA-CYP-SEND-and-Learning-Disability-Report.pdf

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf

Figure 10: The crude rate per 100,000 pupils with SEND support or EHCP in Kent by ethnic group- 2019

Ethnicity category	Ethnicity group	Crude rate per 100,000 Pupils with SEND support	Crude rate per 100,000 Pupils with an EHCP
White	White - British	10,254.7	3,931.95
	Any other white background	7,460.75	2,654.15
	Gypsy / Roma	**19,790**	2,820.27
	White - Irish	9,074.07	3,703.7
	Traveller of Irish Heritage	**25,595**	**4,61.9**
White		10,185.2	3,832.45
Asian or Asian British	Indian	4,608.18	1,774.27
	Any other Asian background	4,401.85	2,733.4
	Bangladeshi	6,976.74	**3,741.2**
	Pakistani	**7,111.8**	1,451.38
Asian or Asian British		5,015.78	2,291.59
Black or Black British	Black - African	5,045.52	2,674.51
	Black Caribbean	**9,147.6**	3,534.3
	Any other Black background	6,539.51	**4,087.2**
Black or Black British		5,457.52	2,826.8
Mixed/Dual background	Any other mixed background	7,316.57	3,112.12
	White and Asian	5,681.04	2,566.74
	White and Black Caribbean	**11,665**	**5,362.2**
	White and Black African	8,793.82	3,862.15
Mixed/Dual background		7,916.77	3,496.5
Chinese		4,367.47	2,560.24
Any other ethnic group		6,147.54	2,663.93
Information not yet obtained		9,339.41	**5,808.7**
Refused		8,892.48	2,910.27
Kent average		**9,652.1**	**3,711.5**

Source: KCC

Figure 11: Number with a learning disability up to age 24 in Kent known to schools and adults 18-24 years known to local authorities

year	2018	2023	2028	2033	expected % increase
number	5296	5566	5721	5777	2.7%

Source: Kent disabled C & YP needs assessment summary 2017[7]

[7] https://www.kpho.org.uk/__data/assets/pdf_file/0020/83243/Disabled-Children-and-YP.pdf

Key observations

- The profile for those aged 18-24 years with a SEND is less well reported. This presents gaps in information such as employment.
- The need of ethnic groups is highlighted and therefore recoding of ethnic group is essential.

2. Categorisation of the SEND population

The breadth and range of needs of the children and young people with SEN support or EHCP will be variable. The next figure provides an overview of the different types of SEN disability in Kent compared to England as identified in March 2018 by the council for disabled children SEND dashboard published in June 2019.

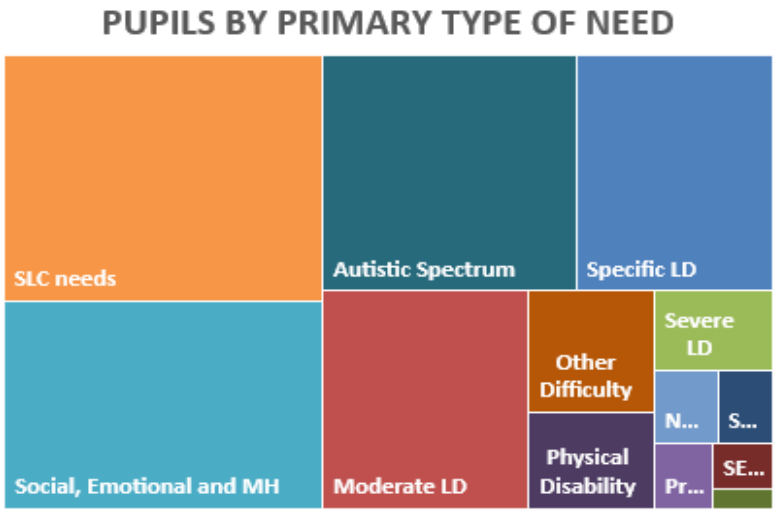
Figure 12: Types of SEN disability, Kent compared to England by number and percentage.

	Number	% of Total	National Average
Specific LD	3,818	13.3%	12.6%
Moderate LD	3,704	12.9%	21.6%
Severe LD	782	2.7%	2.8%
Profound LD	318	1.1%	0.9%
Social, Emotional and MH	5,463	19.0%	16.6%
SLC needs	6,467	22.5%	21.1%
SEN Hearing	321	1.1%	1.9%
SEN Visual	231	0.8%	1.1%
Multi-Sensory	93	0.3%	0.3%
Physical Disability	991	3.4%	3.0%
Autistic Spectrum	4,929	17.1%	10.3%
Other Difficulty	1,270	4.4%	4.6%
No specialist assessment	380	1.3%	3.3%
Total	28,767	100%	100%

Source: Disabled children SEND dashboard

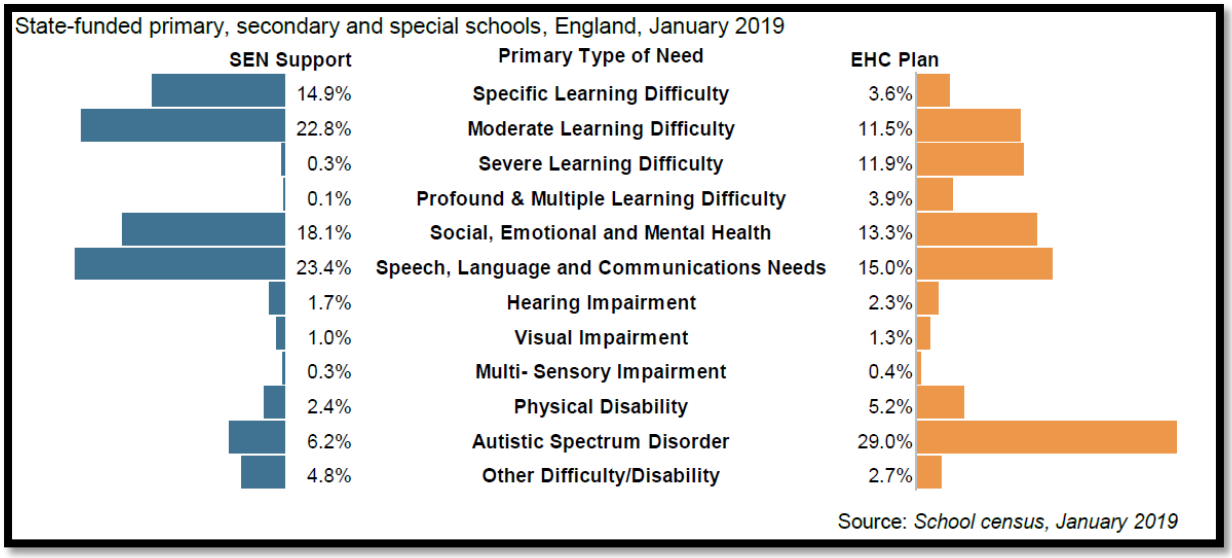
This is then depicted to highlight the primary needs of pupils, which are further explored later in the document.

Figure 13: SEND pupils by primary type of need in Kent



Source: Disabled children SEND dashboard

Figure 14: The distribution of each primary type of need varies greatly between those who are identified as SEN support, compared to those with an EHC plan in England.[8]



2.1 Special educational needs associated with Speech language communication need [SLCN] as a primary need

'SLCN are the most prevalent type of need among boys with Special Educational Needs (SEN) support. Over 60% of all 3-year-olds receiving SEN support have speech, language and communication as their primary need. This gradually decreases as the child ages, reducing to around 15% at age 10 years and 8% at age 15'[9]

Figure 15: The proportion of state funded primary, secondary and special schools of pupils with SEN with SCLN by primary need in England and January 2019

	Primary	Secondary	Special
England	30.6%	11.5%	7.3%
Kent	33.9%	12.9%	7.0%

Source: DfE

2.2 Social emotional and mental health

The proportion of children who have social emotional mental health [SEMH] needs in Kent are similar to the England average as illustrated in figure 16. However, when looking at children with special education needs in school with SEMH primary need the proportion in Kent is higher than England average in state primary, secondary and special schools.

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf

9 Department for Education. *Special educational needs in England.* 2018. Available from: www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018 cited in PHE [2019] Speech, language and communication needs assessment report for Kent

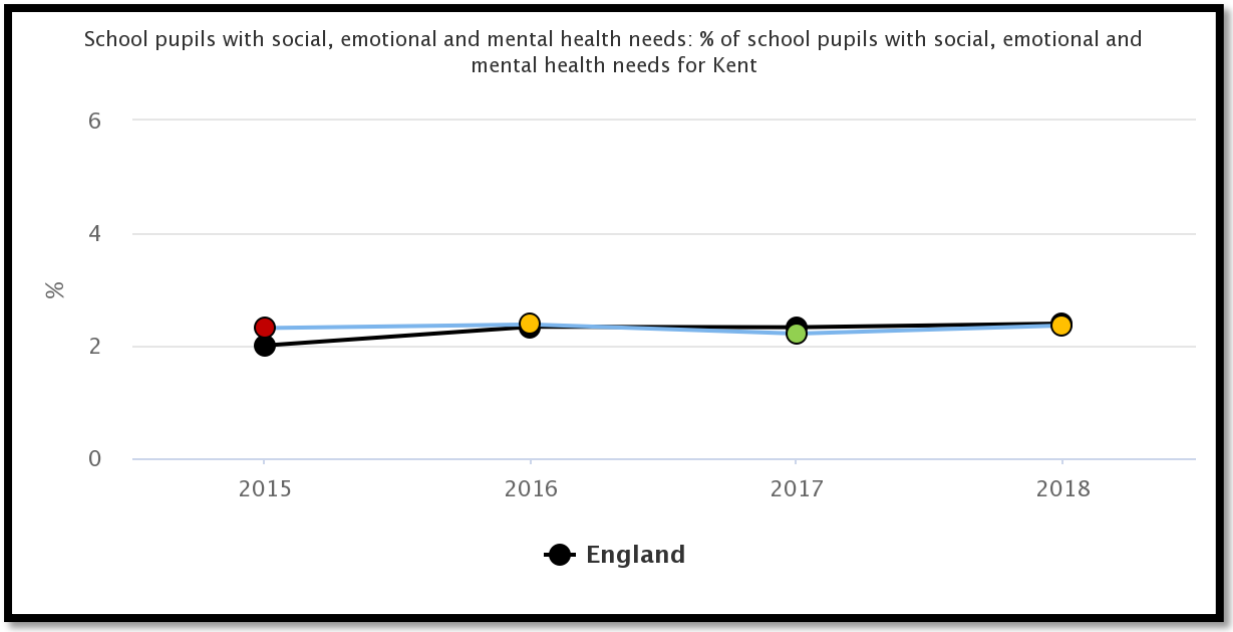
Figure 16: The proportion of state funded primary, secondary and special schools of pupils with SEN with SEMH by primary need in England and January 2019

	Primary	Secondary	Special
England	16.3%	19.6%	12.8%
Kent	19.1%	21.7%	13.8%

Source: DfE

The Timpson review on school exclusion identified that 'Children with SEMH as a primary need but who do not have an EHC plan, are around 3.8 times more likely to be permanently excluded, compared to children with no SEN. Children with SEMH type SEN (who do not have an EHC plan) are also significantly more likely to be excluded for a fixed period, even controlling for other factors.'[10]

Figure 17: School pupils with SEMH needs



Source: PHE fingertips

2.3 Autistic spectrum disorder

Autism is thought to occur in at least 1% of children[11]

The proportion of those identified with SEND is greatest amongst those with autistic spectrum disorder [ASD]. This was highlighted on page 22 and reiterated in the ASD deep dive presented to the 0-25 HWBB in October 2019 which stated that 'the primary SEN type ASC is much greater amongst children and young people with SEN support (9.7 % in Kent,

[10] Timpson review https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807862/Timpson_review.pdf May 36:2019

[11] National Institute for Health and Care Excellence (NICE). *Autism spectrum disorder in under 19s: recognition, referral and diagnosis (CG 128).* 2011. Available from: www.nice.org.uk/Guidance/CG128 cited in PHE [2019] Speech, language and communication needs assessment report for Kent

5.7% in England'[12] Published data illustrates the difference in the rates of children with autism known to schools between England and Kent as shown in the following figure..[13]

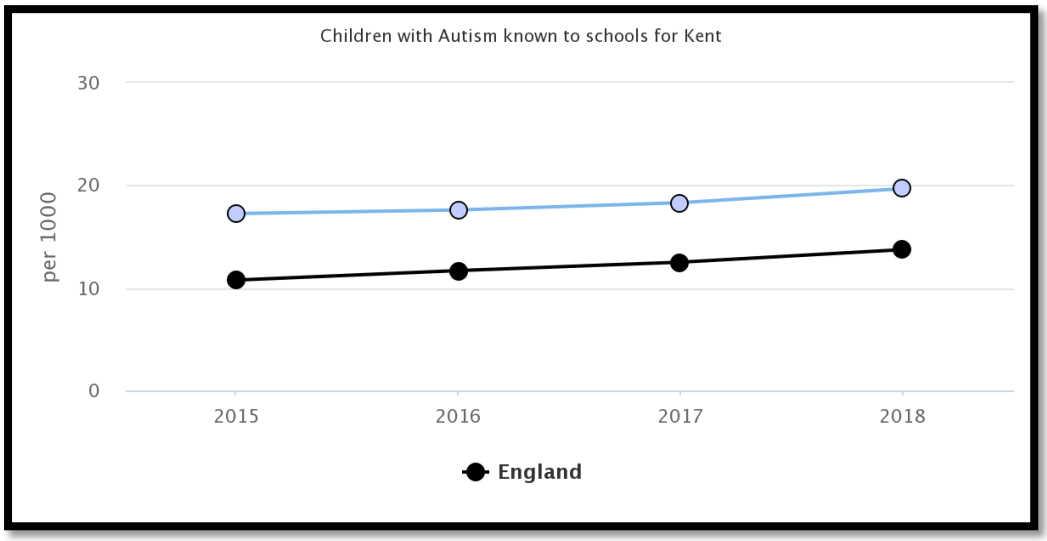
Figure 18: The proportion of state funded primary, secondary and special schools of pupils with SEN with ASD by primary need in England and January 2019

	Primary	Secondary	Special
England	7.9%	10.3%	29.8%
Kent	10.3%	15.0%	48.3%

Source: DfE

The greatest primary need amongst those with an EHCP in England in 2019 was ASD which accounted for 29%.[14]

Figure 19: Children with autism known to schools in Kent 2015-2018



Source: PHE fingertips

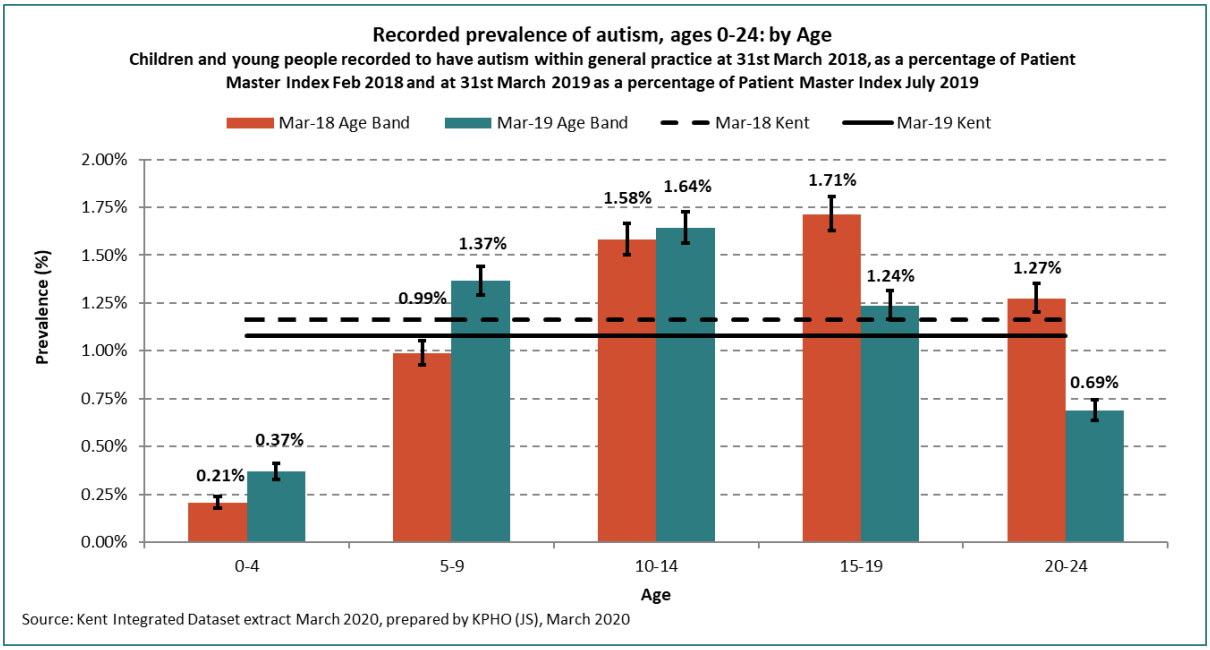
There is increase in the prevalence of autism amongst those aged 0-14 years and then a decrease is observed amongst those aged 15- 24 years.

[12] Neuro Developmental Disorders Deep Dive- presentation to the 0-25 HWBB October 2019

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf

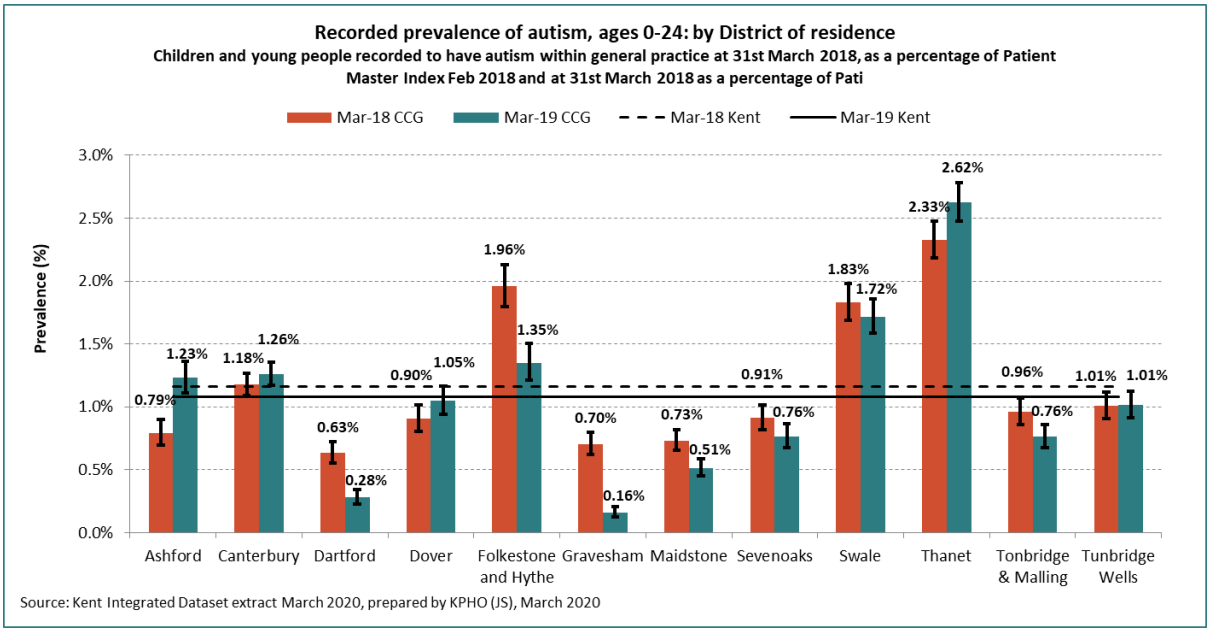
[14] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf

Figure 20: Recorded prevalence of autism aged 0-24 by age band, Kent 2018-2019



The SEND HNA [p66] highlighted an association between 0-24-year olds recorded with ASD registered with a general practice in Kent and deprivation. This analysis showed the most deprived decile recorded prevalence of ASD 1.5% compared to the least deprived with a recorded prevalence of 0.73% Although not presented here this slide shows the districts where deprivation is greatest having a higher recorded prevalence of autism amongst 0-24-year olds. Of note the areas with populations with higher proportion of BAME have much lower recorded prevalence of autism which have also reduced from 2018 to 2019. Understanding the different responses to autism have been reported.[15]

Figure 21: Recorded prevalence of autism aged 0-24 by district of residence, Kent 2018-2019

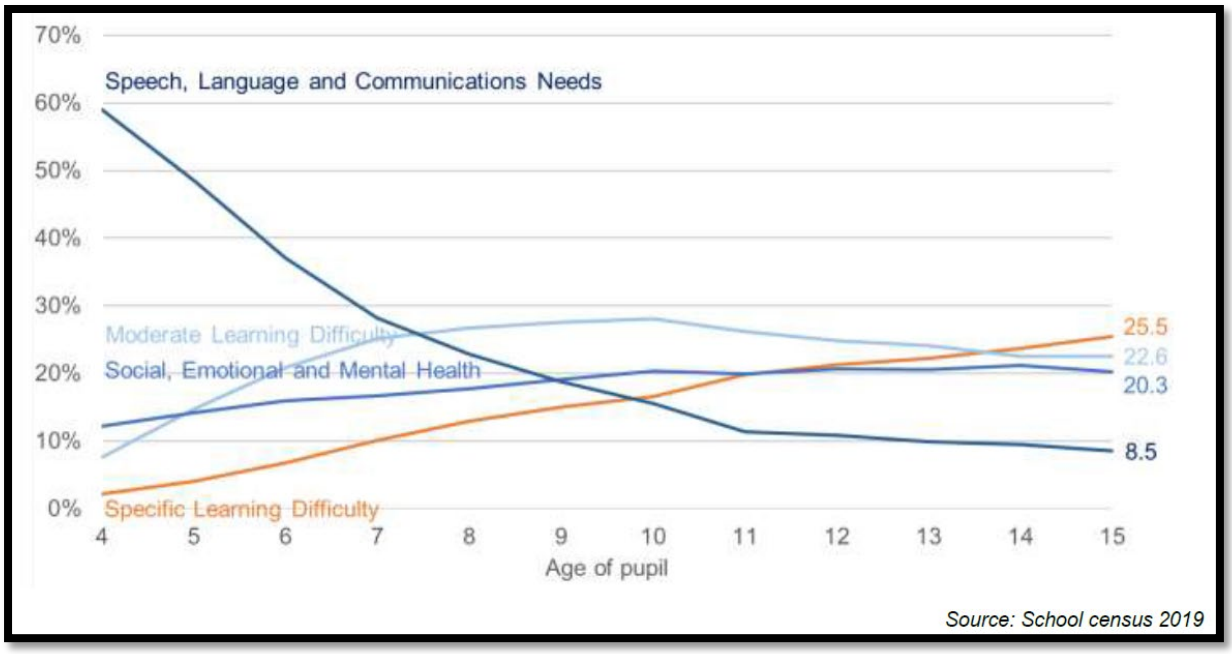


[15] https://www.autismvoice.org.uk/wp-content/uploads/2020/03/Autism-in-BAME-Communities.pdf

Activity to identify the local assessment process for the diagnosis of ASD or ADHD are documented in recent review[16] and audit.[17] These found self-referral by parents was adding to the waiting list demand. A key finding was that there was significant association between teacher screening score and diagnosis but not parent screening score. Of note is that over half of the children following a diagnosis in one provider organisation do not require further input as support is provided elsewhere or is already being given.

The DfE report on special education needs presented the difference on SEND support across ages 4 – 15 years. The distribution in the change of the most prevalent types of need as age increases amongst those with SEN support.

Figure 22: State funded primary, secondary, special school with SEN support, England January 2019[18]

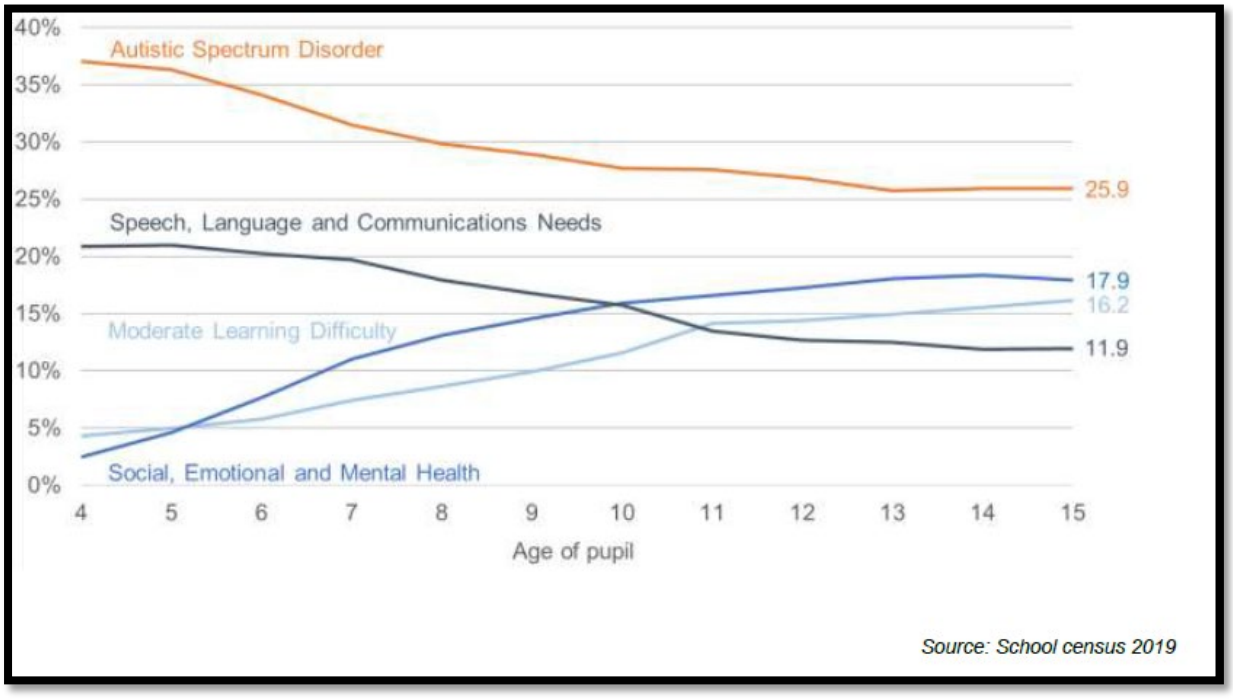


Source: DfE

This report also looked at primary need amongst those with an EHC plan by age. There are less distinct differences between age groups for those pupils with an EHC plan. The most prevalent primary type of need across pupils aged 4 – 15 years with an EHC plan is autistic spectrum disorder.

[16] Report to the Kent 0-25 HWBB Neuro Developmental Disorders Deep Dive
[17] NeFLT and KCC Kent autism spectrum condition predictive screening audit, January 2020
[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf 10:2019

Figure 23: State funded primary, secondary, special school pupils with an EHC plan, England Janu 2019[19]

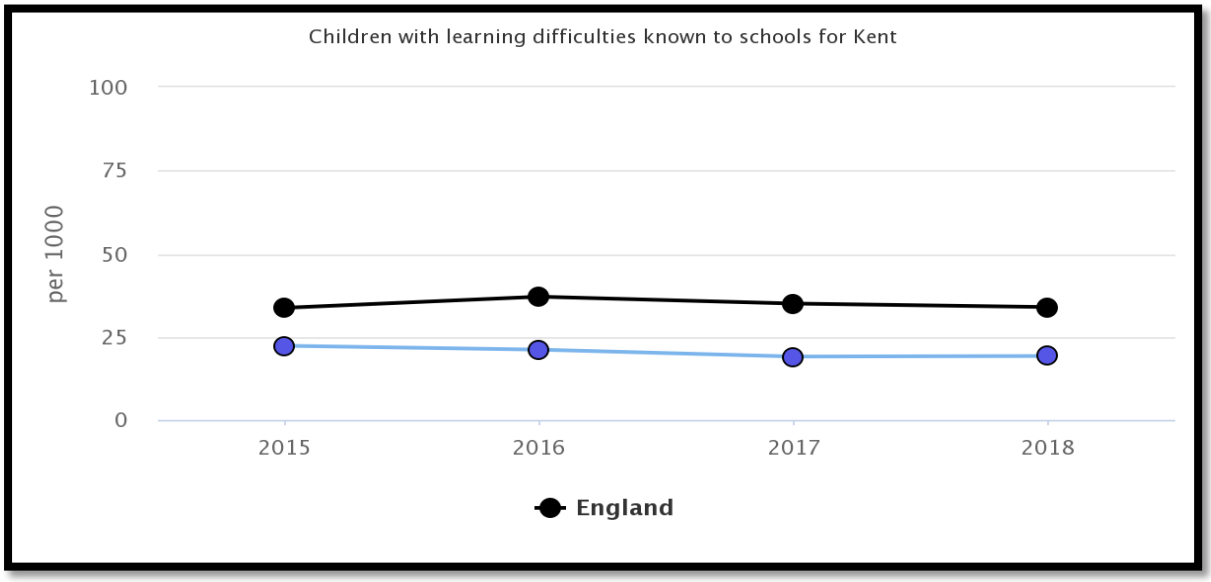


2.4 Learning difficulties

Learning difficulty usually refers to conditions such as dyslexia and dyspraxia. The proportion of children with learning difficulties known to schools in Kent is lower than England for the period 2015-2018 and has remained fairly consistent. 'Children with a learning difficulty may also have SLCN. A considerable number of children with a learning difficulty are likely to have SLCN as well, particularly where this is identified as a secondary need to their learning difficulty.'

19 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf 11:2019

Figure 24: Children with learning difficulties known to schools in Kent 2015-2018



Source: PHE fingertips

2.5 Sensory impairment and sensory needs

Children learn over time to organise sensory information and to develop their response. Some children do not have the ability to cope with sensory stimuli from the people around them or the environment which will be exacerbated by hunger, tiredness, stress or illness. There can be over or under sensory stimulation. For example, listening and looking may lead to sensory overload. This experience may affect behaviour as children or young people utilise different methods to respond and calm their sensory system such as shouting, finding somewhere quiet or rocking. Once in an early year setting or primary school communication, social and emotional needs may be observed as these are overloaded sensory environments. These children and young people may be identified for ASD diagnostic assessment or be recommended for an EHCP.

A sensory assessment which can observe children or young people in their home or school can help to understand individual response and needs. Feedback from adult services highlights that young people who access their services at age 18 have never had their sensory needs assessed, let alone met.

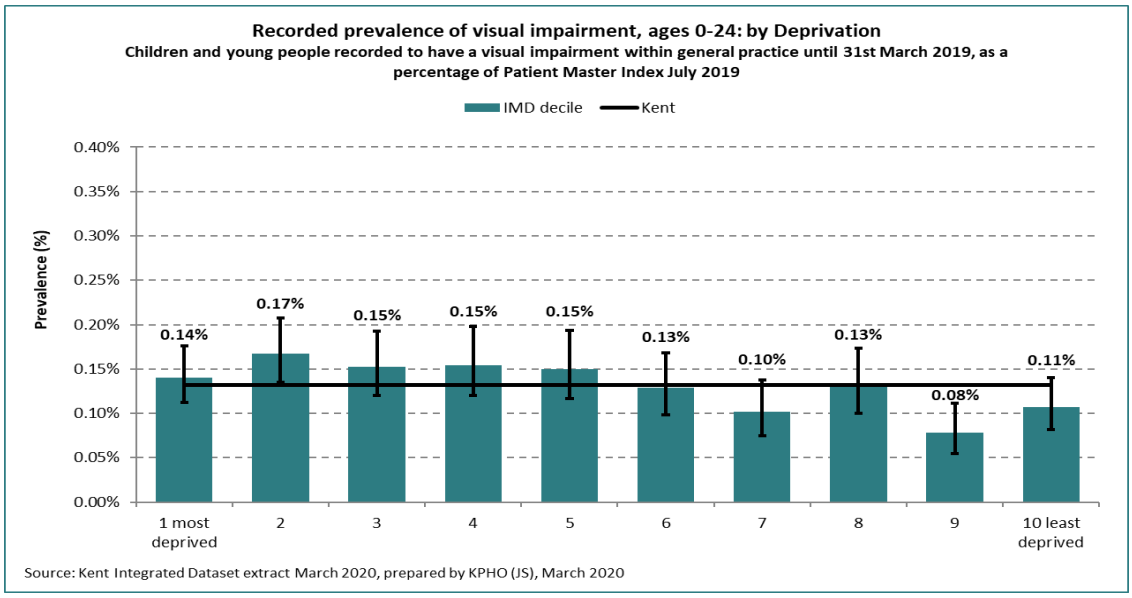
Integration of a sensory assessment into the EHCP process would be beneficial to inform the care plan. Completion of a sensory assessment when children and young people are identified and waiting for an ASD diagnostic assessment, would help support individuals and their families.

2.5.1 Visual impairment

Those children and young people at higher risk of visual impairment include those with learning disabilities, those born very premature and with very low birth weight, a south

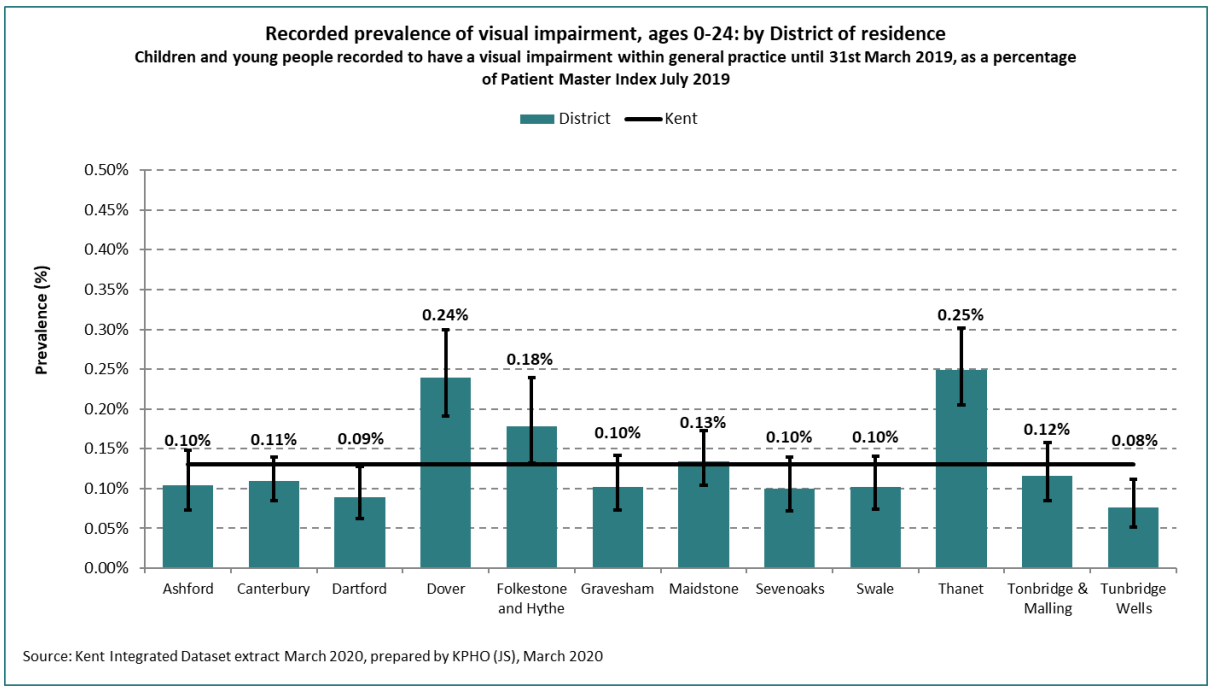
Asian ethnic groups or more deprived backgrounds.[20] However, when looking at the recorded prevalence of visual impairment there is no statistical difference across deprivation groups as shown below.

Figure 25: Recorded prevalence of visual impairment aged 0-24 years by deprivation in Kent 2019



The figure below shows that the districts of Dover and Thanet have statistically significant differences in the recorded prevalence of visual impairment.

Figure 26: Recorded prevalence of visual impairment aged 0-24 years by district of residence in Kent 2019



[20] https://www.visionuk.org.uk/download/Sight-loss-statistics-for-CYP-2018-FINAL.pdf

Since the Kent sensory needs assessment was undertaken in 2016 the school public health workforce has been commissioned to provide vision screening to reception year children in state schools which was implemented in 2017. This follows recommendation by the UK National screening committee[21] and requires parental/carer consent to undertake.

Figure 27: Number and proportion of Year R pupils taking up vision screening in state schools 2017/18 - 2019/20

Academic cohort	No. of Year R children - exc. Independent and Special schools	No of Yr Screened (quarterly report)	Proportion of Year group (%)	Period screening completed
2017/18	17887	9891	55.3%	Q4 Jan 2018 – Q2 July 2018
2018/19	17304	15336	88.6%	Q4 Jan 2019 – Q2 August 2019
2019/20	17177	876	5%	Q4 Jan 2020 – March 2020

Source: KCHFT performance data

One report in 2016 estimated that 'Children with learning disabilities are 28 times more likely to have a serious sight problem than other children.'[22] The lack of vision screening in special schools is potentially creating further inequalities as this requires additional competencies amongst health professionals. NHSE/I have recently considered Kent an early adopter for special school vision screening.

The Specialist Teaching and Learning Service [STLS] Sensory Service in Kent work with children and young people from birth/diagnosis until they leave school who have hearing impairment [HI], visual impairment [VI] or multi-sensory impairment/deaf blindness [MSI]. The team is in the main comprised of teachers who hold a mandatory qualification to teach learners with HI, VI or MSI. There is direct teacher support for those children and young people with moderate, severe or profound HI, IV or MSI impairment.

Figure 28: Numbers of children and young people 0-16 years plus those 16-19 years attending school in Kent with Visual Impairment 2017 and 2020 receiving STLS sensory service.

	Profound	Severe	Moderate	Total
Visual Impairment June 2017	98	140	166	**404**
Visual Impairment June 2020	**100**	**151**	**196**	**447**

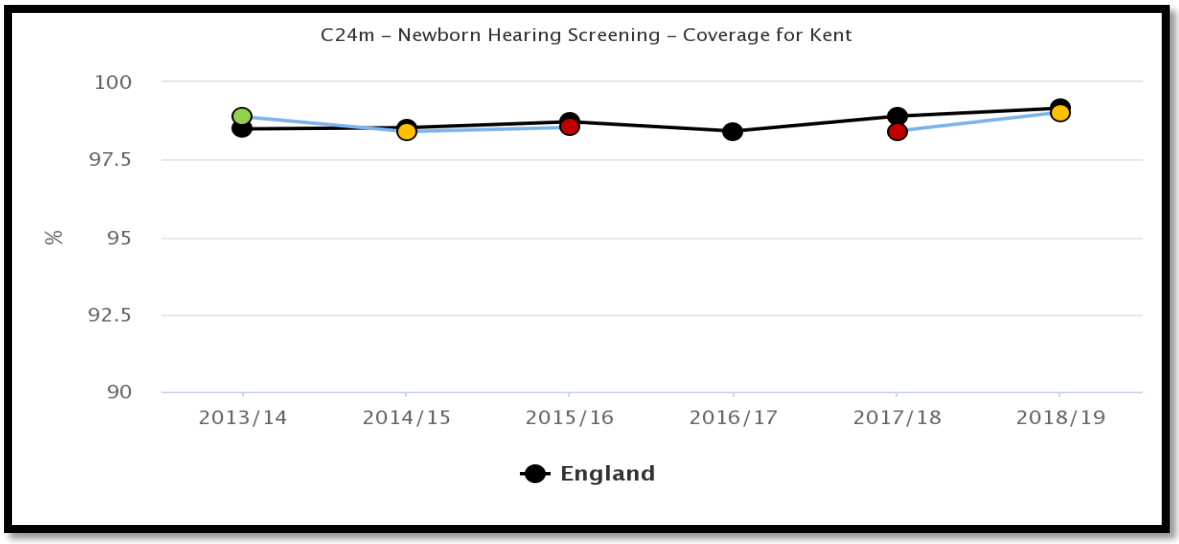
Source: Kent STLS sensory service

[21] https://www.gov.uk/government/publications/child-vision-screening/service-specification
[22] https://councilfordisabledchildren.org.uk/sites/default/files/field/attachemnt/Delivering_an_equal_right_to_sight.pdf [5: 2016]

2.5.2 Hearing impairment

'Between one and two babies in every 1,000 are born with permanent hearing loss in one or both ears.'[23] However, estimates of rates of hearing impairment in children are not routinely reported at local, regional or national level. Kent Public Health Observatory attempted to replicate published methodologies for estimating the prevalence of hearing impairment using locally available GP records from Kent and Medway. Their estimates, however, were significantly different from benchmarks in published literature and therefore insufficient confidence to report here. A new-born hearing screen is undertaken before an infant is 30 days old. Coverage in Kent is consistently high.

Figure 29: Proportion of infants receiving a new-born hearing screen in Kent 2013/14 - 2018/19



Source: PHE fingertips

[23] NHS Choices. *Newborn hearing screening.* 2018. Available from: www.nhs.uk/conditions/pregnancy-and-baby/newborn-hearing-test/ cited in PHE [2019] Speech, language and communication needs assessment report for Kent

Figure 30: Number and proportion of Year R pupils received audiology screening in state schools 2017/18 - 2019/20

Academic cohort	No. of Year R children - exc. Independent and Special schools	No. of Yr R pupils who received audiology screening	Proportion [%] of Year group	Period screening completed
2017/18	17887	10497	58.7%	Q4 Jan 2018 – Q2 July 2018
2018/19	17304	17102	98.8%	Q4 Jan 2019 – Q2 August 2019
2019/20	17177	874	5%	Q4 Jan 2020 – March 2020

Source: KCHFT performance data

The STLS sensory service provide direct teacher support for those children and young people with moderate, severe or profound hearing impairment

Figure 31: Numbers of children and young people 0-16 years plus those 16-19 years attending school in Kent with Hearing Impairment 2017 and 2020 receiving STLS sensory service

	Profound	Severe	Moderate	Total
Hearing Impairment June 2017	113	72	307	**492**
Hearing Impairment June 2020	**121**	**69**	**274**	**437**

Source: Kent STLS sensory service

2.5.3 MSI/Deaf blindness

The following presents an overview of the number of children and young people in Kent with MSI/Deafblindness

Figure 32: MSI/Deafblindness in those aged 0-16 plus those 16-19 attending school, Kent 2017 and 2020

	Exceptional	Profound	Severe	Moderate	Total
MSI/Deafblindness June 2017	8	10	14	4	**36**
MSI/Deafblindness 0-18yrs June 2020	4	7	11	13	**39**
MSI/Deafblindness 19-25yrs June 2020	**<5**	**<5**	**<5**	**<5**	**11**

Source: Kent STLS sensory service

To note from 2018 the STLS Sensory Service was requested to maintain data on young people aged 19-25 previously known to the service.

2.6 Children in need [CIN] or with child protection plans [CPP]

Figure 33: Children in need pupils by age (CIN between September 2018- August 2019)

Age as at end Aug 2018	CIN pupils	CIN pupils % by age	CIN with SEND support	CIN SEND support % by age	CIN with an EHCP	CIN EHCP % by age
4	240	7.4%	36	6.7%	41	4.0%
5	259	8.0%	52	9.6%	52	5.1%
6	312	9.7%	63	11.6%	96	9.3%
7	281	8.7%	55	10.2%	73	7.1%
8	265	8.2%	50	9.2%	74	7.2%
9	269	8.3%	45	8.3%	98	9.5%
10	296	9.2%	51	9.4%	99	9.6%
11	277	8.6%	39	7.2%	115	11.2%
12	250	7.7%	42	7.8%	84	8.2%
13	258	8.0%	40	7.4%	96	9.3%
14	254	7.9%	30	5.5%	105	10.2%
15-16	266	8.2%	38	7.0%	95	9.2%
Grand Total	**3,227**	**100.0%**	**541**	**100.0%**	**1,028**	**100.0%**

Source: KCC

The proportion of children in need offered SEND support has reduced over the time period presented and halved amongst those known to the youth offending team. This maybe a reflection of the system changes in the integrated children's services.

Figure 34: Specialist Children's Services Support (between September 2018 to August 2019)[24]

Specialist Children's Services	Pupils	Pupils % by service	Pupils % by service Jan 2017	Pupils with SEND support	SEND support % by service Jan 2017	SEND support % by service	Pupils with an EHCP	EHCP % by service
Child Protection Plan	1,396	0.7%	3.7%	337	1.7%	1.6%	106	1.3%
Child in Need	3,227	1.5%	3.2%	541	8.4%	2.6%	1,028	13.0%
Known to YOT	306	0.1%		69	1%	0.3%	40	0.5%
Early Help Support	13,349	6.3%		2,808		13.7%	1,213	15.4%
Grand Total	**212,907**	**100%**		**20,550**		**100%**	**7,902**	**100%**

Source: KCC

[24] Note: Children in need (CIN) - pupils who were CIN only (excluding CP or child in care (CIC)) between September 2018 and August 2019.
Child Protection (CP) - pupils who had a child protection plan (excluding CIC) between September 2018 and August 2019.
Youth offending team (YOT) - pupils that were known to the Youth Offending Team between September 2018 to August 2019. Those with a substantive outcome and those that worked with other organisations of interest i.e. Police, probation, community safety.
Early Help Support - Pupils who requested support which proceeded to early help during September 2018 to August 2019.

Figure 35: Children in need pupils by age (CIN between September 2018- August 2019)

Age as at end Aug 2018	CIN pupils	CIN pupils % by age	CIN with SEND support	CIN SEND support % by age	CIN with an EHCP	CIN EHCP % by age
4	240	7.4%	36	6.7%	41	4.0%
5	259	8.0%	52	9.6%	52	5.1%
6	312	9.7%	63	11.6%	96	9.3%
7	281	8.7%	55	10.2%	73	7.1%
8	265	8.2%	50	9.2%	74	7.2%
9	269	8.3%	45	8.3%	98	9.5%
10	296	9.2%	51	9.4%	99	9.6%
11	277	8.6%	39	7.2%	115	11.2%
12	250	7.7%	42	7.8%	84	8.2%
13	258	8.0%	40	7.4%	96	9.3%
14	254	7.9%	30	5.5%	105	10.2%
15-16	266	8.2%	38	7.0%	95	9.2%
Grand Total	**3,227**	**100.0%**	**541**	**100.0%**	**1,028**	**100.0%**

Source: KCC

Key Observation

- Many children identified with SEND have more than one competing developmental need.

3. Inequalities

3.1 Mosaic analysis of deprivation

The mosaic groups are presented to support understanding and illustrate where the greater need of SEND and EHCP is represented across socio demographics. The highest proportion of pupils with SEND support or EHCP are in the 3 most deprived mosaic groups.

Figure 36: Mosaic analysis of deprivation

Mosaic Group	Pupils	Pupils % by Mosaic	Pupils with SEND support	SEND support % by Mosaic	Pupils with an EHCP	EHCP % by Mosaic	
A - Country Living	11,364	5.3%	937	4.6%	318	4.0%	
B - Prestige Position	18,591	8.7%	1,088	5.3%	448	5.7%	Most Affluent
C - City Prosperity	1,141	0.5%	56	0.3%	27	0.3%	
D - Domestic Success	38,038	17.9%	2,379	11.6%	979	12.4%	
E - Suburban Stability	8,506	4.0%	787	3.8%	379	4.8%	
F - Senior Security	1,581	0.7%	156	0.8%	60	0.8%	
G - Rural Reality	13,608	6.4%	1,440	7.0%	579	7.3%	
H - Aspiring Homemakers	45,288	21.3%	3,917	19.1%	1,470	18.6%	
I - Urban Cohesion	2,513	1.2%	202	1.0%	54	0.7%	
J - Rental Hubs	9,087	4.3%	879	4.3%	292	3.7%	
K - Modest Traditions	3,716	1.7%	442	2.2%	184	2.3%	
L - Transient Renters	12,957	6.1%	1,605	7.8%	553	7.0%	
M - Family Basics	40,696	19.1%	5,870	28.6%	2,252	28.5%	
N - Vintage Values	1,031	0.5%	150	0.7%	60	0.8%	
O - Municipal Challenge	2,981	1.4%	463	2.3%	156	2.0%	
Unknown	1,809	0.8%	179	0.9%	91	1.2%	Most deprived
Grand Total	212,907	100%	20,550	100%	7,902	100%	

Source:

3.2 Ethnicity

The inequalities in the health of population amongst those with SEND from different ethnic groups has been reported in this document see figure 10. There are significant differences in the crude rates of those offered SEND support with rates nearly three times higher amongst traveller Irish heritage and double amongst traveller gypsy roma compared to the Kent average amongst all identified as being offered SEND support.

The difference is less marked amongst those with an EHCP but crude rates by ethnic group show those of white and black Caribbean to be high at 5362 per 100,000 pupil population compared to the Kent average of 37115 per 100,000 population. Of concern is that the classified group with the highest crude rate at 5808 per 100,000 population is amongst those categorised under information not obtained.

Figure 37: Proportion of state funded primary, secondary, special school with SEN statement or EHCP, or pupils with SEN support by primary need and ethnic group, England, January 2019[25]

Ethnic group	% SEN statement or EHCP	% SEN support	% SEN statement or EHCP	% SEN support	% SEN statement or EHCP	% SEN support	%SEN statement or EHCP	% SEN support
	SLCN		SEMH		moderate LD		severe LD	
White	14.4%	21%	15.1%	18.6%	12.3%	22.6%	0.3%	11.5%
Traveller Irish heritage	15%	23.1%	22.4%	13.8%	16.1%	34.3%	0.7%	11.5%
Traveller gypsy roma	22.1%	16.9%	19.2%	12.9%	16.3%	38.9%	0.6%	12.6%
Mixed	14.9%	23.8%	16.4%	22.6%	9.3%	20.4%	0.3%	10.9%
White & black Caribbean	13.5%	18.5%	24.9%	26.6%	10.3%	22.7%	0.3%	8.4%
Asian	17.7%	35.4%	2.5%	9.8%	10%	28.1%	0.4%	15.2%
Black	16.9%	33%	9.2%	19.2%	8%	20.5%	0.4%	12.3%
Chinese	21.2%	44.9%	2.3%	10.8%	5.4%	12.7%	0.1%	12.7%
Unclassified	14%	21.9%	13.2%	20%	10.7%	21%	0.5%	10.2%
All	15%	23.4%	13.3%	18.1%	11.5%	22.8%	0.3%	11.9%

Source: School census data

There are stark differences in primary need by ethic group in terms of who has the greatest burden of need and where identified need is considerably lower.

A lower proportion of SEMH as a primary need is observed amongst Asian and Chinese populations and would need further understanding at a local level.

The mental health needs of those of white and black Caribbean heritage suggest 1 in 4 either with an EHCP or SEN support have SEMH as a primary need which needs exploration at a local level.

The crude rate of EHCP and SEN support for pupils in Kent amongst the traveller of Irish heritage and gypsy roma were highlighted on page 15. This analysis of England data illustrates where those primary needs are most evident. In June 2019 government launched their intention to develop a national strategy to tackle entrenched in equality and improve the lives of GRT communities.

3.3 Adverse childhood experiences [ACE] are not distributed equally

Adverse childhood experiences are understood as a group of circumstances or traumatic events before adulthood which impact upon mental and physical health outcomes. In addition, the chronic stress from these events or circumstances has led to the overproduction of cortisol and subsequent damage to the auto immune system. Recent research highlights the differences in population groups experiencing trauma.

- **'Conduct disorder:** Young people who have been exposed to trauma are twice as likely to have a conduct disorder as those who have not been exposed to trauma [26]

[25] https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2019
[26] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2819%2930031-8

- **Attention-deficit hyperactivity disorder (ADHD):** They are also twice as likely to have ADHD[27]
- **Autism spectrum disorder (ASD):** Young people with ASD are more likely to have been exposed to Adverse Childhood Experiences than those who do not have ASD (Berg et al., 2016; Rigles, 2016; Kerns et al., 2017).
- **Intellectual disability:** Young people with intellectual disability are more likely to have experienced trauma than those without (Hatton & Emerson, 2004; Mevissen et al., 2014; Byrne, 2018). '[28]

3.4 Immunisation schedule and screening programme uptake

There is no data set which collects the immunisation uptake of children and young people that records whether the individual has a diagnosed learning disability, a special education need or has an EHC plan. Prevention of common childhood diseases is important but particularly when some learning disabilities may have been as result of preventable disease.

The development of a tool by *in health intelligence* to measure the uptake of the diabetic eye screening programme [usually undertaken aged 12 years] by disability could increase awareness of diabetes and the risk of type 2 diabetes earlier.

3.5 Learning disability annual health checks 14-24 years

The estimated expected prevalence of those aged 14-24 years with a learning disability is 2.6% of the population.[29] The data on the proportion of young people aged 14 and over registered with a learning disability at a general practice is not available on published data sets by age range. The collection of this information is reliant on many factors. These include awareness of parents/carers/foster parents of the benefits of an annual health check in order to help identify health needs early, registration of the diagnosis of a learning disability, uptake of an invitation to attend for an annual health check and uploading of checks completed onto the national data set.

The promotion and increased awareness of these checks amongst professionals and families will help increase the uptake and will be most effective where this becomes a regular health behaviour choice.

An extract from the Kent integrated data set in September 2019 found amongst:

- 480 14-18 years on the QoF LD register in Kent, 104 [21.6%] approximately 1 in 5 had received an LD annual health check and
- 932 19-25year olds on the QoF LD register in Kent 313 [33.5%] approximately 1 in 3 had received an LD annual health check.

[27] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2819%2930031-8
[28] https://www.centreformentalhealth.org.uk/sites/default/files/2020-1/Briefing_54_traumainformed%20schools_0.pdf
[29] https://www.kpho.org.uk/__data/assets/pdf_file/0014/53411/Learning-Disabilities-Annual-Health-Checks.pdf

This suggests that of those 14-25year olds on the QoF LD register in Kent 29.5% had an annual health check. The QoF LD register contains codes for over 200 identified conditions was updated in October 2019 as part of the intention of NHSE to improve care for those with a learning disability or autism.[30]

Medicine reviews will also help control the management and care of those with learning disabilities which this check is another opportunity to utilise. Antipsychotic, epilepsy medicines, drugs used in diabetes are commonly taken by people with learning disabilities. All patients on these medications should be monitored regularly for side effects including weight gain. Some medications used to support in the management of care of individuals with a learning disability can increase body mass. The frequency of monitoring varies for each drug, but an absolute minimum is annually and expectation of monthly monitoring for those initiating new medication.

The introduction of a national programme in 2016 by NHSE Stopping the Over-Medication of people with a learning disability, autism or both [STOMP] was designed to look at the use of psychotropic medicine, typically prescribed to treat mental health, across the health system. 'Psychotropic medicines affect how the brain works and include medicines for psychosis, depression, anxiety, sleep problems and epilepsy. Sometimes they are also given to people because their behaviour is seen as challenging.'[31]

In December 2018 NHSE extended this and launched Supporting Treatment and Appropriate Medication in Paediatrics [STAMP] [32]

An initial review of the proportion of the population aged 14- 18 years prescribed psychotropic medication through primary care in Kent[33] compared to those aged 14-18 years with a learning disability from January 2016 – August 2018 found that no young people with a learning disability had a serious mental health diagnosis. However antipsychotic drugs were prescribed in greater proportions compared to the population cohort as shown in the next figure.

[30] https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf
[31] https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/
[32] https://www.england.nhs.uk/learning-disabilities/improving-health/stamp/
[33] The Kent Integrated Dataset (KID)

Figure 38: Proportion of the population aged 14-18 years prescribed psychotropic medication through primary care in Kent compared to those aged 14-18 years with a learning disability from January 2016 – August 2018 by medication type

	Primary care prescribing of hypnotics, amongst the population aged 14-18 years		Primary care prescribing of antipsychotics, amongst the population aged 14-18 years		Primary care prescribing of antidepressants amongst the population aged 14-18 years	
	All pop cohort % medicated	LD cohort % medicated	All pop cohort % medicated	LD cohort % medicated	All pop cohort % medicated	LD cohort % medicated
Kent	3.0%	24.5%	1.9%	15.7%	3.6%	9.0%

Source: Kent integrated data set [KID][34]

This was collated to understand whether people diagnosed with a learning disability (LD) but not with a serious mental health condition were being overprescribed drugs typically prescribed to treat mental health.

3.6 Epilepsy

Epilepsy can affect anyone and can start at any age. However, one of the age ranges when it is most commonly diagnosed is amongst those aged under 20 years. Factors that might cause epilepsy are difficulties at birth, infections in childhood or following accidents.

- The number of children and young people aged 18 years and under in England and Wales with epilepsy is near 1 in 220.'[35]

The episodes of epileptic seizures will be influenced by the cause including neuropathic disorders, high temperature, poor treatment adherence or management of treatment.

NICE[36] recommends that children and young people with epilepsy should have a regular structured review carried out at least yearly (but may be between 3 and 12 months by arrangement) by a specialist.

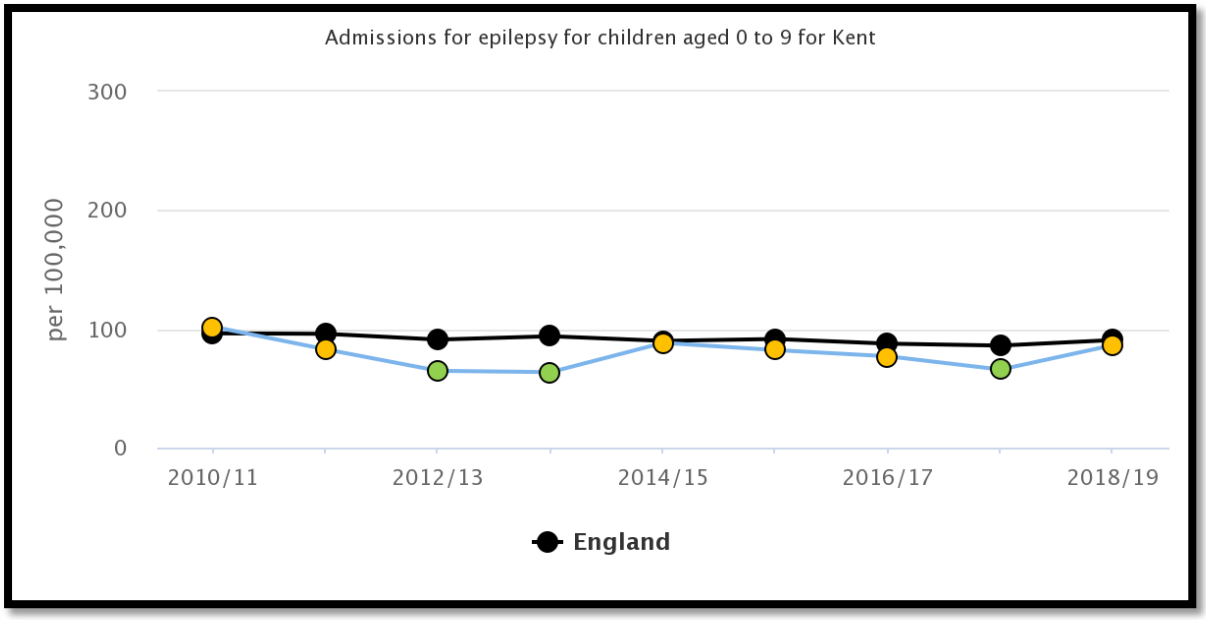
There are differences in the rates of children and young people requiring admission to hospital with epilepsy or status epilepticus by age band and location in Kent. There are differences in the rates of children and young people requiring admission to hospital with epilepsy or status epilepticus by age band and location in Kent. The presentation of admissions for epilepsy from 2010/11- 2018/19 amongst children and young people aged 0-9years, 10-19 years and 0-19 years clearly shows that the greatest demand is amongst those aged 0-9 years in Kent.

[34] The Kent Integrated Dataset (KID), a linked person-level health dataset was used to link GP prescribing data with other GP and demographic records of current Kent patients. At the time of running the KID covered 91% of GP practices. Numbers of patients were extracted for each of the groups, by drug category from January 2016 to August 2018, covering 32 months in total

[35] https://www.youngepilepsy.org.uk/about-epilepsy/what-is-epilepsy/ accessed 14/08/2019

[36] https://www.nice.org.uk/guidance/cg137/chapter/Key-priorities-for-implementation

Figure 39: Crude rate per 100,000 of those aged 0-9 years, admitted to hospital with epilepsy or status epilepticus In Kent 2010/11 - 2018/19



Source: PHE fingertips

3.7 Weight management

There are many potential, but different comorbidities from having excess weight or having a weight which is identified as underweight. The national child measuring programme {NCMP] which measures children in reception and year 6 does not include the weighing and measuring of children in special schools so longitudinal data for this cohort is not known. The NCMP has found in England and is replicated in Kent that overweight and obesity prevalence is generally higher within Black and Asian ethnic groups[37] and in those living within the most deprived areas.[38]

The data presented in figure 30 illustrates the differences in primary need showing that moderate and severe learning disability is not distributed evenly across ethnic groups. It is possible that higher excess weight is also seen in the same ethnic groups. There are prescribed medications which may be used in the treatment, management and care of those with SEND which exacerbate or cause weight gain and similarly those which may cause weight loss, and these are shared in appendix 2.

Identifying, recording and monitoring weight amongst those with SEND as part of the annual health checks programme and/or as part of medicine reviews would be beneficial.

[37] Note that across Kent 19.9% in reception year and 38.2% of year six had ethnicity group not stated. Across England 22.9% in reception year and 35.0% of year six had ethnicity group not stated.
[38] Note using England 2015 IMD deciles.

3.8 Foetal alcohol spectrum disorder

Foetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe impacts on the brain and body of individuals prenatally exposed to alcohol during pregnancy. Individuals with FASD have their own unique areas of difficulties and may experience challenges in their daily living and need support with motor skills, physical health, learning, memory, attention, emotional regulation, and social skills.

FASD is the most common non genetic cause of learning disability in the UK but it is preventable. The 'reality is that a large number of children are born every year in the UK with lifelong physical, behavioural and / or cognitive disabilities caused by alcohol consumption during pregnancy '[39]

One recent study[40] estimated that between 6%-17% of births are impacted by FASD in the UK. In Kent based on 2018 births this would equate to approximately 1,050-2,900 infants in a year.

Another study found evidence of a dose–response relationship between ACEs and alcohol use during pregnancy that remained even after controlling for pre pregnancy drinking and other covariates. (Frakenburger et al, 2019)

There is no service commissioned to diagnose FASD in child or adult hood in Kent or to provide the care for individuals and families. The likely impact is that children, young people and adults are living with undiagnosed FASD, not able to access the information, support and therapies which they need.

More children with complex needs including attachment issues and FASD which are hard to diagnose.

Importantly 'Often the condition goes undiagnosed or is diagnosed for example as autism or ADHD rather than those conditions being recognised as comorbid presentations of FASD.' Moreover 'due to the level of children coming through the care system, attachment disorders are often viewed as the sole cause of presenting signs and symptoms and this can lead to misunderstandings about therapeutic support needs.'[41]

[39] https://www.bma.org.uk/media/2082/fetal-alcohol-spectrum-disorders-report-feb2016.pdf [7:2016]

[40] https://researchinformation.bris.ac.uk/ws/portalfiles/portal/180306963/McQuire_2018_FASD_screening_prevalence_FINAL_PUBLISHED_VERSION.pdf

[41] http://www.fasdnetwork.org/what-is-fasd.html

3.9 Education outcomes

3.9.1 Preschool development

The aim to have a joint development assessment and review process of children aged 2 with the health visiting service and early years provision is in progress. Identifying development needs earlier, communicating with the early years setting provider where this is available, encouraging reporting in the child held record [red book] where the parent gives permission are all steps being taken.

It is too early to report on the outcomes of joint conversation or review at 2 as training for the first two districts to implement this was starting in March 2020 as lockdown commenced and as such has been on hold. Nevertheless, the collaborative working across organisational boundaries to support children through the early years has been very productive.

3.9.2 Education attendance

At an England level in January 2017 22% had school attendance below 90%. In January 2019 this had increased to 24.6% with an EHCP, 17.9% with SEN compared to 9% with no SEN.[42]

In January 2017 7% had a fixed exclusion during the academic year. Amongst pupils from years R – 11 in Kent, 2.5% of all pupils had at least one fixed term exclusion during the academic year September 2018 – August 2019. Of these 6.7% were in pupils with SEND support and 7.4% on an EHC plan compared to 1.9% who had no SEN support.

There is no published up to date analysis regarding fixed exclusions in England. Please note this is expected to be published in July 2020.

3.9.3 Education attainment

The levels of attainment amongst those with SEN support show little change between 2017 and 2019 reporting[43] across the stages. The exception is at key stage [KS] four where there is reduction in attainment recorded amongst non-SEN support pupils and SEN support pupils. This is explained by the reform to GCSEs and different grading system which have led to a decrease in the 8 attainment scores graded 9-1.

Presentation of levels of educational attainment amongst pupils in Kent is shown in the final two figures.

[42] DfE May 2020 Special educational needs and disability: an analysis and summary of data sources https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882802/Special_educational_needs_and_disability_-_an_analysis_and_summary_of_data_sources.pdf

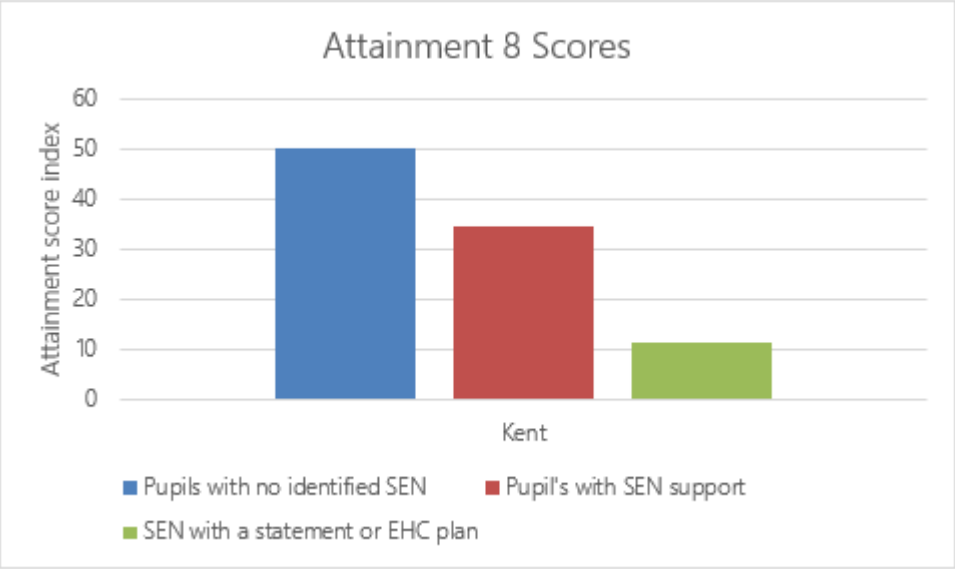
[43] DfE May 2020 Special educational needs and disability: an analysis and summary of data sources https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882802/Special_educational_needs_and_disability_-_an_analysis_and_summary_of_data_sources.pdf

Figure 40: Levels of educational attainment all pupils and SEND pupils, 2017 and 2019

	% all pupils		% SEN support		% EHCP	
	Jan 2017	Jan 2019	Jan 2017	Jan 2019	Jan 2017	Jan 2019
EYFSP- good level of development	79.4%	77%	25.2%	25%	3.1%	not available
EYFSP - Phonics	86%	89%	43.7%	43%	13.3%	not available
KS 2	72.4%	74%	21.9%	22%	9.5%	not available
KS 4	61.6%	49.9%	29.6%	27.6%	6.8%	not available

Source: DfE special education needs statistics

Figure 41: Attainment score for LAC with SEN, 2019



Source: Council for disabled children SEND dashboard April 2020[44]

Summary of key observations

- The breadth and range of health inequity is highlighted by which professional development, family support and service development can change.

[44] https://councilfordisabledchildren.org.uk/help-resources/resources/0-25-multi-agency-send-data-dashboard

4. Covid 19: Impacts on the health and education of those with SEND

School and health care service 'closures mean that individuals with autism spectrum disorder are receiving fewer, if any, crucial therapy hours (e.g. speech therapy, behavioural therapy, and occupational therapy) and classroom time than they normally would. The effects of this pandemic present a profound change of routine for these individuals, which is a considerable challenge, both for them and for their caregivers.'[45]

Opportunity to receive tuition virtually or maintain the routine of attending school have been made available however the percentage of families taking up this offer in Kent has remained low. Of the 23 special schools in Kent most have been open during the lockdown period. The consistency of the offer and capacity of these has been increasing. Levels of anxiety about preparing and attending school may have changed behaviour whilst the disruption to routine may have been difficult to manage in families.

Those individuals with learning disabilities are at greater risk of covid 19 because of co-morbidities such as diabetes alongside the challenges of understanding and compliance of social distancing. More evidence is being collated to identify this further.

The experiences of isolation will have exacerbated the emotional and mental health and wellbeing on the SEND population. For some levels of anxiety will have reduced and others it will have increased. Please note that the adverse effects of some medications taken by those with SEND impact on emotional mental health and wellbeing. These are presented in the appendices.

As the lockdown has continued the resilience of families to maintain and cope with challenges will have been stretched. The need for services and support will escalate. Reviews have also noted the adverse effects of school closure, transmission from children to vulnerable grandparents, loss of education, harms to child welfare particularly among the most vulnerable pupils, and nutritional problems especially to children or whom free school meals are an important source of nutrition.'[46]

[45] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30197-8/fulltext
[46] Viner et al *School closure and management practices during coronavirus outbreaks including COVID-19: a rapid systematic review* [2: 2020] https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30095-X/fulltext

Appendix A

Figure A: School aged pupils with SEND support or EHCP in Kent by ethnic group- 2019

Ethnicity category	Ethnicity group	Pupils	Pupils % by ethnicity	Pupils with SEND support	SEND support % by ethnicity	Pupils with an EHCP	EHCP % by ethnicity
White	White - British	166,762	78.3%	17,101	83.2%	6,557	83.0%
	Any other white background	12,358	5.8%	922	4.5%	328	4.2%
	Gypsy / Roma	2,092	1.0%	414	2.0%	59	0.7%
	White - Irish	540	0.3%	49	0.2%	20	0.3%
	Traveller of Irish Heritage	168	0.1%	43	0.2%	8	0.1%
White		**181,920**	**85.4%**	**18,529**	**90.2%**	**6,972**	**88.2%**
Asian or Asian British	Indian	4,058	1.9%	187	0.9%	72	0.9%
	Any other Asian background	2,817	1.3%	124	0.6%	77	1.0%
	Bangladeshi	989	0.5%	69	0.3%	37	0.5%
	Pakistani	689	0.3%	49	0.2%	10	0.1%
Asian or Asian British		8,553	**4.0%**	429	**2.1%**	196	**2.5%**
Black or Black British	Black - African	5,272	2.5%	266	1.3%	141	1.8%
	Black Caribbean	481	0.2%	44	0.2%	17	0.2%
	Any other Black background	367	0.2%	24	0.1%	15	0.2%
Black or Black British		**6,120**	**2.9%**	**334**	**1.6%**	**173**	**2.2%**
Mixed/Dual background	Any other mixed background	4,852	2.3%	355	1.7%	151	1.9%
	White and Asian	2,922	1.4%	166	0.8%	75	0.9%
	White and Black Caribbean	2,126	1.0%	248	1.2%	114	1.4%
	White and Black African	1,683	0.8%	148	0.7%	65	0.8%
Mixed/Dual background		**11,583**	**5.4%**	**917**	**4.5%**	**405**	**5.1%**
Chinese		**664**	**0.3%**	**29**	**0.1%**	**17**	**0.2%**
Any other ethnic group		**1,952**	**0.9%**	**120**	**0.6%**	**52**	**0.7%**
Information not yet obtained		**878**	**0.4%**	**82**	**0.4%**	**51**	**0.6%**
Refused		**1,237**	**0.6%**	**110**	**0.5%**	**36**	**0.5%**
Grand Total		**212,907**	**100%**	**20,550**	**100%**	**7,902**	**100%**

Source: KCC

Appendix B

Medication for those with SEND

A. Medications which might impact on weight gained

The types of medication that can cause weight gain are mainly in the following classes:

- Drugs used in diabetes
- Antipsychotics
- Antidepressants
- Epilepsy medicines
- Steroid hormones (e.g. prednisolone and contraceptives)
- Antihypertensives

(NB: some medicines in these classes will cause weight loss.)

The mechanism of weight gain is varied depending on medicines type. Weight gain can be caused by:

- Stimulation of appetite
- A decrease in body metabolism
- Alteration in how the body stores and absorbs sugars and minerals
- By causing tiredness and shortness of breath and thus decrease in exercise.
- Retention of water

Appendix C

Medications that may impact negatively on emotional and mental health

Antiepileptics

Suicidal ideation and behavior have been reported in patients treated with anti-epileptic agents in several indications.

Antiepileptics have the following adverse effects, prevalence of which varies with the individual drugs and presence of pre-existing psychiatric disorders: paranoid and hallucinatory symptoms, anxiety, agitation, withdrawal, anxiety, sleep disturbances hostility, confusion and emotional lability, depression, nervousness, thinking abnormally, tics.

Drugs that enhance neuromuscular transmission

Neostigmine: No behavioural or psychiatric side effects noted

Methylprednisolone: potentially severe psychiatric adverse reactions may occur - depressed mood or suicidal ideation is suspected

Skeletal Muscle Relaxants

Dantrolene: Mental depression, mental confusion, insomnia, nervousness (not usually used in children)

Baclofen: sedation, suicide and suicide-related events, lassitude, exhaustion, confusional state, dizziness, headache, insomnia, euphoric mood, depression, hallucinations, nightmares,

Diazepam: Sedation, psychiatric and paradoxical reactions such as excitation, restlessness, agitation, irritability, aggressiveness, delusion, rages, hallucinations, psychoses, memory loss, nightmares, inappropriate behaviour and other adverse behavioural effects. Emotional poverty decreased alertness and depression.

Attention Deficit Disorder

Dexamphetamine: Administration of stimulants may exacerbate symptoms of behaviour disturbance and thought disorders in patients with a pre-existing psychotic disorder. The following have been reported as adverse effects: aggressive behaviour, anxiety, confusion, delirium, depression, drug dependence, dysphoria, emotional lability, euphoria, hallucination, impaired cognitive test performance, insomnia, irritability, libido altered, nervousness, night terrors, obsessive-compulsive behaviour, panic states, paranoia, psychosis/ psychotic reactions, restlessness, tics

Bupropion: Insomnia Depression, agitation, anxiety, delusions, paranoid ideation, restlessness, aggression Suicidal ideation and suicidal behaviour, psychosis

Analgesics

Centrally acting e.g. morphine, buprenorphine: anxiety, nervousness, hallucinations

Tramadol: Psychiatric reactions have been reported

Drugs used in diabetes

Metformin: none limited studies

Gliclazides: none

Appendix D

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